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PUBLIC PRIVATE PARTNERSHIP IN HEALTH SECTOR A CASE STUDY IN JHANSI DISTRICT OF UTTAR PRADESH, INDIA

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CONTENTS

		Page No.
ABBREVIATIONS		5
ACKNOWLEDGEMENTS		6
1.	INTRODUCTION	7
1.1	Relevance and Justification	9
1.2	Research Objectives	12
1.3	Research Questions	12
1.4	Hypothesis	12
1.5	Methodology	13
1.6	Source of Data	15
1.7	Limitations of the Research	15
1.8	Organization of the Research Paper	15
2.	THEORETICAL FRAMEWORK	16
2.1	Definitions	16
2.2	Why PPP?	18
2.3	Stakeholder Analysis	19
3.	ANALYSIS OF DATA AND FINDINGS	22
3.1	Jhansi District – Background	22
3.2	UPHSDP and its innovative project	22
3.3	Identification of Private Partners	25
3.4	Background of NGOs	25
3.4.1	Rashtriya Nirman Yojana	25
3.4.2	St. Paul's Charitable Education Society	26
3.4.3	Jan Sahayogi Sanstha	27
3.4.4	Jan Jagrati	28
3.4.5	Rajput Khadi Gramodhyog Sansthan	28
3.5	Contract Agreement – Terms and Conditions	29
3.6	Stakeholder Analysis	31
3.6.1	Beneficiaries	33
3.6.2	UPHSDP/Public Partner	36

3.6.3	NGOs/Private Partners	37
3.6.4	Staff Employed by NGOs	38
3.6.5	Health Department Officials	38
3.6.6	District Administration Officials	39
3.6.7	Community	40
3.6.8	Quacks	41
3.7	Mutual Benefits to Public and Private Partners	42
3.8	Strengths and Weaknesses	43
3.8.1	Year of Implementation	50
3.8.2	Length of Partnership	50
3.8.3	Partners and Their Profile	51
3.8.4	Motive of the Private Partners	51
3.8.5	Target Population and Coverage Area	52
3.8.6	Type of Partnership	52
3.8.7	Objectives of the Partnership	53
3.8.8	Selection Criteria	53
3.8.9	Services Offered	54
3.8.10	Payment Mechanism	54
3.8.11	Staff and Their Management	55
3.8.12	Constraints of the Private Partners	55
3.9	Access to Health Care and Addressing the Health Concerns of Deprived Sections of the Society	56
4.0	CONCLUSION	59
	BIBLIOGRAPHY	65
	ANNEXURES	68

ABBREVIATIONS

ADPM	Additional District Project Manager
AIDS	Acquired Immuno Deficiency Syndrome
ANM	Auxiliary Nurse Midwife
APHC	Additional Primary Health Centre
APL	Above Poverty Line
BC	Backward Class/Caste
BPL	Below Poverty Line
CHC	Community Health Centre
CMO	Chief Medical Officer
DPM	District Project Manager
DPMU	District Project Management Unit
FC	Forward Class/Caste
IAS	Indian Administrative Service
IFPS	Innovations in Family Planning Services
NGO	Non-Governmental Organization
ODA	Overseas Development Administration
PHC	Primary Health Centre
PPP	Public Private Partnership
PRA	Participatory Rural Appraisal
RPMU	Regional Project Management Unit
SC	Scheduled Caste
ST	Scheduled Tribe
SIFPSA	Small Innovations in Family Planning Services Agency
UP	Uttar Pradesh
UPHSDP	Uttar Pradesh Health Systems Development Project
USAID	United States Agency for International Development

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After working in various positions in the districts as well as secretariat of the Government of Uttar Pradesh for about nine years, I was toying with the idea of taking a break to pursue my academic interest that was rekindled while I was doing MA (Economics) in 2004 after leaving the college in 1994. Government of India's scheme to send civil servants abroad for long term training perfectly fitted my bill and that is how I landed in The Netherlands. I am grateful to the Government of India for selecting me for this programme and to the Government of Uttar Pradesh for permitting me to pursue my studies. Being a post graduate in agriculture, I was thinking of doing research in crop insurance or minimum support price mechanism. But getting data was proving difficult and time was fast running out. Then I started thinking that I should choose a different field. At about the same time, during one of our weekly long walks to 'open market' Mr Sanjeeva Kumar, IAS mooted the idea of doing research in health or power sector. Having seen the difficulties of poor people in accessing quality healthcare, as District Magistrate in five districts, health sector appealed to me. Thus began the journey for this research paper. I am grateful to him for proposing this topic and for all his valuable suggestions.

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Chapter 1

Introduction

Since independence in 1947 India has achieved significant progress in the field of health. Life expectancy has more than doubled from 32 years in 1947 to 66 years in 2004 while in the corresponding period infant mortality has fallen by over 60%. Smallpox and guineaworm have been eradicated while polio and leprosy are on the verge of being eradicated. On the other hand, infant and maternal mortality rates have stagnated since the 1990s. India has one-fifth of world diseases including a third of diarrhoeal diseases and Tuberculosis and a fifth of diabetes. It has also been estimated that by 2015 the incidence of HIV/AIDS will triple, cardiovascular disease and diabetes will more than double, cancer will increase by 25% and more number of people will suffer from mental ill health (Government of India 2005:3-4). According to recent report of UNAIDS, India has the highest number of HIV/AIDS affected people[1]. A clear shift is taking place from communicable diseases to life-style related chronic diseases.

Three major factors for this state of affairs of India's health are poor governance and ineffective role of the state, lack of strategic vision and weak management (Government of India 2005:3-4). In the World Bank's view, poor public health service delivery, lack of health system oversight, unpaid attention to ambulatory curative services, poor inpatient care and low health financing are major concerns of India's health sector (World Bank 2002: 9).

With a population of 166.20 million[2] in 2001, Uttar Pradesh is India's most populous state. All over the world governments play a vital role in providing health services to the people as health is a public good (Wang 2000: 3). The Indian state of Uttar Pradesh has a vast network of public and private hospitals. About 55% of all beds are in public hospitals; the rest is in private sector (Chakraborty 2003: 261). Bed occupancy rate is 30% in public sector and 45% in private sector. One reason for this low utilization is poor quality (World Bank 2000: 3-4). Some important problems that plague UP's health sector are:

[1] http://data.unaids.org/pub/GlobalReport/2006/2006_GR_ANN2_en.pdf accessed on 12 October 2006.
[2] http://www.censusindia.net accessed on 19 May 2006.

(a) Resource constraints:

- Funds - While per capita household expenditure on health in UP for 2004-2005 was Rs 924, per capita government expenditure was Rs 150. Public spending on health for 1998-99 for UP was 0.91% of Gross State Domestic Product. The share of health in the revenue budget has come down from 7.67% in 1985-86 to 5.75% (budget estimate) in 2004-05 (Government of India 2005: 70&72).
- Lack of sufficient medicines and medical equipment due to financial constraints.

(b) Human resource issues:

- Unauthorized absence of doctors and paramedical staff from duty
- Disproportionately higher number of doctors and paramedical staff in urban areas
- Doctors and paramedical staff in rural areas, especially remote areas, are fewer than the number of posts created for a particular hospital
- Discourteous staff
- Moonlighting is common among government doctors
- Insufficient numbers of doctors and paramedical staff – According to the World Health Report 2006, the ratio of physicians per 1000 people in India is 0.60 which is comparable to developing countries like Srilanka (0.55), Malaysia (0.70) and China (1.06) but lower than developed nations like Australia (2.47), Canada (2.14), UK (2.30) and US (2.56)[3]. Against the requirement of 35 medical colleges calculated as per the norm of one medical college for five million people, UP has only 12 medical colleges with 1262 seats (Government of India 2005: 61).

(c) Systemic problems:

The Indian health system is affected by many systemic problems like corruption at various levels, poor service quality in public hospitals, poor disease surveillance mechanism, insensitivity of medical bureaucracy, concentration of trained private practitioners especially in the urban centres and presence of quacks in villages and small towns. In Uttar Pradesh, accessing public health facilities is a major problem for people living in remote areas; this situation is being exploited by quacks. According to recent

[3] http://www.who.int/whr/2006/annex/06_annex4_en.pdf accessed on 13 October 2006.

reports, there are 32,245 unqualified and unregistered medical practitioners in UP (Hindustan Times 2006).

Because these problems afflict the health sector, many people seek the services of private for-profit providers. Due to the absence of well developed health insurance schemes, people pay out-of-pocket. It has been estimated that private health spending accounts for more than 84 per cent of all health spending in India and one-fourth of Indians who are hospitalized become poor (World Bank 2002: 3-4). This situation is double blow to the poor: they suffer from their inability to afford costly healthcare services, and costly care plunges them further into poverty.

1.1 Relevance and Justification:

The Government of Uttar Pradesh has initiated comprehensive public sector reforms. Reforms are either underway or have been planned in the areas of governance, fiscal management and civil service renewal. Reforms are also in progress in key sectors of the economy like power, public enterprises, transport, irrigation, health and education (World Bank 2000: 4). The following issues in health sector have attracted the attention of the Government of Uttar Pradesh and have led to embarking on health system reforms (UPHSDP 2001: 15-17):

- Inadequate health budget – decline to 4.7% of revenue expenditure of the state in 1998-99 from 6.0% in 1997-98
- Imbalanced expenditure – wage bill has increased from 68% in 1991-92 to 77% in 1997-98 of total expenditure due to upward revision in scale of pay
- Problem of incremental budgeting – budgetary allocation is hiked on incremental basis
- Problem of levying user charges – those who can afford to pay are not charged adequately
- Inadequacy in developing strategies to cope with future health needs resulting in ad hoc measures
- Lack of accountability to the public
- Mindless expansion of public hospitals without equipping the existing ones with sufficient staff and equipment and without putting them to optimum use
- Accessibility problem for marginalized sections of the society

- Poor quality of service in government hospitals and lack of proper mechanism to ensure quality
- Staff shortage and lack of proper training
- Inadequate attention paid to utilize the services of private health providers
- Inefficient delivery services which could otherwise be improved through contracting
- Plethora of programmes at the state level and lack of coordination among the agencies implementing them

Uttar Pradesh Health Systems Development Project, a World Bank funded project, is an important step to address these problems. Four pillars of this project are (i) policy reforms, (ii) strengthening and renovating existing resources, (iii) skill development of human resources and (iv) public and private partnership[4].

In addition to UPHSDP, few other programmes are also being implemented by the Government of UP. Some aid agencies are supporting these initiatives of the state government. To implement some of the policy reforms, the government has set up State Innovations in Family Planning Services Project Agency (SIFPSA). It is implementing the United States Agency for International Development (USAID) aided Innovations in Family Planning Services (IFPS) in order to make high quality family planning and reproductive health services available to the people of the state through developing partnership between the public and private sectors[5]. Apart from IFPS, USAID supports the following programmes in UP's health sector:

1. Reproductive, Child Health, Nutrition and HIV/AIDS (RACHNA)[6] provided through *anganwadis* (mother-and-child care centres)
    - food rations to women and children
    - micronutrient supplements such as iron-folate and vitamin A
    - antenatal care
    - child immunization against six vaccine-preventable diseases
    - birth-spacing options for couples

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[4] http://uphealth.up.nic.in/uphsdp/profileobjectives.htm accessed on 20 May 2006.
[5] http://www2.usaid.gov/in/our_work/activities/Health/health_ifps.htm accessed on 20 May 2006.
[6] http://www2.usaid.gov/in/our_work/activities/Health/health_rachna.htm accessed on 20 May 2006.

- education about HIV/AIDS
- promoting safe sex
- fostering practices for child growth during the first six years of life
- teaching methods to ensure better health and nutrition

2. Micronutrient A2Z[7] helps to improve micronutrient status of those people who are at risk
3. Program for Advancement of Commercial Technology – Child and Reproductive Health (PACT-CRH)[8] helps the private sector in developing capability to supply products and services of high quality health technologies and to create public demand for them
4. Polio Eradication[9]
5. Urban Child Health Program's[10] objective is to improve health of urban poor.

The European Commission and the UK Department for International Development (DFID) also play significant roles in UP's health sector reforms. The European Commission Health and Family Welfare Sector Programme[11] targets decentralization, better management, capacity building, quality improvement and sustainability. DFID supports the national polio vaccination campaign and the national AIDS control programme and also is developing a Reproductive and Child Health-2 Programme to enable the government to achieve the following Millennium Development Goals – (i) Goal 4: Reduce infant and child mortality rates by two-thirds by 2015, (ii) Goal 5: Reduce maternal mortality ratios by three-quarters by 2015 and (iii) Goal 6: Halt and reverse the spread of HIV, TB and malaria by 2015[12].

Among the different reform measures being taken up by the government to deal with the various issues mentioned earlier, Public-Private Partnership assumes significance because of the significant role played by the private sector in offering health

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[7] http://www2.usaid.gov/in/our_work/activities/Health/health_a2z.htm accessed on 20 May 2006.

[8] http://www2.usaid.gov/in/our_work/activities/Health/health_pact.htm accessed on 20 May 2006.

[9] http://www2.usaid.gov/in/our_work/activities/Health/health_polio.htm accessed on 20 May 2006.

[10] http://www2.usaid.gov/in/our_work/activities/Health/health_uchp.htm accessed on 20 May 2006.

[11] http://echfwp.com/ accessed on 20 May 2006.

[12] http://www.dfidindia.org/states/national.htm accessed on 20 May 2006.

services to the people of the state. Out of 37,903 doctors registered with Indian Medical Council, Uttar Pradesh, 29,398 doctors are in private sector. The number of beds in public and private sectors in UP are 57,227 and 46,269 respectively (UPHSDP 2001: 5-6).

Due to the significant presence of private health providers in UP, PPP has huge potential for the future. The National Commission on Macroeconomics and Health set up by the Government of India also recognizes the future importance of PPP (Government of India 2005: 54-55). As of now, the potential of private providers has not been properly tapped in Uttar Pradesh. Recently some private for-profit providers have been appointed on a contract-basis to tackle the problem of shortage in government hospitals, and an experiment is being carried out by Uttar Pradesh Health Systems Development Project in partnership with not-for-profit private providers to deliver primary health care services. This research looks at the UPHSDP-NGO partnership in providing preventative and limited curative health care in Jhansi district of Uttar Pradesh, India.

1.2 Research Objectives:

1. To review the functioning of UPHSDP-NGO model of PPP in Jhansi district of Uttar Pradesh.
2. To understand the perspective of various stakeholders of this PPP model.
3. To review the perceived strengths and weaknesses of this model.
4. To know the impact of PPP model on coverage of and access to healthcare.

1.3 Research Questions:

1. How do different stakeholders perceive the PPP model under study?
2. How were the private partners identified?
3. What are the terms and conditions of contract agreement?
4. What are the mutual benefits to public and private partners?
5. How are the needs of poor and other deprived sections of the society addressed by this model?
6. What are the strengths and weaknesses of this model?

1.4 Hypothesis:

The study will test the hypothesis that Public-Private Partnership in the health sector leads to increased coverage and better access.

1.5 Methodology

The Uttar Pradesh Health Systems Development Project (UPHSDP), a World Bank funded project of Government of Uttar Pradesh, is experimenting with an innovative scheme in 28 out of 70 districts of Uttar Pradesh in partnership with non-governmental organizations (NGOs). The main objective of this project is to provide preventive and limited curative health care services to the disadvantaged sections of the society in remote areas where access is a main problem.

Out of 28 project districts, Jhansi district in the backward Bundelkhand region has been selected for the study. In the year 2005-06, five NGOs were selected under the scheme of which four NGOs -- Rashtriya Nirman Yojana (National Construction Scheme), St. Paul's Charitable Education Society, Jan Sahayogi Sanstha (Public Assistance Organization) and Jan Jagrati (Public Awareness) -- were allotted 13, 10, 11 and 7 villages respectively. A fifth NGO, Rajput Khadi Gramodhyog Sansthan (Raiput Khadi Village Industries Organization), was allotted seven slums of Jhansi Municipal Corporation.

Stakeholder analysis has been done to assess the views and stakes of stakeholders through focused group discussions and semi-structured interviews. To know the views of beneficiaries and community, two villages were selected per NGO among those NGOs that worked in the rural area and one slum was selected in case of the NGO that worked in the urban area. The villages selected were Motikatra and Virauna covered by Rashtriya Nirman Yojana, Ahraura and Kakarvai covered by St. Paul's Charitable Education Society, Parasar and Mavaigrid covered by Jan Sahayogi Sanstha, and Patha and Dhakkarwara covered by Jan Jagrati. In case of Rajput Khadi Gramodhyog Sansthan, Dadiapura slum was selected. A list of beneficiaries and other stakeholders who were interviewed is shown in Annexure 1.

Stakeholder analysis reveals the views and stakes of various stakeholders mentioned below (checklist used to elicit the views of stakeholders is given in Annexure 2).

1. Beneficiaries – 49 beneficiaries were interviewed. Those who were present at the site at the time of interview were chosen.

2. UPHSDP/Public partner – Project Director of UPHSDP and seven other officials shared their experience and views.

3. NGOs/private partners – views of five office bearers one from each NGO were elicited

4. Staff employed by NGOs – Views of three doctors, one health supervisor and one dai were ascertained.

5. Officials of health department – Chief Medical Officer, Deputy Chief Medical Officer who had earlier served as District Project Manager, State NGO Coordinator and accountant were interviewed.

6. Officials of district administration – Held discussions with the present District Magistrate, ex-District Magistrate and District Economic and Statistical Officer.

7. Community – Views of four Gram Pradhan (elected head of village panchayat), one ex-pradhan and one ward member were obtained. Scores of other people also took part in discussion.

8. Quacks – one quack was interviewed.

Based on the following parameters, strengths and weaknesses of the model have been assessed:

a. Year of implementation
b. Length of partnership
c. Partners and their profile
d. Motive of the private partners
e. Target population and coverage area
f. Type of partnership
g. Objectives of the partnership
h. Selection criteria
i. Services offered
j. Payment mechanism
k. Staff and their management
l. Constraints of the private partners

1.6 Source of Data

The study involved use of primary as well as secondary data. Primary data were obtained through focused group discussion and semi-structured interview with the help of a checklist from various stakeholders (Annexure 2). Secondary data were compiled from books, journals, internet sources, Project Directorate of Uttar Pradesh Health Systems Development Project etc.

1.7 Limitations of the Research:

This research has the following limitations:

1. Bundelkhand is the most backward region of the state. Different regions of the state have different geographical nature and the private partners' activities are limited to one or few districts. So certain findings of this study may not hold good for other regions of the state.
2. Stakeholder analysis as a tool has certain limitations. It 'often involves sensitive and undiplomatic information. Many interests are covert, and agendas are partially hidden' (ODA 2005). Though utmost care was taken to elicit correct information from various stakeholders, some stakeholders may not have been forthright in answering at least some questions because the researcher is a civil servant in UP.
3. When conducting field research in August 2006, health posts run by NGOs were not functional. It would have been better had they been functional at the time of conducting the interviews.

1.8 Organization of the Research Paper:

The research paper has four chapters. Chapter 1 deals with the general state of health in India with specific reference to Uttar Pradesh, problems being faced by the health sector of Uttar Pradesh, importance and relevance of the research topic, objectives of the research, research questions, hypothesis to be tested, methodology, source of data and limitations of the research. Details of the theoretical framework of Public-Private Partnerships and various concepts involved are explained in Chapter 2. Chapter 3 analyses the data obtained during fieldwork in Jhansi district of Uttar Pradesh and summarizes the findings. Chapter 4 provides conclusions of the study and recommendations.

Chapter 2
Theoretical Framework

This chapter defines the various concepts involved in PPP, explains the importance of PPP and elucidates stakeholder analysis.

2.1 Definitions:

The public sector includes all 'organizations and institutions that are financed by state revenue and that function under government budgets. They include government departments, semi-autonomous bodies, civic bodies, agencies, etc. Public sector partners may include national government, district administration, municipal authorities, local government bodies, parastatal corporations, state universities and research organizations' (Venkatraman and Bjorkman 2006: 2). The private sector consists of both private for-profit and not-for-profit (NGO) providers. According to Venkatraman and Bjorkman the private health sector includes individual medical practitioners, diagnostic centres, ambulance providers, blood banks, commercial operators, religious institutions, charitable institutions, philanthropic institutions, industrial establishments, local or international development organizations and community groups. For Bennett (1981 cited in Aljunid 1995: 333), the private sector includes all those organizations and individuals working outside direct state control; it includes both for-profit individuals and organizations and not-for-profit organizations. According to Claquin (1981 cited in Aljunid 1995: 333), private practitioners are 'individuals who were perceived by the community to provide resources and assistance in illness but were not employed by the government health service'.

The term 'partnership' has been defined differently by different authors. Wang defines partnership as "any form of joint effort or undertaking of public and private players for achieving common objectives. Sometimes sharing common objectives may not be a core condition since partners may have different views and objectives" (Wang 2000: 6). For Brinkerhoff, two elements which are important in partnership are mutuality and organizational identity; partnership is a "dynamic relationship among diverse actors, based on mutually agreed objectives, pursued through a shared understanding of the most rational division of labour based on the respective comparative advantages of each

partner. Partnership encompasses mutual influence, with a careful balance between synergy and respective autonomy, which incorporates mutual respect, equal participation in decision making, mutual accountability and transparency" (Brinkerhoff 2002: 21). According to Paoletto (2000) who defines partnership as "collaborative activities among interested groups, based on mutual recognition of respective strengths and weaknesses, working towards common agreed objectives developed through effective and timely communication", four conditions need to be met for a partnership to occur. These are: a) the partners should have common objectives; b) there should be an agreement between the partners to undertake certain activities; c) these activities should build on each other's strengths and d) these actions should overcome weaknesses. For the World Health Organization, partnership is a "means to bring together a set of actors for the common goal of improving the health of the population based on mutually agreed roles" (WHO 1999 cited in Venkatraman and Bjorkman 2006: 4). The common elements of partnership are 'beneficence (public health gains), non-malfeasance (must not lead to ill health), autonomy (of each partner), jointness (shared decision-making) and equity (benefits to be distributed to those in need)' (Venkatraman and Bjorkman 2006: 4).

While characteristics of the subjects like socioeconomic status, ethnicity, age, gender and sources of finance, characteristics of the disorder and characteristics of the service like geographical accessibility, quality of care, price of care and type of services available influence utilization of health services (Aljunid 1995: 335-341), the success of the partnership depends on various factors. Perceived need, willingness and ability to collaborate are important (Bazzoli *et al* 1997: 537). Samii *et al* (2002) classify the factors responsible for successful management of partnership into three categories: (i) pre-formation features including selection of partners, size of partnership, the learning and unlearning process and context of partnership; (ii) key formation features like resource dependency, commitment symmetry, performance symmetry, common goal symmetry, cultural appreciation symmetry and converging working cultures and (iii) post-formation conditions like leadership, partnership team, intensive communication, consensus-building approach, immediate implementation and alignment of cooperation learning capability.

2.2 Why PPP?:

Public Private Partnership in the provision of public services is a concept that started in the industrialized countries. But Paoletto (2000) argues that partnership is something basic to human nature and it can work in any society. Partnership between public and private sectors in health sector is desirable since each sector has certain advantages and certain disadvantages. Health being a public good, it is the duty of the government to ensure that every citizen has adequate access to proper healthcare at affordable prices. The public sector has the advantage of vast network and resources. On the other hand, the private sector is considered to be more flexible, responsive and innovative than the public sector (Brinkerhoff 2002: 24) but its reach may not be as good as that of the public sector and it does not address equity concerns of the government as profit is the main motive of private for-profit providers.

Though commitment to public service and not profit is the driving force behind the activities of private not-for-profit providers, their presence is limited. In India, the especially prominent role of the NGO sector is limited to some poor and backward areas, especially those areas inhabited by tribals (World Bank 2001: 4). NGOs play an important role in many areas of Uttar Pradesh (UPHSDP 2001: 5). The motives of NGO and for-profit providers are different. Unlike NGOs, profit is the main motive of for-profit providers. Hence government can make better use of one of these two depending on the context (Chakraborty 2005: 353). The governments are not able to keep pace with ever increasing demands by an ever increasing population and very often chunks of public money that could have been otherwise spent on primary health care goes to tertiary institutions (Mitchell 2000: 62). In UP 61.18% of health budget was spent on primary health care in 2001-02 and the corresponding figures for secondary and tertiary health care were 21.62% and 7.8% respectively; the balance was spent to meet administrative expenditure and on social health insurance and research and training (Government of India 2005: 78). Though the budget allotted to primary healthcare in UP is sizable, more funds are required to meet the demands of its burgeoning population.

The role of government is important in overcoming market failures, providing for the poor, the rural and under-served populations, implementing appropriate regulations to ensure quality and controlling costs. The private sector can be expected to shoulder

greater responsibility in improving quality, improving customer service, improving management standards investing research and development, developing market-based systems of rationing and developing new services (Bloom *et a*l 2000: 25-27). It is assumed that partnership will (a) reduce the financial burden of the government, (b) strengthen the capacity of the private sector to cater to the health needs of the people and (c) improve the quality of health care through improved management structures (Kumar 2003: 3041). But Maynard has a word of caution when he says that 'market defects ensure that health care markets both private and public fail to generate efficiency or the achievement of distributional targets' (Maynard 1986: 1161).

2.3 Stakeholder Analysis:

Overseas Development Administration (ODA) defines stakeholder analysis as 'identification of a project's key stakeholders, an assessment of their interests, and the ways in which these interests affect project riskiness and viability' and stakeholders are 'persons, groups, institutions with interests in a project or programme' (ODA 1995). According to the World Bank,[13] 'any entity with a declared or conceivable interest or stake in a policy concern' is a stakeholder. Stakeholders can be classified as primary and secondary stakeholders. Primary stakeholders are those who are 'ultimately affected, either positively (beneficiaries) or negatively (for example, those involuntarily resettled) and 'intermediary in the aid delivery process' are called secondary stakeholders (ODA 1995). Allen and Kilvington (2001) define primary stakeholders as 'immediate communities of interest' and 'the intermediaries in the process' which 'may include government agencies and other institutional bodies' are defined as secondary stakeholders.

Not all stakeholders have equal power and influence. Different strategies need to be adopted to enlist the support of various stakeholders for successful implementation of any policy or programme or project. Some stakeholders are 'key stakeholders' who 'can significantly influence, or are important to the success of the project' and influence is the ability of the stakeholders 'to persuade others or coerce others into making decisions, and following certain courses of action' (ODA 1995). According to Overseas Development

[13] http://www1.worldbank.org/publicsector/anticorrupt/PoliticalEconomy/PDFVersion.pdf accessed on 24 October 2006.

Administration (1995), relative power and influence of stakeholders depend on many things. In formal organizations factors like legal hierarchy, what kind of authority the leadership has over others, who controls the resources, kind and extent of knowledge one possesses and strength vis-à-vis other stakeholders are important. Among primary stakeholders and informal interest groups, their socio-economic status, quality of leadership, the extent to which they control strategic resources, their influence on other stakeholders through informal means and their extent of dependence on other stakeholders matter much.

Stakeholder analysis involves three steps: drawing up stakeholder table, assessing the importance of each stakeholder to project success and identifying the risks and assumptions that will affect success and design of the project (ODA 1995). According to Allen and Kilvington (2001), conducting a stakeholder analysis involves (i) identifying major stakeholder groups, (ii) determining interests, importance and influence and (iii) establishing strategies for involvement.

As per the World Bank[14], stakeholder analysis should normally be done in the early stage of policy formulation and ideally it should be done before implementing the proposed reform so that potential obstacles can be identified and tackled.

Stakeholder analysis is a useful tool in knowing the interests of various stakeholders, in assessing how these interests will affect the project, in exploring how coalitions of stakeholders can be built upon and in assessing appropriate kind of participation (ODA 1995). According to Allen and Kilvington (2001) it can be used to: "identify and define the characteristics of key stakeholders; draw out the interests of stakeholders in relation to the problems that the project is seeking to address (at the identification stage) or the purpose of the project (once it has started); identify conflicts of interests between stakeholders, to help manage such relationships during the course of the project; help to identify relations between stakeholders that may enable "coalitions" of project sponsorship, ownership and cooperation; assess the capacity of different stakeholders and stakeholder groups to participate; help to assess the appropriate type of participation by different stakeholders, at successive stages of the project cycle, e.g.

[14] http://www1.worldbank.org/publicsector/anticorrupt/PoliticalEconomy/PDFVersion.pdf accessed on 24 October 2006.

inform, consult, partnership – all of these have different possible models." As Schmeer[15] says this analysis enables 'policy makers and managers to interact more effectively with key stakeholders and to increase support for a given policy program.' But as made clear under 'limitations of the research', it is not always possible to get frank views of the stakeholders on all the issues.

[15] http://www.lachsr.org/documents/policytoolkitforstrengtheninghealthsectorreformpartii-EN.pdf accessed on 24 October 2006.

Chapter 3
Analysis of Data and Findings

3.1 Jhansi District – Background

The state of Uttar Pradesh is divided into 17 divisions and 70 districts for administrative convenience. Jhansi district is located in the backward Bundelkhand region and forms part of Jhansi division. The district has been divided into five tehsils/subdivions *viz.*, Jhansi Sadar, Moth, Mauranipur, Garautha and Tahrauli. For the purpose of developmental works, it has been divided into eight developmental blocks *viz.*, Moth, Chirgaon, Bamaur, Gursarai, Bangra, Mauranipur, Badagaon and Babina (District Socioeconomic Review 2006). The district is spread over an area of 5024 sq.km. It has a population of 17.44 lakh of which 10.33 lakh live in 760 villages that span 452 village panchayats and 7.11 lakh live in 17 urban centres that includes Jhansi Municipal Corporation. The sex ratio is 870 females for 1000 males. People belonging to Scheduled Castes and Scheduled Tribes constitute 28.8 percent of the district's population. The literacy rate is 51.6 percent but only 33.8 percent for women (Statistical Bulletin - Jhansi 2004 and SIFPSA 2004).

There are 1078 beds in hospitals run by the state government, 255 beds in hospitals run by the central government and its undertakings and 1200 beds in the private sector (personal communication, ADPM, UPHSDP, Jhansi 2006). Despite the wide network of public hospitals, people from over 70 per cent of the villages have to travel a distance of more than five kilometres to access an allopathic clinic run by the government (Statistical Bulletin - Jhansi 2004).

3.2 UPHSDP and its innovative project

With its Project Development Objective "to establish a well managed health system in Uttar Pradesh which delivers more effective services through policy reform, institutional and human resource development, and investment in health services", UPHSDP was launched on 26 July 2000. It initially had a total base cost of Rs 4.5 billion and a credit amount of SDR 70,560,000 from the World Bank. The Project has two main components *viz.*, (i) policy reform, management development and institutional strengthening and (ii) improving health service quality and access. (UP Health Systems Development Extension Project 2005). The policy reforms related to PPP include

regulating the private sector for which a draft bill has been prepared and is being deliberated upon at the government level. To improve access to and quality of healthcare NGO-run health post scheme has been introduced. According to Mr. S.K.Pandey, Financial Consultant, UPHSDP the project launched in July 2000 was scheduled to finish on 31 December 2005 and covered 28 districts. But since substantial funds remained unutilized by this date, the project was extended for a period of two years commencing from 1 January 2006. The extension project focuses on four districts; during this phase some activities including health posts have been retained.

The Project Directorate of UPHSDP or Project Management Unit (PMU) is the arm of Government of Uttar Pradesh to implement the World Bank funded scheme. In view of the poor state of health services in the public sector, this innovative scheme of health posts was perceived as a way to improve the existing system. It is headed by a senior officer of the Indian Administrative Service who is normally of the rank of Secretary to the state government, though the present Project Director is of the rank of Principal Secretary to the state government. Having an officer of this seniority to head the Project Directorate helps to sort out policy issues that are decided at the higher levels of government. In order to ensure that there are no policy level hitches at the higher level, two committees have been formed. One is a Project Governing Board headed by the Chief Secretary of the Government of Uttar Pradesh; the other is a Project Steering Committee headed by the Principal Secretary, Medical, Health and Family Welfare department. To ensure better coordination the Project Director of UPHSDP serves as member secretary of both committees (UPHSDP 2001).

The Project Director is assisted by a Chief Administration Manager, Additional Directors, a Finance Controller, a Chief Engineer (Civil) and these officers in turn are supported by an adequate number of junior officers and clerical staff. The Project Directorate staff include experts in the field of health, engineering and management. Most of the staff have been drawn from various departments of the state government on deputation basis. Next level below the PMU is composed of Regional Project Management Units (RPMU). Four RPMUs were created at Varanasi (for the eastern region), Meerut (for the western region), Jhansi (for Bundelkhand region) and Lucknow (for the central region). For the extension phase, these RPMUs have been abolished. The

third tier is the district. In each district a district project management unit (DPMU) has been created which was originally headed by an officer of the rank of Deputy Chief Medical Officer. For the extension project, the Chief Medical Officer of the district has been designated as District Project Manager; s/he is assisted by a Deputy District Project Manager (who is the Deputy Chief Medical Officer earlier served as District Project Manager) and other staff (UP Health Systems Development Extension Project 2005).

Since 2003-04 UPHSDP has experimented with a scheme of establishing health posts in partnership with NGOs in remote areas where access to healthcare is a problem. The objective of this scheme is 'to provide preventive and curative healthcare services to the disadvantaged section of the society specially the women and the poor'. Apart from offering natal and post-natal care as well as immunization, the health posts refer those patients who cannot be treated at their level to government hospitals. In districts with a medical college like Jhansi, patients are referred to medical college hospital too as and when the need arises.

According to Mrs. Neena Shukla, a Social Scientist in UPHSDP, altogether 72 NGOs took part in this scheme in 2003-04 and it was expanded in 2004-05 to 119 NGOs of which 52 NGOs were old and 67 were new. The agreement originally signed for 12 months was supposed to end in December 2005 was extended initially until March 2006, then until April 2006 and finally until May 2006. These extensions for short periods were necessitated since there was some delay in extending the project for a further period of two years. For 2006-07, 266 NGOs have been selected of which 67 are old. The villages to be covered by health posts and the location of health posts are decided in consultation with local health department officials. Once the NGOs are selected, they are required to conduct a baseline survey using the Participatory Rural Appraisal method. On the basis of this survey, a work plan is prepared before formally setting up health post. According to Dr I.K.Jain (DPM, Jhansi) and Dr O.P.Goel (ADPM, Jhansi) health posts were established in Jhansi for the first time in 2004-05 with the help of five NGOs. Of these five NGOs, four served rural areas and one served slum areas of Jhansi Municipal Corporation. For the current year (2006-07), in addition to these five NGOs, three more have been selected. All of them have started baseline survey work after signing agreements with UPHSDP.

3.3 Identification of Private Partner

Selection of the right NGOs is a critical component of the scheme. According to Dr. O.P.Goel (ADPM, Jhansi) and Mrs. Neena Shukla (UPHSDP Social Scientist) applications were invited from eligible NGOs through advertisement in local newspapers. Only those NGOs which had been registered under the relevant laws and could produce audited income and expenditure statement for last three years could apply under the scheme. The requirement to be based in the district effectively prevented outside NGOs without any local base from applying under the scheme. Having 'service in health sector' as an objective was another requirement though prior experience in health sector was not necessary. Eligible private partners were also required to have necessary staff and sufficient infrastructure. The terms 'necessary staff' and 'sufficient infrastructure' were not properly defined and were left to be assessed by the public partner. Applications received in response to the advertisement were scrutinized at the district level and negotiations were held with NGOs regarding the area in which to set up a health post. Those NGOs that were eligible in the eyes of district project management unit and were willing to work in the area identified were recommended to the regional committee. The regional committee more or less finalized selection of private partners although final and formal approval was given by the Project Directorate.

For 2006-07, although eligibility conditions remained the same, private partners had to apply to the Project Directorate directly. The latter in turn, had the applications scrutinized by Indian Institute of Management in Lucknow before giving final approval. Thus district level officers were kept out of the loop.

3.4 Background of NGOs

3.4.1 Rashtriya Nirman Yojana (National Construction Scheme)

This NGO was registered on 18 November 1997 under the Societies Registration Act of 1860 and registration has been renewed to 16 November 2007. Mr. Pradoot Krishna Goswami is the chairman; there are ten other members. While two of them (including the chairman) claim 'social service' as vocation; others are engaged in service or business activity. It is not possible to survive by just doing 'social service'. They must be earning their livelihood out of running the NGO.

As per its regulations this NGO has thirty-five objectives covering a wide range of developmental activities of which eight are related to the health sector. It has the following experience: organizing training about health under Border District Cluster Project, taking up extension activities in 18 villages under Total Sanitation Campaign, involvement in Urban Reproductive and Child Health of European Commission, using PRA technique under SIFPSA project, training for rearing of poultry birds with the help of Krishi Vigyan Kendra (Farm Science Centre), Bharari and training under Rajiv Gandhi Rashtriya Peyjal Mission (Rajiv Gandhi National Mission for Drinking Water) in Chitrakoot district. Experience of this NGO is mainly in the area of organizing training programmes and has no prior experience in providing health services.

According to the Chairman, there are five full-time and two part-time employees. Annual turnover for 2005-06 was Rs 0.5 million which is expected to become Rs 1.8 million in the current financial year. It has worked in Gursarai block and covered a population of 14,891 spread over eleven villages. This NGO depends mainly on government funds for its existence.

3.4.2 St. Paul's Charitable Education Society

Registered on 9 July1998 and renewed to 8 July 2008, St. Paul's Charitable Education Society has nine objectives of which five are related to health care. Mr. Deepak Kumar is the chairman of this NGO. The management committee has nine other members. Except the chairman whose occupation is 'social service', others have some other job to do. According to Mr. Deepak Kumar, this NGO has experience of adopting 30 villages over five year period since 1999 for polio eradication with assistance from World Vision of India that is funded by USAID. It has organized vocational training to youth in TV and radio repair with assistance from Ministry of Youth Affairs of Government of India. Training for women in stitching was organized in 2005-06 which was sponsored by Ministry of Women and Child Development, Government of India. Other experiences are: organizing vocational training in repairing of pumpset and other electrical appliances for unemployed youth living below poverty line, running a school with classes upto fourth standard where food and stationery are provided free, taking up HIV/AIDS awareness programme from 2004 to 2006 in National Highways 25 with financial help form Nuffid Foundation (UK) and creating awareness about HIV/AIDS

programme through funds made available by Uttar Pradesh AIDS Control Society. This NGO's experience in health sector is mainly limited to awareness creation.

In the financial year 2005-06, the NGO had a turnover of Rs 1.6 million of which about Rs 0.8 million was from foreign funding agencies and Rs 0.2 million was donated by churches and other Christian organizations. The NGO employs ten persons full-time and eleven part-time. Besides, there are 32 volunteers. Among the five NGOs studied, this was the only one that got some funds from foreign sources. It covered ten villages of Bamaur block with a population of 12,653.

3.4.3 Jan Sahayogi Sanstha (Public Assistance Organization)

This organization was registered on 22 October 2000 which has been renewed to 21 October 2010. Its board consists of fifteen members including the chairman; 'social service' is the main occupation of three of them. All of them are educated with at least degree. It shows that setting up an NGO is a source of livelihood for educated and unemployed people. Mr. Inderjeet Singh is the Chairman and Mr. Ram Swaroop Pal is the Manager. A key person of this NGO, Mr. Pal was originally an employee of the health department who had worked as male social worker and extension educator before retiring in 1996 as health education instructor at Jhansi Regional Health and Family Welfare Training Centre. Out of fifteen objectives of this organization, three are related to health. This NGO has organized eye camps under the aegis of District Blindness Control Society which is a government body headed by the District Magistrate and funded by the Government of India. Other experiences include working as counselor for AIDS in 2003-04 in Jhansi District Hospital, enrolling ten persons for eye donation, organizing voluntary health orientation camps in the villages and creating awareness about child labour. Hence its experience in health sector is limited.

According to Mr. Ram Swaroop Pal this NGO employs five persons full-time besides utilizing the services of two male doctors and one lady doctor as and when required. Annual turnover for 2005-06 was approximately Rs 0.6 million. It primarily depends on government funds for survival. Twelve villages in Badagaon block with a population of 10,612 were served by it.

3.4.4 Jan Jagrati (Public Awareness)

Founded on 20 October 2000, the society has been renewed to 19 October 2008. Headed by Mr. Surendra Kumar Sahu, this NGO has thirteen objectives which include two objectives directly related to health. Though the NGO has been involved in polio eradication campaigns and runs a counseling centre in collaboration with Bundelkhand Social Workers Association, the health post scheme of UPHSDP is in fact the first major project taken up by it. According to Mr. Surendra Kumar Sahu it has eleven employees of whom two work full-time. It has an annual turnover of Rs 0.3 million. It was allotted seven villages of Mauranipur Block with a population of 12,606.

3.4.5 Rajput Khadi Gramodhyog Sansthan (Rajput Khadi Village Industries Organization)

This society was registered on 7 June 1986 which has been renewed from time to time; the registration is valid to 6 June 2010. Mr. Vijay Singh Yadav is the Chairman and Mr. Rankendra Singh is the Secretary. There are nine other members. All members of the management committee hail from rural areas and are engaged in agriculture. Apart from looking after the various activities of the NGO, Mr. Rankendra Singh also works as a contractor. This organization has thirty-three objectives including six related to the health sector. Experiences of Rajput Khadi Gramodhyog Sansthan include organizing training for women in basket-making under the government sponsored Development of Women and Children in Rural Areas (DWCRA) scheme, forming self help groups in Lalitpur and Mahoba under Swarna Jayanti Swarozgar Yojana (Golden Jubilee Self-Employment Scheme) of the Ministry of Rural Development, taking part in the Swajaldhara scheme in Lalitpur district to provide drinking water, creating awareness about population control in Lalitpur district and forming self-help groups under the World Bank funded Uttar Pradesh Diversified Agriculture Support Project. It has no experience in providing health services. According to Mr. Rankendra Singh nine persons including one part-time employee have been employed by this NGO. Its annual turnover is Rs 1.6 million. It was allotted five slums of Jhansi town where 15,200 people are living.

All the NGOs mainly depend on government funds for their survival except one that gets some foreign funds too. Each has so many objectives, probably because they

want to engage themselves with government schemes in various sectors. None has any experience in running clinics. Though the management committees of these NGOs have many members, these are run by one or two persons. Many people have probably been included in the management committees because of legal requirements. In the garb of doing 'social service' these NGOs provide a source of livelihood for some 'enterprising' individuals.

3.5 Contract Agreement – Terms and Conditions

Each agreement had a written contract signed by both the partners (see Annexure 3). Agreement mentioned an "annexure A" that listed the services to be provided. But none of the five NGOs knew about annexure A nor did the public partner. In the absence of annexure A, services to be provided by the private partners were guided by the circulars issued from time to time by the Project Directorate and the Regional Project Management Unit (RPMU), which were conveyed to the private partners by the District Project Management Unit (DPMU). Strangely, none of the NGOs has any complaints about this vital aspect.

Regarding opening hours of the health posts, there was no mention in the agreement. Rather an RPMU circular dated 1 April 2005 clarified that health posts should be open from Monday to Saturday from 8 am to 2 pm. No clear provisions were in the agreement about what would happen if the private partner violated this aspect. In fact, as the study found, a very flexible approach was adopted as far as opening hours of health posts were concerned. Or perhaps one can say that monitoring was totally lax. One NGO was allowed to send doctors to various villages on rotation, another was allowed to open two health posts altogether for four days, one NGO operated health post only once a week and two NGOs neither opened health posts nor organized health camps.

The agreement clearly stipulated that payment would be made in installments: the first installment of 20% was to be made after unequivocal acceptance of the letter of award against a bank guarantee or on completion of a specified benchmark and its approval by the regional committee; the second installment of 30% was to be made on submission of the field survey report and six monthly progress reports against agreed indicators and their approval by the competent authority (Regional Project Manager); 30% was to be made as the third installment on submission of the third-quarter draft

analysis report of field-work and other deliverables of monitoring indicators and their approval by the Regional Project Manager; and the final 20% was to be made after acceptance of the final report by the Project Director (see Annexure 3). The NGOs were asked to prepare a budget for an amount of Rs 287,000 per health post for one-year period. They were free to allot this money under various heads as they deemed fit with approval from the competent authorities (see Table 1). The agreement also talked about payment to be made in 30 days of receipt of invoice but was silent on what would happen if the public partner did not stick to this deadline. As found by this study the first and fourth installments were paid in arrears and the private partners could not do much about such delay.

Table 1: Budget of health posts run by various NGOs (in Rupees)

Item of expenditure	Rashtriya Nirman Yojana	St. Paul's Charitable Education Society	Jan Sahayogi Sanstha	Jan Jagrati	Rajput Khadi Gramodhyog Sansthan
Baseline survey	9000	3000		3000	15000
Salary	126000	156000	114000	150000	130000
Awareness creation	34000	8000		32700	10000
Health camps	30000	21000		36900	72000
Medicine		44500	42000	10000	20000
Equipments		6000			10000
Rent for the building	12000	6000		6000	4800
Furniture	15000	6300		5000	20000
Traveling allowance/Transportation	35000	20000	45000	14400	
Stationery	10000	5000		12500	10000
Miscellaneous	16000	10500	86000	16500	17200
Total	287000	286300	287000	287000	299000*

(Source: NGOs and District Project Manager, UPHSDP, Jhansi)

* Against the Rs 299000 budget submitted by Rajput Khadi Gramodhyog Sansthan, an amount of Rs 285000 was approved and released.

Note: Budgets of the five NGOs have been grouped under major heads for easy comparison although the original budgets have less or more number of categories for different NGOs.

The agreement prescribed the reports to be submitted. Necessary forms were supplied to the private partners to maintain records. The NGOs had nothing to complain against the number of records to be maintained. These records were not put to optimum use. For instance, record of patients referred to government hospitals could have been used by the health department officials to keep track of patients referred. That would have improved referral service.

The agreement was silent about the number and qualifications of staff although the number of staff to be employed was communicated separately to the NGOS. Mentioning qualifications of the staff would have been better.

3.6 Stakeholder Analysis

This section analyses the views and opinions of various stakeholders. Primary stakeholders are beneficiaries who are people of the area whom the project professes to serve. UPHSDP, NGOs, staff employed by NGOs, officials of health department, officials of district administration and community are secondary stakeholders. NGOs are also key stakeholders as they are vital for success of the project. Quacks, though not formally involved in the project, are affected and in turn try to affect the project; hence they are external stakeholders. Table 2 sketches the interests of different stakeholders and their potential impact on the scheme.

Table 2: Interests and potential impact of various stakeholders

Name of stakeholder	Type of stakeholder	Interests	Potential impact on the scheme
Beneficiaries	Primary	* Access to good quality health care in the same or nearby village * Access to free medicines * Immunization of pregnant women and children	Positive Positive Positive

UPHSDP	Secondary	* Making healthcare available to people of remote areas * Giving Special emphasis to women and poor * Improving health indicators * Improving the health system * Achieving the targets set by the World Bank * Spending money * Finding suitable NGO partners to run health posts * Effective monitoring	Positive Positive Positive Positive Positive and negative Positive and negative Positive Positive
NGOs	Secondary / key stakeholder	* Service to the society * Financial benefits to the NGO * Building reputation of the NGO * Providing employment to some people	Positive Negative Positive Positive and negative
Staff employed by NGOs	Secondary	* Finding some job * Financial gain * Mental Satisfaction * Building reputation (applicable to doctors) * Finding prospective customers for their private clinics (applicable to doctors)	Positive and negative Negative Positive Positive Positive and negative
Officials of health department	Secondary	* Achieving the targets set by the project directorate * Improving health indicators * Improved performance in national health programmes * Creating awareness among the public about various health related issues and programmes	Positive and negative Positive Positive Positive

		* Reducing workload in government hospitals	Positive and negative
Officials of district administration	Secondary	* Improving health indicators * Reduction in complaints about public health facilities * Improved performance in national health programmes * Creating awareness among the public about various health related issues and programmes * Effective monitoring of the scheme	Positive Positive Positive Positive Positive
Community	Secondary	* Better access to healthcare * Improved quality in health services * Better quality of life in the villages * Creating awareness about various diseases and the issues related to them	Positive Positive Positive Positive
Quacks	External	* More income from their practice * Inefficient public health facilities * Lack of awareness among the public about various issues related to health sector * No competition from health department or any qualified medical practitioner	Negative Negative Negative Negative

(Source: Format adopted from ODA 1995; the contents are the author's own)

3.6.1 Beneficiaries

The ultimate objective of the scheme is to improve access to health services by people living in remote areas. Hence they are the primary stakeholders. This heterogeneous group consists of people with varying socio-economic status as the scheme caters to health needs of all people living in the area serviced by health posts. Their interests are access to good quality healthcare in the village where they live or in the nearby villages so that they do not have to travel long distances, getting medicines free of cost and immunizing all children and pregnant women. Their interests are consistent

with the stated objectives of the scheme; hence their impact on the scheme is positive. In Dadiapura slum of Jhansi town and Dhhakarwara mothers of new born children did not bother that their children and they were not immunized. It is because the NGOs failed to do the job of creating awareness about immunization programme and the local officials of health department failed in carrying out immunization activity.

The influence of beneficiaries on the design of the scheme and its implementation is almost negligible as they could not do anything wherever the NGOs did not do their job properly or when officials of the health department failed to monitor the functioning of the scheme (Interviews with beneficiaries of different villages and Dadiapura slum of Jhansi town). No doubt they have influence over the government through their voting power, but this power cannot be exercised immediately. Moreover the voting pattern is influenced by many other considerations; a scheme like this rarely has an influence on voting. Table 3 summarizes the views of beneficiaries about the project.

Table 3: Views of Beneficiaries about the project

Village /location	Name of NGO	Views of beneficiaries
Motikatra and Virauna	Rashtriya Nirman Yojana	*Doctor used to come only once in a week or ten days *Doctor should come daily even if for three-four hours *Only Ayurvedic doctor came and he did not give injections *Strong preference for injections and allopathic doctor *Need for lady doctor *Slight improvement on immunization front *Dai took care of deliveries in Motikatra *Free medicine was a positive aspect *During emergency there was need to go to private doctors *Quack was useful as he was readily available and he was better than private practitioners in neighbouring town as he charged less
Ahiraura and Kakarvai	St.Paul's Charitable Education Society	*Doctor and staff were very courteous. Doctor was already known as he used to do private practice earlier in block headquarters *Ahraura is very remote and becomes inaccessible especially during monsoon season

		*The health post was opened on Tuesdays and it would have been ideal if it was opened daily *Blood test and other pathological tests should be done in health post *Doctor gave medicine free of cost but he did not give injection Injections were given during health camps when another doctor came from town *Need for lady doctor *No discrimination on the basis of caste or economic status *It would be better if Ahiraura has full fledged additional primary health centre *Kakarvai has an ayurvedic clinic though doctor did not come regularly for the past several months and pharmacist posted there helped patients by giving medicines *Health post in Kakarvai was open on Mondays, Wednesdays and Fridays *There is weekly market at Kakarvai when people from surrounding villages congregate and they also made use of health post *During emergency people went to town and pharmacist posted in government ayurvedic hospital helped in this
Parasar and Mavaigrid	Jan Sahayogi Sanstha	*Qualified allopathic doctor used to visit on Tuesdays *Doctor and staff were very caring and we did not have to pay them anything *Free medicines were given *People of Mavaigrid preferred to go to Jhansi due to custom and better transportation facilities *Patients referred by health post doctor were not given any preferential treatment in government hospitals *Ladies prefer to see lady doctor *Poor women of scheduled tribe community still preferred to go to quack

Patha and Dhhakarwara	Jan Jagrati	*No health post was opened *No health camp was organized *Even ANM of health department came once in a month or so *Children and pregnant women were rarely immunized *No option but to go to nearby PHC or to see a quack
Dadiapura slum of Jhansi town	Rajput Khadi Gramodhyog Sansthan	*No health post was ever opened in the area. The building shown by NGO man was functioning as school *No health camp was organized *Many tribal families live in this area *No immunization of mother and children *Preferred to go to government hospital or private doctors

3.6.2 UPHSDP/Public Partner

The interests of the public partner are making health care available to people who are living in remote areas, giving special emphasis to women and the poor, improving health indicators of the state, improving the health system of the state, achieving the targets set by the World Bank, spending the money available for the scheme, finding suitable NGO partners for the scheme and effective monitoring. While generally the interests of UPHSDP have a positive impact on the scheme, achieving the targets and spending the money may sometimes have negative impacts as they may force the public partner to compromise on quality. UPHSDP has enormous influence vis-à-vis implementation of the scheme as it is responsible for the selection of private partners who ultimately run the health posts and it controls the funds. But it does not have direct control over staff of the health department. The Project Directorate views the scheme as successful, yet admitting that some NGOs may not be doing well. In its view, selection of NGOs is critical for the success of the scheme and to ensure that the right NGOs are selected. For 2006-07, the task of screening of NGOs was delegated to an independent body -- the Indian Institute of Management, Lucknow -- that has also been asked to evaluate formally last year's activities. Screening of NGOs was previously done by regional level committees on the basis of recommendations of district level committees (Interview with Staff of Project Directorate, UPHSDP). But it seems to be a retrograde

consume less time. It also showed that the Project Directorate had more faith in the Indian Institute of Management than in its own field-level functionaries.

3.6.3 NGOs/Private Partners

NGOs are key stakeholders because success of the project depends to a large extent on their commitment to the cause and the sincerity of purpose. The NGOs are interested in service to the society, building a good reputation for themselves, financial gains and giving employment to some people. The scheme provides a great opportunity to serve the society. Health is an area where the good work done by the NGOs would be appreciated by all sections of the society as everyone benefits from it. Through good service, the private partners can build a good reputation for themselves among the public that will enhance their credibility and acceptability, among the public representatives who may support them and may come to their rescue if need be and among the government officials who may give more work to well performing NGOs.

To run any organization one needs funds. The NGOs claimed that they also had contributed some money obtained from members as membership fees and from others as donations (Interviews with NGO representatives). But some health department officials felt that NGOs have not contributed any money for the scheme rather they have siphoned off scheme money that could have been as high as 20%. This shows some degree of mutual distrust between public and private partners. For any NGO to survive, they need money. Without an in-built provision for some profit, they would be tempted to save some amount wherever possible; this may at times compromise the quality of the services offered and run counter to the objectives of the scheme.

Finally, the NGOs have an interest in employing some people in some scheme or others who have been working with these NGOs for quite sometime so that they do not leave these organizations. For instance, every NGO employed somebody as coordinator. As long as the scheme requires the services of such personnel, it is a good thing; otherwise it will have negative impact on the scheme as they would eat into the funds of NGO without doing much work. NGOs do have some influence on the design of the scheme. The terms of reference for 2006-07 are clearly based on feedback received from NGOs and functionaries of the health department.

3.6.4 Staff Employed by NGOs

The staff were interested in finding a job, financial gain, mental satisfaction, building reputation for themselves and finding prospective customers for their private nursing homes. The last two interests were specific to doctors. In a market characterized by cut-throat competition for employment, finding paramedical staff at a reasonable rate is not difficult. But owing to the distance from Jhansi town, the NGOs found it difficult to find suitable doctors; as a result they had to spend more. This specific interest of staff had both positive and negative impacts on the scheme. Those employed would, of course, try to maximize their gain; this had negative impact. Some staff (especially one retired doctor) I interviewed cited mental satisfaction as the reason why he chose to work in the health post (Interview with Dr N.K.Saxena). This had positive impact. In the same manner doctors' attempts to build good reputation for themselves had positive impact. One doctor who was involved in health camps, though not admitting it openly seemed to be interested in finding prospective customers for her private clinic (Interview with Dr Chandra). This objective cannot be termed as totally negative as long as it does not interfere with the doctor's work in health camps and/or health posts. In fact, this would have some positive impact as the doctor would be eager to provide good service so that the patients may come to his/her private nursing home for illnesses that cannot be treated in health posts.

Staff pointed out that monetary allocation for medicines was not sufficient. The staff were unhappy that there was some interruption in renewing the scheme for 2006-07 as this affected their income. They did not face interference in the villages; rather they got community support especially during health camps where the people were more than willing to give chairs, tables and even food.

3.6.5 Health Department Officials

The interests of health department officials are achieving the targets set by the health directorate, improving health indicators, improved performance in national health programmes, creating awareness among the public about health related issues and programmes and reducing work-load in government hospitals. While generally the interests of the department coincide with the objectives of health post and thereby would have positive impact on the scheme, two aspects impact the scheme negatively. They are

pressure from above to achieve the targets and the desire to reduce work-load in government hospitals. The former leads to compromising on quality through slackness in monitoring which occurred in two of the NGOs, namely Jan Jagrati and Rajput Khadi Gramodhyog Sansthan; the latter leads to not honouring the referral slips sent by the health posts to government hospitals.

They were happy that they were no longer involved in the selection of NGOs. It showed their aversion to taking responsibility and their inability and/or unwillingness to cope with political pressure at local level, which occasionally accompanies such selection processes. Some kind of political pressure was hinted by the officials in selecting Rajput Khadi Gramodhyog Sansthan. Officials of the health department at the district level wield sufficient influence that if tapped properly, can contribute immensely to improve quality of the output from the scheme. For instance, they have wide experience in providing health services, implementing various national health programmes, conducting health camps and immunizing pregnant women and children. They also have good knowledge about the reputation and capacity of local NGOs working in health sector that can be used in selecting good NGOs. They can also be used as performance monitors. The Chief Medical Officer of the district has administrative control over all doctors and other staff of CHCs, PHCs and APHCs. By using the CMO effectively, the entire machinery under her/her can be made to work for the success of the scheme.

3.6.6 District Administration Officials

In the hierarchy of district administration, the district magistrate occupies the prime position. S/he is the representative of government at the district level whose involvement is vital for the successful implementation of any scheme that involves coordination between different departments or between government departments and public representatives. To put it simply s/he is the pivot around which the district administration revolves. The interests of the district administration are improving health indicators, reduction in complaints about public health facilities, improved performance in national health programmes, creating awareness about health related programmes and issues among the public and effective monitoring of the scheme. The interests of district administration officials match with the scheme objective of providing health care services to all people; hence they would have positive impact on the scheme. But health is not the

only department under their administrative control. Normally they give adequate attention to health only during polio eradication campaigns and during periods of disease epidemics that attain political significance.

Their influence in the area is enormous. Unfortunately in 2004-05, the district magistrate was not officially involved in the district-level monitoring committee and was kept out of the loop. This anomaly has now been rectified. The views of these officials were that the scheme was good but it was taken up on a very small scale with little perceptible improvement in healthcare in a district as big as Jhansi. They favoured expanding it to other areas. No complaint was received by them either from NGOs regarding payment or from the public regarding quality of service in health posts (Interview with Dr M.K.S.Sundaram, IAS and Mr. L.Venkateshwarlu, IAS). The NGOs did not complain for two reasons: one, delay of few months in payment by government department was not seen as abnormal and two, there was fear of retribution from health department officials. There are two reasons for public not complaining. People of those villages where heath posts were functioning were happy that they were at least getting some service. People of those villages and Jhansi slums where the NGOs failed to open the health posts did not complain because they were not aware that some NGO had been given money to establish heath post in their area.

3.6.7 Community

The community includes the public of the area as well as their representatives. The interests of the community are better access to healthcare, improved quality in health services, better quality of life in the villages and creating awareness about diseases and the various issues related to them. These interests of the community had positive impact on the scheme in those villages where health posts were operational (Interviews with public and their representatives in many villages). The community in general appreciated the scheme but preferred a full-fledged hospital open everyday rather than open on fixed days of a week. People highlighted the need for allopathic practitioners and lady doctors.

The village pradhan is a key figure as s/he is elected directly by the people. S/he wields sufficient influence in the area so that her or his support for any programme like a health post would make it an instant success. Pradhans were not given any formal role in the scheme in 2004-05 although now they have been made members of monitoring

committees at local level. Involvement of the gram pradhan in the scheme depended on the rapport established with him/her by the staff of health post. For instance according to Mrs. Shantidevi, Gram Pradhan of Parasar, she was closely associated with the health post. But Mr. Gnanaram, Gram Pradhan of Kakarvai said that neither the doctor posted in health post nor the NGO sought any help from him nor did they apprise him about the activities of health post. Had their support been enlisted earlier and had they been involved formally, their voice might have prevented instance of misuse of funds of the scheme by Jan Jagrati. Similarly involvement of elected representatives of Jhansi Municipal Corporation would have prevented misuse of funds by Rajput Khadi Gramodhyog Sansthan.

All the pradhans cannot be expected to play a positive role; some of them would have been indifferent and few could have created trouble too. Some NGO representatives opined that the greater role envisaged for pradhans during the current year is not good as they have their own political and personal interests and many of them do not reside in the villages. They also apprehended that some pradhans might use their new role to blackmail NGOs. It showed that NGOs do not trust gram pradhans though they do not have any bad personal experience in dealing with them. This fear stemmed partly from the general credibility crisis faced by pradhans as people who indulge in corrupt practices and partly because the NGOs do not want their work to be monitored closely by the community.

3.6.8 Quacks

In India, it is not uncommon to find people rushing to unqualified persons practicing medicine in villages and small towns. Such quacks cater to many people in remote areas and they charge less than qualified private practitioners. In case of emergencies they are available any time. In fact one senior government doctor succinctly said: 'it is because of these quacks, people do not agitate against those doctors of government hospitals who rarely go to the hospital. If there were no quacks, people would have held demonstrations against health department long back. In healthcare there is alternative to public health system in the form of quacks'.

Due to problems in accessing good quality health care at affordable prices in the villages, the disadvantaged sections of society are forced to seek the services of quacks.

Quacks are external stakeholders since they are formally not involved in implementation of the project and their interests clash with the objectives of the scheme. Their interests are more income from their practice, inefficient public health facilities, lack of awareness among the public about various issues related to health sector and no competition from health department or any qualified medical practitioner. I interviewed one quack (name and identity withheld) who claimed that he has obtained an 'ayurved ratna' degree from Kanpur but, according to health department officials, that degree is not recognized. He claimed that he has clinic at village A (name of the village withheld) and comes to village B (name of the village withheld) where he sees patients daily for two hours. These two villages were served by a health post established in a nearby village. The quack claimed that since the health post was started, the number of patients coming to him was reduced by about 40%. He further claimed that initially he charged the cost of medicine plus 20% but after the health post was set up he reduced his mark-up to 10%. However, that did not lead to more patients coming to his clinic and hence he had restored the original fees. In his own words, if the health post continues to run in that area, his business will be down by 60 to 70% within one year and he will be forced to shift elsewhere. The owner of the building which housed the health post (name withheld) said that initially the quack requested him not to give his house on rent for the health post as he feared that that would adversely affect his practice. This example shows the negative impact of the interests of quacks on the scheme but at the same time, highlights the fact the quacks cannot influence the scheme much because their practice is illegal. Hence they do not come out openly to oppose the scheme.

3.7 Mutual Benefits to Public and Private Partners

Through this scheme, the public partner can reach areas not properly served by the public health system due to distance from government hospitals. Where it worked effectively, improvements were made in delivery through trained personnel and the immunization of mothers and children. Reducing the cost of service is not an explicit objective of the public partner. On the other hand, private partners who want to grow are constrained by the lack of resources as, barring one, all others are solely dependent on government funds for their survival. The scheme gives NGOs an opportunity to get public funds to realize their professed objective of serving the society. It also caters to

their objective of expanding their activities to different sectors and different geographical areas.

3.8 Strengths and Weaknesses

Strengths and weaknesses of the scheme are assessed based on twelve parameters as given in Table 4 (strengths have been highlighted in bold letters and weaknesses have been italicized).

Table 4: NGO-wise strengths and weaknesses

Parameter	Rashtriya Nirman Yojana	St. Paul's Charitable Education Society	Jan Sahayogi Sanstha	Jan Jagrati	Rajput Khadi Gramodhyog Sansthan
Year of implementation	*Since the scheme was implemented in 2004-05, it was a new scheme for both partners. All five private partners had no prior experience of running hospitals. The experience of the public partner in running health posts in partnership with NGO was limited to some districts.*				
Length of partnership	*The contract was initially for one year. It was extended for another five months in three installments which caused uncertainty.*				
Partners and their profile	**Good knowledge about the area being a local NGO and Experience in using PRA technique which came in handy in conducting baseline survey.**	**Good knowledge about the area being a local NGO, chairman has some academic qualification in the area of health, experience in polio eradication, collaboration with**	**Good knowledge about the area being a local NGO, manager is a retired employee of health department with good contacts and experience in organizing eye camps.**	**Good knowledge about the area being a local NGO and past involvement in polio eradication campaign.** *This was the first major project taken up, annual turnover*	**Good knowledge about the area being a local NGO.** *No experience in health sector and secretary was too involved in his vocation as contractor.*

	Small NGO with annual turnover of Rs 0.5 million and no prior experience in running hospitals.	**other NGOs, biggest of the five NGOs in terms of financial resources with annual turn over of Rs 1.6 million and experience in creating awareness about HIVAIDS.** *No prior experience in offering clinical services.*	*Small NGO with annual turnover of Rs 0.6 million and no experience in running clinics.*	*was Rs 0.3 million and no prior experience in running heath centres.*	
	Public partner: **Dedicated District Project Management Unit at state, regional and district levels, experience in providing health care, unusually high level of commitment at state level and good physical infrastructure in terms of office building, vehicle, etc.** *State has division as an administrative unit above district but region was a new concept not familiar to the officials, Deputy CMO was made District Project Manager and CMO was not given any formal role and*				

	district administration (District Magistrate) was not assigned any formal role.				
Motive of the private partners	**Professed objective of social service.** *Dependence on government funds for survival.*	**Professed objective of social service.** *To some extent dependence on government funds for survival.*	**Professed objective of social service.** *Dependence on government funds for survival.*	**Professed objective of social service.** *Dependence on government funds for survival.*	**Professed objective of social service.** *Dependence on government funds for survival.*
Target population and coverage area	*Area was not compact.*	*Distance between villages covered was too far which necessitated opening health posts at two places, Kakarvai where one of the health posts was opened has government ayurvedic hospital.*	**Area was compact.** *People from Kiriya and Mavaigrid villages preferred to go Jhansi due to custom and better transport facilities.*	*Small river interrupted the villages covered obstructing movement especially during monsoon season.*	*Jhansi town was already very well served by public health system.*

<table>
<tr><td>Type of partnership</td><td colspan="5">**Public had a choice to choose between government hospital and health post.** *It meant that public did not mind much wherever NGOs failed to provide services through health posts.*</td></tr>
<tr><td>Objectives of partnership</td><td colspan="5">**Aimed to serve 'difficult and remote' areas. Special emphasis on women and poor.** *The terms 'difficult' and 'remote' were not clearly defined.*</td></tr>
<tr><td>Selection criteria</td><td colspan="5">**Being based in the project area, NGOs had knowledge about geography, culture and socio-economic conditions of their area. Insistence on adequate number of staff and audited records of income and expenditure for last three years.** *Desire of NGOs to work in blocks nearer to district headquarters and exclusion of reputed experienced NGOs who are not based in the project area.*</td></tr>
<tr><td>Services offered</td><td>**Free medicines, periodical health camps and involvement of dai in institutional deliveries.**

Insufficient funds for medicines and cases referred were not given</td><td>**Free medicines and involvement of allopathic doctor for health camps.**

Budget allocated for medicines was not sufficient and referral service was defunct since government</td><td>**Free medicines and health camps.**

Amount allotted for medicines was insufficient and referral service was a flop due to non-cooperation of government hospitals.</td><td>*According to the people interviewed, no service was offered.*</td><td>*According to the people interviewed, no service was offered.*</td></tr>
</table>

	any special treatment in government hospitals.	*hospitals did not respect referral slips issued by health post doctor.*			
Payment mechanism	**Number of installments was neither too high nor too low and NGOs had no complaint about it.** *Inordinate delay of six months in releasing first installment and three months in releasing fourth installments, non-adherence to 30-days time limit mentioned in the agreement regarding payment and non-invocation of bank guarantee clause in the agreement to give advance money.*				
Staff and their management	**Flexibility in recruitment and service conditions of staff.** *Qualification of staff was not made clear by the public partner and no specific training was*	**Flexibility in recruitment and service conditions of staff and deployment of allopathic doctor for health camps.** *Qualification of staff was not made clear by the public partner and no*	**Flexibility in recruitment and service conditions of staff and deployment of allopathic doctor in health post.** *Qualification of staff was not made clear by the public partner and no*	**Flexibility in recruitment and service conditions of staff.** *Qualification of staff was not made clear by the public partner and no specific training was imparted to the staff.*	**Flexibility in recruitment and service conditions of staff.** *Qualification of staff was not made clear by the public partner and no specific training was imparted to the staff.*

	imparted to the staff.	*specific training was imparted to the staff.*	*specific training was imparted to the staff.*		
Constraints of the private partners	*Budget allotted for health post was same irrespective of the distance of heath post from Jhansi while they mainly had to depend on doctors living in Jhansi. Faced difficulty in hiring services of allopathic doctors who demanded more money and were generally unwillingly to travel long distances. One dai was not sufficient to attend to institutional deliveries in all villages covered by health post.*				

3.8.1 Year of Implementation

Although the scheme was originally implemented in the state in the year 2003-04, in Jhansi district it was implemented only in 2004-05. For the NGO as well as the health department staff it was a new scheme. The health department officials did not have any experience running health posts or hospitals with the help of NGOs or any other private partner. As far as the NGOs are concerned, though four of the five NGOs *viz*., Rashtriya Nirman Yojana, St. Paul's Charitable Education Society, Jan Sahayogi Sanstha and Rajput Khadi Gramodhyog have had some kind of involvement in health related activities, it was mainly related to awareness creation or organizing some health camps. So they had no experience as to how to run a health post or medical facility in remote areas and how to find and recruit qualified medical and paramedical staff for the facility. This was a major weakness.

3.8.2 Length of Partnership

The partnership was originally for a period of one year from December 2004 to December 2005 (see Annexure 3). But it was initially extended upto 31 March 2006 for those NGOs whose work was satisfactory and who continued to work since 1 January 2006 *vide* letter number 419/UPHSDP/06 dated 2 February 2006 issued by the Project Director. Later on, it was extended upto 30 April 2006 *vide* letter number 932/UPHSDP/06 dated 28 March on the basis of 'no objection' received from the World Bank and finally extended till May 2006. There was tentativeness in extending the contract period. The NGO representatives were unanimous in their view that one year is too short a period to plan various things required to run a health post, rather it should be at least three years and preferably five years with a clause to extend it after every year on the basis of satisfactory services provided by the health post. The NGOs opined that had the contract been for five years, they would have employed better qualified doctors and paramedical staff. Even finding a suitable building to run the health post would have been easier as the building could have been leased in for five years.

Quite interestingly, the first extension starting from 1 January 2006 was given on 2 February 2006. But the NGOs were told orally that there is every possibility of getting extension for some more months and hence they were asked to continue their work. This kind of arrangement that leads to uncertainty is not liked by the NGOs. They are right in

feeling that they would have had to spend from their pocket if extension had not been given as promised informally.

3.8.3 Partners and Their Profile

In terms of infrastructure, the public partner is well equipped with dedicated PMU, RPMUs (now abolished) and DPMUs. Barring few staff posted in the Project Directorate, others are employees of health department of the state government with wide experience in providing healthcare. This being an ambitious and high profile project involving regular monitoring from the World Bank, there has a been an unusually high level of commitment from the public partner. On the negative side, the concept of region was not a familiar one to the officials which jeopardized the functioning of RPMUs. Deputy CMO was designated as the DPM while CMO was not given any formal role. The District Magistrate who is the chief coordinator and the state government's representative at the district level was not assigned any formal role.

As regards the private partners, all of them are local NGOs with knowledge about the area that has made it easy for them to win the confidence of and enlist the support of the local people for the scheme. Rashtriya Nirman Yojana has experience in using PRA technique. Barring Jan Jagrati which is a relatively new NGO, other NGOs have had some kind of experience working with and for the public in sectors such as education, self-employment, rural development, health, etc. But their experience in health is mainly related to awareness creation. They employ very few people mostly part- time employees. Their annual turnover is less than Rs 2 million.

3.8.4 Motive of the Private Partners

The NGOs claimed that their motive for taking up this scheme is their commitment to social service and to do something for the people of backward Jhansi district (Interview with NGO representatives). The secretary of Rajput Khadi Gramodhyog Sansthan claimed that his mother died of cancer and he could not treat her for want of money and that made him to resolve to work for better health condition of poor people. On the other hand, health department officials were unanimous in their view that many of these NGOs have been formed by youth who wanted some kind of job and they are taking up various government schemes including the present one with the objective of making their ends meet. Three of the five NGOs *viz.*, Rashtriya Nirman

Yojana, St. Paul's Charitable Education Society and Jan Sahayogi Sanstha have some kind of commitment to social service as evident from the feedback from the public of the area. This is undoubtedly their strength. But the views of health department functionaries are not off the mark. The NGOs being dependent on funding from government or other sources for their survival, they can not be expected to do service without adequate compensation. Whether this is a weakness depends on how one views it. From a practical point of view, it can not be termed as a weakness as long as the funds are not misused. Jan Sahayogi Sanstha has an added advantage as it is run by somebody who has retired from health department. His contacts in the department have helped him find qualified doctor for the health post.

3.8.5 Target Population and Coverage Area

The population covered by the NGOs varied from 10,612 to 15,200. In the case of Rashtriya Nirman Yojana the area covered was not compact. While Motikatra village is at a distance of 16km from the sub-divisional headquarters Garautha, Virauna is 8km from Garautha on the other side of the main road. Central point for the thirteen villages covered by it is Garautha which already has an additional primary health centre. St. Paul's Charitable Education Society opened health posts at Ahraura and Kakarvai village as the distance between the villages was too far and the doctor shared time between these two places. Kakarvai is the biggest of the ten villages covered by it and has a weekly market also where villagers from the neighbouring villages assemble; but Kakarvai has a government ayurvedic hospital. Jan Sahayogi Santha's health post was located at Parasar village. Though geographically it is almost centrally located, people from Khiriya and Mavaigird villages normally don't prefer to go to Parasar though it is within a distance of 4-5 km, rather they prefer to go to Jhansi which is about 15 km due to tradition and better transport facilities. The villages covered by Jan Jagrati are divided by a small river which obstructs movement across it during rainy season. Rajput Khadi Gramodhyog Sansthan was chosen to serve slum areas in Jhansi town. Overall, although the number of people covered was not a problem, the area was not compact.

3.8.6 Type of Partnership

The type of partnership is more like grant-in-aid where some grant is given by the government to the NGOs in return for specified services to be provided to the public.

Here the public partner had contracted out to NGOs certain services in certain areas which were earlier delivered by government hospitals. But this contract does not prevent the public from going to public health facilities directly without first going to health post. The strength of this model is that the public have the choice of either going to the health post or to public health facilities. Their access to public hospitals is not contingent upon their being referred by the health posts. This in itself becomes a weakness to a certain extent that the public do not mind much whether the health post is open regularly or not.

3.8.7 Objectives of the Partnership

The main objective of the partnership is to provide preventive and limited curative health care to people living in remote and difficult areas with special emphasis on disadvantaged sections of the society like the poor and women. The objective is laudable but what exactly is meant by remote and difficult areas is subject to various interpretations as these terms have not been defined clearly. This has led to a situation where some slums in Jhansi town were also selected under the scheme. But the areas given to four NGOs are remote in terms of accessibility, distance and transport facilities.

3.8.8 Selection Criteria

The main criteria for selection of NGOs are that they should be based in the project area, should have field experience in the area, should have adequate number of staff and should be in a position to produce audited records of income and expenditure for at least three years. The stipulation that the organization should be based in the project area has both positive and negative aspects. On the positive side, the organizations have thorough knowledge about the geography, culture and socio-economic conditions of the area. This is a great asset since acceptability of the organization matters at least in the beginning so that people will not hesitate to throng the health post run by it. On the negative side, it prevents other NGOs that may have experience in running health centres in other parts of the country but want to expand their activities to newer locations. The other point about selection of NGOs is that their willingness to work in remote areas. All blocks are not equidistant from the district headquarters. Barring St. Paul's Charitable Education Society, other NGOs want to work in a block that is close to the district headquarters. But acceding to this demand was not practically possible and hence they were persuaded to apply for different blocks.

3.8.9 Services Offered

The services include treating common ailments, antenatal and postnatal care, registration of all pregnant women, immunization of pregnant women and children, giving iron and folic acid tablets to pregnant women, referring those patients who can not be treated at the health post level to primary health centre, community health centre, district hospital or medical college hospital depending on the nature of illness and organizing health campus in different villages periodically. It is not uncommon to find people treating themselves for common ailments like cold, fever, etc. Still many people preferred to go to the health posts for the simple reason that they got medicines free of cost. As regards immunization, the NGOs employed health supervisors too whose job was to create awareness about immunization and other health related issues. Providing free medicines, conducting periodical health camps and utilizing dais for institutional deliveries are strong points. On the other hand, NGOs and their staff were unanimous that budget allocated for medicines was insufficient. Patients referred by the health posts were not honoured by government hospitals. The health posts also did not keep track of the patients referred by them. There was no mechanism in place to get feedback or to follow up. This was due to lack of coordination between PMU and CMO. According to the people interviewed Jan Jagrati and Rajput Khadi Gramodhyog Sansthan did not provide any service.

3.8.10 Payment Mechanism

As per the agreement payment was to be made in four installments. They NGOs had no complain against the number of installments. But they were unanimous in saying that it was difficult to do baseline survey without getting advance money. It was suggested that at least 25% advance should have been given to start the work against bank guarantee. Though there was a provision in the agreement for releasing 20% of the total amount against bank guarantee, this was not done. It took almost six months to make the first payment and about three months to release fourth installment although there was no delay in releasing second and third installments. The private partners had nothing to say against the number of installments.

3.8.11 Staff and Their Management

The NGOs were expected to employ a minimum of four staff i.e., one doctor, one ANM, one paramedical staff and one class IV employee/dai. Method of recruitment was not prescribed and was kept flexible. The NGOs were free to employ them part-time or full-time. The amount to be paid to staff of the health post was also not fixed by the public partner. These are some strengths of the scheme. It was not prescribed as to whether the doctor should be allopathic or ayurvedic. Barring Jan Sahayogi Sanstha, other NGOs utilized the services of ayurvedic doctors for two reasons: (i) ayurvedic doctors charged less as compared to allopathic doctors and (ii) ayurvedic medical practitioners were easy to find even in small towns as compared to qualified allopathic practitioners. For the kind of work done by the health posts, even ayurvedic medical doctor is sufficient but many of the villagers stressed that they preferred injections and because there was no allopathic doctor in the health post they had to make do with tablets only. The people served by the health post run by Jan Sahayogi Sanstha were happier because they had a qualified allopathic doctor retired from the health department. There was no difficulty in finding qualified paramedical staff. With respect to the number of dai, the NGOs felt that dai is normally a local lady who attends to deliveries in the villages and it was essential to employ one dai per village and having just one dai for the entire area is not sufficient; this made it difficult to keep track of all pregnant women. The NGOs also stressed that the staff should have been adequately trained by UPHSDP before deploying them in the health posts. Incidentally for 2006-07, training programme has been included.

3.8.12 Constraints of the Private Partners

Terms of reference for 2005-06 were not clear. The NGOs were asked to prepare a budget for an amount of Rs 2,87,000 for the health post for a period of one year which was approved by the competent authorities. They were free to allot the money under various heads as they deemed it fit. This was a strength as well as weakness. It was good in the sense that it gave the NGOs flexibility to allot money under various operational heads and weakness because no minimum amount was prescribed for items like medicines. Flexibility in budget allocation made monitoring difficult.

Another constraint was that the amount sanctioned for the health post was uniformly fixed at Rs 287000 irrespective of the distance of health post from the district headquarters. The NGOs felt that normally they had to recruit doctors from Jhansi town and the farther the health post was from Jhansi town, the more money they had to spend on account of transportation.

Other constraints are finding qualified allopathic doctors at reasonable rates, lack of training for the field staff, short duration of partnership and large number of villages to be covered by the health post.

3.9 Access to Health Care and Addressing the Health Concerns of Deprived Sections of the Society

The emphasis of the scheme is to address the health concerns of women and poor. This part analyzes whether this objective has been fulfilled or not. Distance and cost of service are two important factors that prohibit deprived sections of the society from accessing health. The scheme aims to address the distance factor in particular. But in reality not all the villages covered by a health post benefit equally from the point of view of distance. For some villages covered by health posts, existing additional primary health centres or primary health centres proved to be nearer than the newly opened health posts. For other villages these health posts proved to be a boon because residents did not need to travel far to see a doctor.

This problem of distance arose mainly because of poor planning in choosing areas to be covered. The criterion of population covered was given more importance than distance. Rashtriya Nirman Yojana tackled this problem by asking its doctor to go to all the villages in rotation. While it did not solve the problem entirely, sending the doctor to villages in rotation meant that the doctor visited each village once a week or so. People of Virauna felt that often they had to go to Garautha or to local quack since they could not wait for a week. But they admitted that this arrangement was better than not having any doctor visiting the village at all. St Paul's Charitable Education Society tried to address this problem by opening two health posts in Ahiraura and Kakarvai and by asking the doctor to divide his time between these two locations. Since the days were fixed, people did not face much problem.

Anyone going to a primary health centre or additional primary health centre has to pay a registration fee of two rupees. But health posts have no registration fee. As medicines for some common ailments were given free of cost, people visited these health posts. Number of patients served by the health posts and corresponding government hospital of the area are shown in table 5.

Table 5: Number of patients served by the health posts and corresponding government hospitals

NGO's name	Number of patients served by the health post from June 2005 to May 2006	Number of patients served by corresponding government hospital	
		From June 2004 to May 2005	From June 2005 to May 2006
Rashtriya Nirman Yojana	4407	22103	23529
St Paul's Charitable Education Society	8129	1470	1555
Jan Sahayogi Sanstha	4230	5067	5881

(Source: ADPM, Jhansi)

Table 5 shows that as compared to the previous twelve months, number of patients treated by the government hospitals increased during the period when the health posts were operational. There are two reasons for this. First reason is that there is general increase in population of the area. Secondly, health posts increased overall coverage. That is those people who were not going to hospital or quacks for common ailments went to the health posts because of easy accessibility and free medicines.

Many people of Parasar village belonging to upper and backward castes were happy with the services offered by the health post. There are a few families of scheduled tribes in this village who live below poverty line. I discussed with some women of this community. Strangely they have never been to a health post though it was situated hardly 500 m from their huts. They rather preferred to travel about two kilometres to an adjacent village to see a quack. The main reason for this was that the doctor in health post was not giving injections but only tablets. However, the quack in Pali used to give two injections normally. The villagers did not even mind paying the quack for this. The doctor manning

Parasar health post was a qualified allopathic doctor who had retired from government service. But in other health posts, the doctors were qualified ayurvedic practitioners who could not give injection anyway. This demand for injection came from the people in almost all the villages visited. It shows that although cost of service is an important factor, people often are willing to pay a fee provided they perceive that the relief would be immediate. Rather than real quality of service, perception matters much -- perception about what is good and perception about the quality of any health facility that has something to do with government. Otherwise, why would the poor women belonging to scheduled tribes borrow money and go to a quack when a qualified doctor was ready to treat them free of cost while people who are relatively better off and more aware went to health post. To tackle this problem, awareness needs to be created among the deprived sections of society. In fact, this was one of the roles of health supervisors employed by the NGOs. But just one health supervisor covering about ten villages could not do this job. It needs concerted effort by the government, NGOs and the media at large.

Other factors too, according to the villagers, affect access; they are:

(i) Quality of doctor – an overwhelming majority of villagers prefer an allopathic practitioner to one who has acquired a degree in ayurved. But the NGOs find it difficult to engage an allopathic doctor because there are few qualified allopathic doctors in remote areas. The way out is to call somebody from Jhansi but they invariably have higher charge. Normally an ayurvedic doctor charges Rs 400 per day plus transportation costs whereas allopathic doctors charges Rs 500 per day plus transportation. As if to strike a balance between the demands of public and the funds available under the scheme, St. Paul's Charitable Education Society engaged allopathic doctor for health camps and ayurvedic doctor to man the health post.

(i) Behaviour of staff – generally people think that doctors and staff of health posts are more polite than doctors and paramedical staff of government hospitals. Even health department officials agree.

(ii) Availability of medicine – in case of common ailments (like cold and fever), the people either ignore them or buy medicine through medical store. They do not go to hospital unless the ailment hampers their day-to-day activities. Since the health posts provide medicine free of cost, they prefer to go there.

Chapter 4

Conclusion

PPP is considered to be one of the solutions by Government of India as well as Government of Uttar Pradesh to address various problems faced by health sector. It assumes significance especially in view of the predominant role played by private sector in health provisioning in India. The World Bank funded UPHSDP is experimenting with running health posts in remote areas that are not adequately served by government hospitals. This scheme has all the four elements of partnership defined by Paoletto (2000) – the partners share a common objective of serving society through providing healthcare services, there is a written agreement between both the partners though it is lacking in certain aspects, the strength of NGOs is combined with access to funds that is the forte of the public partner and this has led to overcoming respective weaknesses of public partner in making health service available in remote areas and of private partners in gaining access to financial resources. According to Venkatraman and Bjorkman (2006), partnership has five common elements. Of these, the present model has beneficence, non-malfeasance and equity. To a large extent the partners did not interfere with each other's work. There is autonomy as well, especially for the private partners in recruiting staff, deciding their service conditions and allocating budgets under various heads. But jointness of decision making is limited. The public partner plays a pivotal role in selecting villages, deciding the services to be offered and fixing the duration of contract while private partners are given freedom to decide operational modalities within broad parameters. Therefore, in operational details, autonomy prevails over jointness of decision making. Nevertheless, since there is mutuality and organizational identity as defined by Wang (2000), the relationship between both partners can be described as a 'partnership'.

Eight stakeholders were identified. Beneficiaries are the primary stakeholders whose interests are in consonance with project objectives but they are found to have little influence to make it work better to serve their interests. Rather they are just 'takers' who take whatever services are offered to them. This condition can be improved by creating awareness about their rights. This is the only model of PPP the beneficiaries have seen

and they feel that it is better than government hospitals as the service provided by the health posts is free and they are easily accessible in terms of distance. They also feel that health post open daily is better than the present model. They want the health posts to be manned by allopathic doctors. Ladies prefer lady doctor.

Of the six secondary stakeholders, NGOs are key stakeholders as they hold the key to the project's success. For NGOs, experience of running health posts in partnership with the public partner is new. They appreciate the flexibility given in recruiting staff and deciding their service conditions. The NGOs feel that the contract should be for a period of three to five years, advance money should be given, payment by the public partner should be prompt, staff should be trained, there should be one dai per village and budget allotted to the health posts should be according to their distance from district headquarters.

Interests of UPHSDP and health department officials have both positive and negative impacts on the project but these stakeholders are influential in deciding the contours of the project and ensuring its implementation. Officials of UPHSDP view the scheme as a successful one despite facing problems in some places. Regarding the procedure to select private partners, in the view of UPHSDP, it is better to get the applications of private partner scrutinized by some independent agency than leaving it to the district officials. District officials are also happy with this arrangement as they fear pressure at local level to select unqualified NGOs. According to officials of health department, making Deputy CMO as DPM was not correct. Now CMO has been made DPM and this has resulted in better coordination at district level. Health department officials agree with the beneficiaries that health post staff are more courteous than staff of government hospitals. Monitoring by the officials of health department was lax.

Staff employed by NGOs generally have positive impact on the scheme although some are eager to find a job and attract prospective clients for their privately-run nursing homes. Their influence on the scheme is limited. In their view amount allotted for medicines was insufficient. They do not have any difficulty in seeking cooperation from the community.

The influence of the wider community, which includes members of society and their representatives, is limited. In some villages elected pradhans were taken into

confidence by the NGOs where as in other villages they were not. The pradhans seek formal role for themselves in the scheme. There is a consensus among the community that their elected representative should be given more say in running the health posts. The NGOs apprehend that this may lead to interference in their work.

District officials, a group of powerful stakeholders whose interests match project objectives, do not have much role to play. They view the scheme as useful but also feel that the scheme caters to very few people and it should be taken up on large scale.

Quacks are external stakeholders whose interests are hurt by the project but they cannot do much due to their limited influence stemming from their illegal status. They think that if the scheme continues, they will have to shift their 'clinics' elsewhere.

Building a coalition between beneficiaries, community, UPHSDP and officials of district administration would have forced health department officials to monitor the working of private partners closely, which would have ultimately resulted in better service delivery by the NGOs.

Only those NGOs are chosen that have a base in the project area with at least three years of experience, not necessarily in health sector. Knowledge about the area and its population are important since people go to health post only if they have confidence in it. A mix of outside NGOs with experience in providing healthcare who employ local staff and local NGOs would have introduced some competition. Competition among the private partners will lead to better service delivery since only the more efficient ones will be selected.

The applications of NGOs to set up health post were sent to the RPMU by DPM. The RPMU scrutinized the application and final approval was given by the Project Directorate. This procedure has been modified by involving an independent agency to scrutinize the applications.

The contract agreement was simple and flexible in giving the private partners much needed space in matters related to recruitment of staff and service matters. These were crucial for the success of the project. However, services to be provided and opening hours of health posts should have formed part of the agreement rather than indicating them through circulars and letters. Provision of penal clauses for non-provisioning of agreed services and non-payment of money within prescribed time limit would have

acted as deterrent to both partners to carry out their responsibilities more efficiently and in a time-bound manner.

The project has led to mutual benefits to both partners. UPHSDP has been able to take health services to remote areas while NGOs get much needed financial resources to fulfill their objectives of serving people.

The PPP model has increased access to healthcare irrespective of socio-economic status. It has also increased coverage. Quite importantly those people who earlier went to quacks or nearby private practitioners availed the services of the health posts. Despite poverty, some people preferred to go to the quacks for reasons like preference for injections, insufficient working days of the health posts and wrong perception about the service provided by the quacks due to lack of awareness.

The scheme has strengths like localness of NGOs with some kind of prior experience in the project area, flexibility of contract agreement vis-à-vis recruitment and service conditions of staff, flexibility in allocating budget under various heads depending on local requirement, dedicated units of public partner at state, regional and district level, freedom given to beneficiaries to choose between health post and government hospital, cooperation from local community, etc. Some of the important weaknesses are that the NGOs do not have prior experience in running health centres, a contract period of one year is felt to be too short, delay in releasing first and fourth installments, government hospitals not respecting referral slips issued by health posts, insufficient budget allocation for medicines, dependence of NGOs on government funds for survival, same amount of monetary allocated to all health posts irrespective of their distance from district headquarters, not prescribing qualification of staff, lack of training for staff, non-compact area, non-deployment of lady doctors, dependence on ayurvedic doctors, laxity in monitoring by health department officials, no formal role for elected village level public representatives and no formal role for the District Magistrate.

Nevertheless, the general perception among people served by Rashtriya Nirman Yojana, St. Paul's Charitable Education Society and Jan Sahayogi Sanstha was that health posts were quite useful as people could get medicines free of cost, they did not have to pay registration fee, they did not have to travel to nearby towns to see doctor/quack, there was improvement in delivery of children by trained dai, in some

villages there was improvement in immunization of mothers and children, health post staff were courteous in their behaviour and although no special treatment was given to deprived sections of society, they were not discriminated against. But people from those areas served by Jan Jagrati and Rajput Khadi Gramodhyog Sansthan said that these NGOs neither opened the health posts nor organized health camps. This can be ascribed to lack of commitment by the private partner in sticking to the agreement, lack of proper monitoring by the public partner, non-awareness about the scheme among the community members and lack of in-built mechanism in the agreement to involve elected local representatives and officials of district administration.

Learning lessons from the past, the following measures have already been taken by UPHSDP for 2006-07:

- Terms of reference have been made clear
- A district level committee has been formed headed by the District Magistrate for better monitoring
- A field level committee has been created in which Gram Pradhans have also been included
- Unit cost of health post has been slightly increased to Rs 3 lakhs and variable cost of Rs 1.5 lakh has also been added; budget breakup is now very clear
- Number of people to be covered by health post has been reduced
- Criteria to select the area under the scheme have been well defined
- Chief Medical Officer has been designated as District Project Manager
- Provision has been made for a registered lady doctor to visit the health post once a week for seven hours
- Male doctor will visit for three days a week from 9 am to 4 pm
- Trained ANM/Nurses and trained dai will be available six days a week
- Training will be given to health post staff

Some areas of concern remain unaddressed. Making the contract duration three to five years, giving advance money to the private partner against a bank guarantee, ensuring time-bound payments to the private partner, giving allowance for distance of the health post from the district headquarters, increasing the frequency of visits by lady doctor, keeping the health posts open on all days, strengthening referral system and

making penal provisions in the agreement to counter failure by the public and private partners to deliver on their commitment are recommended to make the public private partnership in running health posts more effective.

Various stakeholders consider the scheme to be good but there are some shortcomings. The instant model of PPP does address health concerns of the society, including its marginalized sections. The model has increased access and coverage to healthcare but it critically depends on selection of good private partners, effective monitoring by the public partner and building effective coalition between different stakeholders whose interests coincide with project objectives. This model can be expanded on a large scale provided the government is able to commit financial resources for such an endeavour. Since the health posts are not intended to replace existing APHCs and PHCs, the government has to find extra resources for that. Finding suitable NGOs will be a problem during the initial years if expansion of this model is planned. After few years, this problem will diminish as local NGOs would have gained sufficient experience in running the health posts. Allocation of sufficient funds by the government and survival needs of the private partners will make the project sustainable even when this model is replicated across the state.

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Annexure 1
List of persons interviewed

S.No	Name	Date of interview
	State level:	
1	Mr. Sailesh Krishna, IAS, Project Director, UPHSDP, Lucknow	17 Aug 2006
2	Dr C.K.Singhal, Additional Director MDP), UPHSDP, Lucknow	07 Aug 2006
3	Mrs. Neena Shukla, Social Scientist, UPHSDP, Lucknow	07 Aug 2006
4	Mr. S.K.Pandey, Financial Consultant, UPHSDP, Lucknow	21 Aug 2006
5	Mr. Shishir Mittal, Joint Director, UPHSDP, Lucknow	07 Aug 2006
6	Mr. Bharat Shah, Joint Director (Management), UPHSDP, Lucknow	17 Aug 2006
7	Mr. J.P.Singh, Assistant Director, UPHSDP, Lucknow	07 Aug 2006
8	Dr Poonam Tiwari, Assistant Director (Medical), UPHSDP, Lucknow	07 Aug 2006
9	Dr Maya Kant Awasthi, Professor, Indian Institute of Management, Lucknow	17 Aug 2006
10	Dr Jabir Ali, Assistant Professor, Indian Institute of Management, Lucknow	17 Aug 2006
11	Mr. Alok Kumar Singh, State NGO Coordinator, Directorate of Family Welfare, Lucknow	18 Aug 2006
	District level:	
12	Mr. L.Venkateshwarlu, IAS, District Magistrate, Jhansi	11 Aug 2006
13	Dr M.K.S.Sundaram, IAS, District Magistrate, Ghaziabad (previously District Magistrate, Jhansi)	03 Aug 2006
14	Dr I.K.Jain, Chief Medical Officer/District Project Manager, UPHSDP, Jhansi	11 Aug 2006
15	Dr O.P.Goel, Additional District Project Manager, UPHSDP, Jhansi	11 Aug 2006
16	Mr. Raghav Kumar Trivedi, District Economic and Statistical Officer, Jhansi	10 Aug 2006
17	Mr. Pradoot Krishna Goswami, Chairman, Rashtriya Nirman Yojana	10 Aug 2006
18	Mr. Deepak Kumar, Chairman, St. Paul's Charitable Education Society	10 Aug 2006
19	Mr. Ram Swaroop Pal, Manager, Jan Sahayogi Sansthan	10 Aug 2006
20	Mr. Surendra Kumar Sahu, Jan Jagrati	10 Aug 2006
21	Mr. Rankendra Singh, Secretary, Rajput Khadi Gramodhyog Sansthan	11 Aug 2006
22	Dr N.K.Saxena, MBBS (worked for Jan Sahayogi Sanstha)	11 Aug 2006
23	Dr Chandra, BAMS (worked for Rajput Khadi Gramodhyog Sansthan)	11 Aug 2006

24	Dr D.P.Khare, BAMS (worked for St. Paul's Charitable Education Society)	11 Aug 2006
25	Mr. Ashuthosh Goswami, Accountant, Office of District Project Manager, UPHSDP, Jhansi	11 Aug 2006
26	**Village/site level:** Mrs. Kamla w/o (late) Compoder (worked as dai for Rashtriya Nirman Yojana at Motikatra)	09 Aug 2006
27	Mr. Senthil Vyas s/o Nathuram Vyas (worked as health supervisor for Jan Sahayogi Sanstha at Parasar)	10 Aug 2006
28	A quack (name and identity withheld)	10 Aug 2006
29	Mr. Lakhanlal s/o Premi, 42 years, Kumhar(BC), BPL, village: Virauna	09 Aug 2006
30	Mr. Baijnath s/o Kabule, 75 years, Kori(SC), BPL, village: Virauna	09 Aug 2006
31	Mr. Kalicharan s/o Sharman, 53 years, Yadav(BC), BPL, village: Virauna	09 Aug 2006
32	Mr. Anil Yadav s/o Lakhanlal, 22 years, Yadav(BC), APL, village: Virauna	09 Aug 2006
33	Mr. Balram s/o Banmali, 38 years, Chamar(SC), APL, Ex-Pradhan , village: Virauna	09 Aug 2006
34	Mr. Manor Kumar Chubby s/o Bauble, 24 years, Brahmin(FC), BPL, village: Virauna	09 Aug 2006
35	Mrs. Phoola w/o Butan, 45 years, Chamar(SC), BPL, village: Virauna	09 Aug 2006
36	Mr. Mansingh s/o Milapchand, 30 years, Yadav(BC), BPL, Member of Gram Panchayat, village: Motikatra	09 Aug 2006
37	Mr. Nandram s/o Dhaniram, 31 years, Ahirwar(SC), BPL, village: Motikatra	09 Aug 2006
38	Mrs. Savitri w/o Sripath, 42 years, Chamar(SC), BPL, village: Motikatra	09 Aug 2006
39	Mrs. Rajkumari w/o Ramkishore, 25 years, Chamar(SC), BPL, village: Motikatra	09 Aug 2006
40	Mr. Bhaiyyalal s/o Vanshi, 35 years, Chamar(SC), BPL, village: Motikatra	09 Aug 2006
41	Mr. Heeralal s/o Vanshi, 45 years, Chamar(SC), BPL, village: Motikatra	09 Aug 2006
42	Mrs. Shantidevi w/o Shyamlal, 40 years, Yadav(BC), APL, Gram Pradhan, village: Parasar	10 Aug 2006
43	Mrs. Kamladevi w/o Malkhan Singh, 42 years, Sahariya(ST), BPL, village: Parasar	10 Aug 2006
44	Mrs. Kamla w/o Devsingh, 40 years, Sahariya(ST), BPL, village: Parasar	10 Aug 2006
45	Mrs. Ramkali w/o Mohan, 43 years, Sahariya(ST), BPL, village: Parasar	10 Aug 2006

46	Mr. Lakshman s/o Rattu, 60 years, Sahariya(ST), BPL, village: Parasar	10 Aug 2006
47	Mrs. Mamta w/o Rakesh, 38 years, Vanshkar(SC), BPL, village: Parasar	10 Aug 2006
48	Mrs. Malti w/o Bhagwandas, 42 years, Ahirwar(SC), BPL, village: Parasar	10 Aug 2006
39	Mr. Komal Singh Yadav, 55 years, Yadav(BC), APL, village: Parasar	10 Aug 2006
50	Mrs. Gyanvati w/o Malkhan Singh, 44 years, Yadav(BC), APL, Gram Pradhan, village: Ahraura	10 Aug 2006
51	Mr. Malkhan Singh s/o Sonelal, 46 years, Yadav(BC), APL, village: Ahraura	10 Aug 2006
52	Mr. Kunwar Singh s/o Annara, 40 years, Yadav(BC), BPL, village: Ahraura	10 Aug 2006
53	Mr. Omprakash s/o Rajalal, 48 years, Patel(BC), APL, village: Ahraura	10 Aug 2006
54	Mrs. Devkunwar w/o Munnalal, 35 years, Dheemar(BC), BPL, village: Ahraura	10 Aug 2006
55	Mr. Munnalal s/o Ramgopal, 50 years, Dheemar(BC), BPL, village: Ahraura	10 Aug 2006
56	Mrs. Deshvani w/o Daru, 70 years, Yadav(BC), BPL village: Ahraura	10 Aug 2006
57	Mrs. Prema w/o Karan Singh, 55 years, Yadav(BC), APL, village: Ahraura	10 Aug 2006
58	Mr. Jayant Kumar s/o Ganesh Prasad, 40 years, Kori(SC), BPL, village: Ahraura	10 Aug 2006
59	Mr. Kamlesh Kumar s/o Brajey, 42 years, Chamar(SC), BPL, village: Ahraura	10 Aug 2006
60	Mr. Brajesh Kumar s/o Devendra Kumar, 25 years, Chamar(SC), APL, village: Ahraura	10 Aug 2006
61	Mr. Surendra Kumar/o Baburam, 45 years, Brahmin(FC), APL, village: Kakarvai	10 Aug 2006
62	Mr. Kalicharan Gautam s/o Lakshminarain Gautam, 37 years, Brahmin(FC), APL, village: Kakarvai	10 Aug 2006
63	Mrs. Malti Mishra w/o Ramendra Kumar Mishra, 40 years, Brahmin(FC), APL, Anganwadi worker, village: Kakarvai	10 Aug 2006
64	Mr. Munwar Singh s/o Eswar Dayal, 35 years, Yadav(BC), APL, village: Kakarvai	10 Aug 2006
65	Mr. Deshpath Sahu s/o Kamal Sahu, 26 years, Sahu(BC), APL, Constable in Border Security Force, village: Kakarvai	10 Aug 2006
66	Mr. Ratiram Sahu s/o Kamal Sahu, 39 years, Sahu(BC), APL, village: Kakarvai	10 Aug 2006
67	Mr. Gnanaram s/o Mannulal, 27 years, Kori(SC), APL, Gram Pradhan, village: Kakarvai	10 Aug 2006

68	Mr. Mahadev Prasad s/o Raghuvir Singh, Ward boy, Ayurved hospital, Kakarvai	10 Aug 2006
69	Mr. Pappu s/o Kannu, 33 years, Chamar(SC), BPL, Dadiapura, Jhansi	11 Aug 2006
70	Mrs. Chinku w/o Tulsi, 50 years, Dhobi(SC), BPL, Dadiapura, Jhansi	11 Aug 2006
71	Mrs. Muuni w/o Kalicharan, 45 years, Sahariya(ST), BPL, Dadiapura, Jhansi	11 Aug 2006
72	Mrs. Pushpa w/o Saraman, 30 years, Sahariya(ST), BPL, Dadiapura, Jhansi	11 Aug 2006
73	Mr. Brajkishore s/o Parat Singh, 36 years, Sahariya(ST), BPL, Dadiapura, Jhansi	11 Aug 2006
74	Mr. Rameshwar s/o Ramcharan, 40 years, Sahu(BC), APL, village: Dhhakarwara	11 Aug 2006
75	Mr. Pannalal s/o Radheylal, 40 years, Ahirwar(SC), BPL, village: Dhhakarwara	11 Aug 2006
76	Mr. Ramprasad s/o Satole, 65 years, Ahirwar(SC), BPL, village: Dhhakarwara	11 Aug 2006
77	Mrs. Champadevi w/o Premdas, 35 years, Ahirwar(SC), BPL, village: Dhhakarwara	11 Aug 2006
78	Mr. Premdas s/o Seth, 40 years, Ahirwar(SC), BPL, village: Dhhakarwara	11 Aug 2006
79	Mrs. Jokhandevi w/o Munna, 30 years, Ahirwar(SC), BPL, village: Dhhakarwara	11 Aug 2006
80	Mr. Pramod s/o Gyasi, 20 years, Barar(SC), BPL, village: Dhhakarwara	11 Aug 2006
81	Mr. Ramesh Kumar s/o Vidhyadhar Tiwari, 49 years, Brahmin(FC), APL, village: Dhhakarwara	11 Aug 2006
82	Mrs. Premadevi w/o Ramesh Kumar, 47 years, Brahmin(FC), APL, Gram Pradhan, village: Dhhakarwara	11 Aug 2006
83	Mrs. Rajabeti w/o Matadeen, 28 years, Kumhar(BC), BPL, village: Dhhakarwara	11 Aug 2006
84	Mr. Matadeen s/o Halkaye, 30 years, Kumhar(BC), BPL, village: Dhhakarwara	11 Aug 2006

Annexure 2

Checklist for interview/discussion

Stakeholder: Beneficiaries **Level: Village/urban slum**

Primary[16]:

1. Where do they seek health services now and where did they seek health services in the past?
2. Convenience – in terms of distance, timing, accessibility, staff availability and staff behaviour
3. Services offered in health post – range of services and availability of medicines – limited or more than what they expect?
4. Cost of service as compared to the past
5. Differential treatment to various sections of society
6. Perception about health post in terms of infrastructure and cleanliness
7. Overall do they think that service has improved as a result of PPP (if yes in what areas) or has it remained the same or has it deteriorated (if yes in what area)?

Stakeholder: UPHSDP Project Directorate **Level: State**

Primary:

1. Experience about the project so far and the lessons learnt
2. What changes have been made in the PPP model based on the experience?
3. What are the plans for the future to make the PPP model more effective?
4. Role of the World Bank in pushing this model of PPP

Secondary[17]:

1. Year of implementation of the project
2. Organizational structure
3. Main objectives of the project
4. Evaluations done so far

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[16] Primary denotes primary source of data

[17] Secondary denotes secondary source of data

Stakeholder: NGO/Private partner **Level: District**

Primary:

1. Experience of the NGO in general
2. Experience of the NGO in health sector
3. Is the NGO providing health services in other areas too? If yes, details thereof
4. Source of finance
5. Opinion/feedback on selection process
6. Opinion/feedback on terms and conditions of agreement
7. Opinion/feedback on payment (timely release of funds)
8. Opinion/feedback on documentation and monitoring (including reports)
9. Opinion/feedback on support from project staff and other officials of district
10. Opinion/feedback on support from community and beneficiaries
11. Opinion/feedback on scope for expansion
12. Opinion/feedback on logistical support
13. What are the areas they think they have achieved something and what are the areas in which there is scope for improvement?
14. Experience about referral system
15. Experience about infrastructural facilities
16. Motive(s) behind taking up this project
17. Experience about recruiting staff
18. What are the suggestions to improve this PPP model?

Secondary:

1. When was the NGO registered?
2. What are the objectives of the NGO?
3. Ownership of NGO and profile of owner(s)

Stakeholder: Staff employed by NGOs **Level: District/village**

Primary:

1. Profile of the staff
2. Motivation behind joining the health post

3. Feedback about working conditions – hours of work, salary, perks and benefits and other service conditions

4. Experience about infrastructure

5. Was there any interference from any quarter?

6. Feedback about support/cooperation received from community, health department staff, etc.

7. Views about maintaining various records – usefulness of these records and difficulties in maintaining them

Stakeholder: Officials of Health Department **Level: District**

Primary:

1. Experience/feedback on convenient location of health posts
2. Feedback on accessibility
3. Feedback on having qualified staff
4. Opinion about behaviour of health post staff especially towards poor and other marginalized groups of society
5. Experience about availability of medicines in health posts
6. Feedback on supervision and monitoring
7. Perception about cooperation/support from community for this PPP model
8. Experience about maintenance of records by NGOs
9. Perception about strengths and shortcomings of this PPP model

Stakeholder: Officials of District Administration **Level: District**

Primary:

1. Experience/feedback on convenient location of health posts
2. Feedback on accessibility
3. Feedback on having qualified staff
4. Feedback on behaviour of heath post especially towards deprived sections of society
5. Experience about availability of medicines
6. Feedback on supervision and monitoring
7. Perception about support from community for this PPP model

8. Opinion about release of funds

9. Opinion about nature of contracting – fairness and transparency issues

10. Perception about strengths and weaknesses of this PPP model

11. Feedback on complaints about health posts

12. Scope for replication of this model and upgrading health posts into full fledged health centres

Stakeholder: Community **Level: Village**

Primary:

1. Convenience – in terms of distance, timing, accessibility, staff availability and staff behaviour

2. Services offered in health post – range of services and availability of medicines – limited or more than what they expect?

3. Cost of service as compared to the past

4. Differential treatment to various sections of society

5. Perception about health post in terms of infrastructure and cleanliness

6. Overall do they think that service has improved as a result of PPP (if yes in what areas) or has it remained the same or has it deteriorated (if yes in what area)?

Stakeholder: Quacks **Level: Village**

Primary:

1. How has health post affected their practice?

2. What strategies were adopted to cope with loss of business to health post?

3. What future strategies have been thought about?

Annexure 3

INNOVATIVE PROPOSALS CONSULTANT SERVICES

Subject: Appointment of NGO/CBO/Consultant for carrying out innovative scheme in identified underserved/difficult/backward areas under Uttar Pradesh Health Systems Development Project to provide and supplement medical, health and family welfare service delivery in Uttar Pradesh.

Agency:____

1. Set out below are the terms and conditions under which ______________________(hereinafter referred to as the Consultant/NGO) have agreed to carry out for UPHSDP, Lucknow the above mentioned assignment specified in the attached proposal (Annexure – A) which is treated as part of the agreement.
2. For administrative purpose, Regional Project Manager/District Project Manger, UPHSDP, ______________Region/________________District has been assigned to administer the assignment and to provide the Consultant with all relevant information/support services needed to carry out the assignment. The services will be required in __________________district for a period of __________year from the award of contract i.e., ___________.
3. The Project Director, UPHSDP, Lucknow may find it necessary to postpone or cancel the assignment and /or shorten or extend its duration. However, every effort will be made to give the Consultant, as early as possible, notice of any such changes. In the event of termination, the Consultant shall be paid for the services rendered for carrying out the assignment to the date of termination, and the Consultant will provide the UPHSDP, Lucknow with any reports or parts thereof, or any other information and documentation gathered under this Agreement prior to the date of termination.
4. The services to performed, the estimated time to be spent, and the reports to be submitted will be in accordance with attached proposal (Annexure-A).

Following reports/Outputs (from the date of signing of contract) will be submitted/required by the Consultant.

a. Inspection Report
b. Field Survey Report
c. Quarterly Progress Report
d. Annual Completion Report

5. This Agreement, its meaning and interpretation and the law of Union of India shall govern the relations between the parties.

6. This Agreement will become effective upon confirmation of this letter on behalf of the Consultant and will terminate on ______________(specify date) or such other date as mutually agreed between the Regional Director, UPHSDP and the Consultant.

7. Payment for the services will not exceed the total amount of Rs 2,87,000/- (Rupees Two Lakhs and Eighty Seven Thousand Only). The above remuneration includes al the costs related to carrying out the services including overhead and any taxes imposed on the Consultant. The Regional Director, UPHSDP, ___________Region will pay to ___________________________within 30 days of receipt of invoice as follows: a remuneration of

Amount	Currency	Subject to completing formality
20%	Indian Rupees	After unequivocal acceptance of letter of award against bank guarantee or on completion of survey and its approval by the Regional Committee
30%	Indian Rupees	On submission of the field survey report and 6 monthly progress against agreed indicators & its approval from the competent authority (RPM)
30%	Indian Rupees	On submission of IIIrd Quarter draft analysis report of field work & other deliverables of monitoring indicators and its approval from the RPM
20%	Indian Rupees	After the acceptance of the final report by the competent authority (PD)

8. The Consultant will be responsible for the appropriate insurance. In this regard the Consultant shall maintain workers compensation, employment liability insurance for their staff on the assignment. The Consultant shall also maintain comprehensive general liability insurance, including contractual liability coverage adequate to cover the indemnity of obligation against all damages, costs, and charges and expenses for injury to any person or damage to any property arising out of, or in connection with the services which result from the fault of the Consultant or its staff. Consultant shall provide the UPHSDP with certification thereof upon request if need arises. UPHSDP will not be responsible for any loss whatsoever caused to the Consultant in executing the contract.
9. The Consultant shall indemnify and hold harmless the UPHSDP, Lucknow against any and all claims, demands and/or judgements of any nature brought against the UPHSDP, Lucknow arising out of the services by the Consultant under this Agreement. The obligation under this paragraph shall survive the termination of this Agreement.
10. The Consultant agrees that any manufacturing or construction firm with which they might be associated will not be eligible to participate in bidding any goods or works resulting from or associated with the project of which this consulting assignment form a part.
11. All final reports and other documents or any software submitted by the Consultant in the performance of the services shall become and remain the property of the client. The Consultant may retain a copy of such documents but shall not use them for purposes unrelated to this contract without the prior written approval of the client.
12. The Consultant undertakes to carry out the assignment in accordance with the highest standard of professional and ethical competence and integrity, having due regard to the nature and purpose of the assignment and to ensure that the staff assigned to perform the services under this Agreement conduct themselves in a manner consistent herewith.

13. The Consultant shall pay the taxes, duties, fee, levies and other imposition levied under the applicable law and the client shall perform such duties in this regard to the deduction of such tax as may be lawfully imposed.
14. The Consultant also agrees that all knowledge and information not within public domain which may be acquired during the carrying out of this assignment shall be for all time and for all purposes regarded as strictly confidential and shall not be directly or indirectly disclosed to any person whatsoever, except with the UPHSDP, Lucknow's written permission.

Annexure:

Place: Authorized Signatory for the Consultant

Date: Authorized Signatory for the Client