Health sector reform and public-private partnerships for health in Asia: Implications for sexual and reproductive health services

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1. Introduction

1.1 Introduction
In most countries of the world, financing as well as provision of health services has historically involved both public and private sector actors. The nature of relationship between these two may lie anywhere along the following broad spectrum:

- **Parallel activities**: This represents a situation where the two sectors co-exist with little contact between each other, and providing different sets of services to different sectors of the population. One example of this would be the activities of, and population groups served by, private sector traditional healers for mental illnesses as compared to publicly provided psychiatric services under the western system of medicine.

- **Competitive activities**
  Activities in the public and private sectors have similar objectives, cater to the same clientele and compete with each other. This may result in expanded choices for users and greater efficiency for both sectors, or represent a wasteful duplication of activities.

- **Complementary activities**
  Activities or services from the public and private sectors complement each other either geographically and in term of population coverage, or in terms of range of services provided, e.g. primary care by the public sector and specialist care by the private sector. This may happen incidentally – as for example when the public sector is unable to invest in specialist services. However, it is increasingly the result of specific policy decisions by government to promote the participation of the private sector. For example, governments may choose to play a regulating or financing role, leaving the provision of most curative services to the private sector.

- **Collaborative activities**
  Public and private sector actors work together on the basis of shared objectives, strategies and agreed monitoring and evaluation criteria, usually through the formation of a new joint entity for implementation.

This paper focuses on the last two types of relationships described above: public and private sectors working complementarily or collaboratively in the health sector. While these kinds of relationships between the public and private sectors...
in health are not new, the 1990s has witnessed the development of specific kinds of complementary and collaborative relationships between the two sectors, known as ‘public-private partnership’ (PPP). This has been associated with the growth of ideological and policy support for the idea that public and private sector should work together.

‘Public-private partnership’ and increasing the role of private sector in health are themes which currently occupy a central position in health sector reform agendas throughout the world.

According to Reich (2002), public-private partnerships involve at least one private-for-profit and one not-for-profit or public actor as partners. The private sector is constituted of many different elements, including both non-profit and for-profit entities. In some definitions of PPPs ‘private’ is defined as corporate, for profit enterprises, and ‘public’ as national and local governments and multilateral agencies, as well as other not-for-profit organisations: Non governmental organisations (NGOs) and private foundations (2). However, others choose to classify NGOs as belonging to the private sector (3).

The difficulty in classifying NGOs organisations arises because of the heterogeneity of this group. They include private foundations and organisations which are mainly donors, and play a financing role similar to that of the government. Such organisations would best be classified as ‘public’ within public-private partnerships. So also may NGOs that are not-for-profit and are engaged in service delivery.

However, there are also non-governmental organisations which function like enterprises, earn a profit but instead of distributing these to their share holders, use the profits in support of activities that further their mission. Many family planning associations, for example, function in this way (4, p.20) Profit-earning non-governmental organisations producing health products and commodities or providing health services may fit better into the ‘private’ sector category.

In this paper, we have chosen to define private as corporate, for-profit enterprises and that part of the non-governmental sector which aims to generate a profit. Public includes national and local governments, bilateral donors and private not-for-profit foundations organisations which play a role similar to that of the government in terms of financing health care services.

The paper examines public-private partnerships in the health sector, especially those related to sexual and reproductive health services, in select countries of Asia. Our attempt is to understand their potential implications for equity in the availability, accessibility, affordability and quality of health services. The paper is based on published literature and information available on the web.
There seem to be two parallel discourses in the published literature on public-private partnerships, one related to partnerships at the global level and the other which concerns itself predominantly with partnerships at the national level. While we take note of global PPPs, the paper examines mostly PPPs at the national level. Published information on how a global PPP in the area of sexual and reproductive health functions at the country level appears to be limited.

The first section of the paper looks at the factors that underlie the emergence of Public Private Partnerships, and the nature of public-private partnerships at the global and country levels. Section two starts with looking at diverse public-private partnerships in sexual and reproductive health services that have existed in developing countries over the past several decades and presents case examples from select Asian countries of specific types of partnerships. Section three draws on the general literature on public private partnerships to interrogate the implications for sexual and reproductive health services.

1.2 Global economic and political factors underlying the emergence of Public Private Partnerships for health

PPPs are not new, and have existed in one form or another for a long time. What are new are the scope and influence of PPPs in the 1990s and the legitimacy they have gained from major global players, as a major strategy for health development.

A number of factors appear to have contributed to the growth of Public Private Partnerships in the 1990s. From the perspective of international organisations – the UN and WHO among them – there was growing realisation of the need to engage with the corporate sector whose influence reached beyond the confines of nation states. This was especially important for the success of international campaigns for the eradication of diseases, because these required the adequate availability of drugs and vaccines, and their effective distribution on a global scale.

Financial imperatives also encouraged such partnerships. At a time when funds for the UN were drying up, the opportunity to raise resources from the private sector could hardly be ignored. Private Foundations played a major catalysing role in the emergence of public private partnerships at a global level. For example, the establishment of the United Nations Foundation Inc in 1998 and a vast endowment from the Bill and Melinda Gates Foundation were instrumental in the formation of Public Private Partnerships involving the WHO. In her report to the Executive Board of WHO in 1999, the Director General mentioned that ‘both these foundations have made partnerships and collaboration with the private sector a key feature of their grant giving (5, p.1). The amounts involved were very large – US$ 100 million annually was committed by the UN Foundation for a period of ten years, while the Gates Foundation made an endowment grant of US$ 17 thousand million (5). Other reasons commonly given for the UN’s interest
in Public Private Partnerships include a desire on the part of the UN system to get back to the centre stage of action, and to be seen as pursuing efficiency, which a collaboration with the private sector would bring (2,6).

What were the factors that made it appealing for the private-for-profit sector to enter to such partnerships? As the power of organised corporate capital grew with the globalisation of 1990s, the corporate sector sought to have a greater voice in international organisations in order to protect its business interests internationally. The International Chamber of Commerce (ICC) established a systematic dialogue with the UN, in efforts to ‘establish global rules for an ordered liberalism’ (6). In the health sector, the pharmaceutical industry in particular was interested in evolving international regulations that would prevail over national regulatory mechanisms to protect business interests. Public Private Partnerships provided the pharmaceutical industry with a bargaining chip for implementing Trade related aspects of intellectual property rights (TRIPs) agreements, and to prevent compulsory licensing issued by governments on public health grounds (6). This would help companies maintain their high levels of profitability from products they have developed.

Another consideration was the possibility of penetrating and developing new markets. For example, the Global Sustainable Development Facility (GSDF), a partnership between leading corporations and the UNDP aim to include two billion new people in the global market economy by 2020 (6). The Hindustan Lever in India wants to invest in water and sanitation development in the country because this will contribute to the creation of a market for its soaps and hygiene products. Similarly, GlaxoSmithKline invests in hygiene and sanitation activities across Africa so that there is greater awareness about worm disease, and consequently, a greater demand for the drugs produced by the company for treating this condition (3).

The improved image of the particular company resulting from its participation in Public Private Partnerships would also help increase consumer preference for their brands, and is thus a form of advertisement similar to sponsorship of events.

Alongside these factors related to changes in the attitudes of the UN and global business has been the emergence of a way of thinking which believes that market style reforms are the answer to the problems faced by the health sector in most countries of the world. There is growing literature making the case for the appropriateness and benefits of PPPs for health development, which puts forth most of the above arguments (2,3,7,8). Public-private partnerships in health are seen as win-win arrangements in which diverse actors with varied motivations and philosophies work together, albeit with different motivations, and are able to contribute to health development.

The major arguments in favour of PPPs run as follows (2,3,6,7,8):
It has become necessary to pool all available resources to promote the common good of better health for all, and especially the poorest in the poor countries of the world. What is more, it is the responsibility of national governments to do so in the interest of its people.

They help improve health sector efficiency. Private for-profit institutions bring with them a way of doing business which is more effective and efficient, and complement the social commitment of public sector institutions. The private sector is also competent in making initiatives and projects sustainable, which will help ensure stability and long-term sustenance of health programmes.

PPPs will bring the benefit of the private sector’s expertise in reaching and motivating consumers. This could help achieve wider population coverage with health promotion messages, services and products such as bed-nets for malaria or contraceptive pills. The other partner - international organisations in the public sector- can help provide the private sector efforts with legitimacy, the global outreach necessary to advocate for replication of successful initiatives, and the regulatory mechanisms necessary to ensure that social goals are not compromised.

The quality of health and allied services will improve because the monopoly for provision of goods and services by the public sector will be replaced with competition between public and private sectors.

Competition between public and private sectors will also ensure that resources are allocated more efficiently in the health sector. Government public health interventions could be restricted to areas where there is market failure.

PPPs would contribute to health equity. Those able to pay will use private services while public resources are targeted to reach those who cannot pay.

The public sector should limit its role to financing, and purchase health care from a number of potential providers who compete with each other. Competition is the ‘key’ to efficiency.

Table 1 below summarises the contributions of and benefits for the public and private sectors from public-private partnerships for health (8).
Table 1. Possible benefits for and contributions of the private-for-profit and public sectors in public-private partnerships for health (8)

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Private for-profit sector</th>
<th>Public sector</th>
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<tbody>
<tr>
<td></td>
<td>➢ Enhanced image as a global corporate citizen increases brand equity</td>
<td>➢ Better services with higher coverage leading to improved health, which assists economic development</td>
</tr>
<tr>
<td></td>
<td>➢ Team motivation (I like working for a socially engaged company)</td>
<td>➢ Liberation of resources helps reaching the poor</td>
</tr>
<tr>
<td></td>
<td>➢ Shared risk in moving to new markets and developing those markets</td>
<td>➢ Tools and techniques for consumer research marketing</td>
</tr>
<tr>
<td></td>
<td>➢ Influence in international organisations’ circle</td>
<td>➢ Learning about clients as consumers</td>
</tr>
<tr>
<td></td>
<td>➢ Insight into the nature of future markets (the unserved majority)</td>
<td></td>
</tr>
<tr>
<td>Contributions</td>
<td>➢ Marketing and management expertise</td>
<td>➢ Catalyst role</td>
</tr>
<tr>
<td></td>
<td>➢ Consumer focus in product development</td>
<td>➢ Legitimacy/institutional home</td>
</tr>
<tr>
<td></td>
<td>➢ Resources</td>
<td>➢ Resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td>➢ Knowledge of target markets</td>
</tr>
<tr>
<td></td>
<td></td>
<td>➢ Facilitate regulatory environment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>➢ Best practices and global vision</td>
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The World Bank has played an instrumental role in fostering support for public-private partnerships in developing countries. According to a World Bank document,

‘Economic growth – and the opportunity to break free from poverty – depend on a dynamic business sector, unencumbered by corruption, red tape, or needless legal restrictions. (9)

In order to help governments – especially in developing countries – build sound public policy to stimulate private-sector involvement, the World Bank Group has created Private Sector Advisory Services. Private Sector Advisory Services now work in more than 100 countries to create a favourable legal environment for the development of the private sector and to improve public services through the involvement of the private sector (9).
This was not simply a question of ideology, but based on financial imperatives. According to an address by the World Bank’s President in a conference on PPPs, total official assistance to the developing world was currently at the lowest levels in two decades, because governments were not keen to put money into direct assistance. This had affected the International Development Assistance (IDA) – the World Bank’s concessional lending arm, which relies on donor support. The private sector increasingly fills this vacuum (10).

There have also been a number of Conferences and symposia around the world, including in the Asian Region, to promote the idea of public-private partnerships. In 1994, the World Health Organization’s South East Asia Regional Office held a meeting on improving the complementarity of the private and public sectors in health (11). A joint Asia Development Bank (ADB)-World Bank Conference was held in Manila in November 1999 on Public Private Partnerships in health and education (12). In October-November 2000, the ADB Institute in Thailand and the National Economic and Social Development Board (NESDB) jointly organised a conference on Public Private Partnerships in health in Thailand (13). In 2001, a WHO-SEARO meeting on the management of STIs recognised an important role for partnership with the private sector to help the prevention and control of STIs (14).

These global developments underlie or facilitate the introduction of public-private partnerships as an integral component of health sector reforms in many countries, including in Asia.

1.3 Examples of public-private partnerships in health

As already mentioned, PPPs may be classified into those that are global in scope, and those which operate at national and sub-national levels.

Global public–private partnerships

A number of global public-private partnerships have come into existence during the 1990s. Of these, there are at least 16 global PPPs which involve the WHO in significant ways. (2)

Global PPPs may be broadly categorised as those related to
- products: their donation, development and/or distribution
- strengthening health programmes
- strengthening health service delivery (2,3,6)

An example of a global public private partnership is the Global Alliance for Vaccines and Immunisations (GAVI). Partners of this alliance include national governments, PATH, which is an international NGO, the International Federation of Pharmaceutical Manufacturers’ Association (IFPMA), public health and research institutions, private foundations such as the Bill and Melinda Gates
Foundation, the Rockefeller Foundation, the World Bank group and UNICEF and WHO. This partnership aims to promote immunisation of children in developing countries and also provide financial support for the development of new vaccines (6).

Medicines for Malaria Venture, set up as an independent foundation to spur the development of new anti-malarial drugs brings together WHO and the World Bank, IFPMA, the Rockefeller Foundation, a number of bilateral donors and the Global Forum for Health Research as well as the global Roll Back Malaria partnership (6).

In the area of sexual and reproductive health, Accelerating Access Initiative is a global Public Private Partnerships set up to provide access to HIV/AIDS related treatment and care in poor countries, in which five international organisations collaborate with five transnational pharmaceutical companies (6).

UNFPA’s Global Initiative on Contraceptive Requirements and Logistic Management Needs aims to expand commercial markets for contraceptive products. It also forges public-private partnerships to reduce contraceptive costs. This initiative is funded by the Rockefeller Foundation, Packard Foundation and the DFID (4, p.63).

Public-private partnerships at the country level

Literature on public-private partnerships in health at the country level alludes to a much broader range of arrangements between the public and private sectors in health. There appears to be a thin line dividing the concept of public-private partnerships defined in such broad terms as above, and ‘privatisation’, which involves a greater role of the private sector vis-à-vis the state. For the purpose of this paper, we exclude from ‘partnerships’ policy measures such as providing tax exemptions or subsidies to the private sector, and joint activities exclusively among members of the private sector, as for example, an international business entity and a national one. We consider all other arrangements that involve public and private sector actors engaged in some form of interaction or collaboration in the implementation of activities for promoting a health goal.

Country level PPPs in health are found both in developing and in industrialised countries. Partnerships in industrialised countries are often related to social insurance schemes and more recently, to public hospitals, in one or more of the forms listed in the table above. In a recent scheme in the UK, for example, private firms bid competitively for projects involving financing, and constructing new hospitals, maintaining the facility and providing non-clinical services, while clinical services are provided by the public sector. Arrangements that involve the private partner leasing a public hospital, and managing both clinical and non-clinical services are found in Australia, Sweden and other countries (15). Those
working on ageing related services (16) have made a case for public-private partnership for financing long-term care in the United States.

In developing countries, policies that consciously promoted the role of the private sector in health were often the result of shrinking health budgets following the economic crises of the 1980s. One of the first forms this took is involving the private sector in the management of public hospitals and health centres. Subsequently, health sector reform projects of the 1990s have actively promoted PPPs for carrying out specific health activities and/or for covering specific sectors of the population.

The USAID has been a leader in initiating a number of public-private partnerships in sexual and reproductive health services. Starting already in the 1980s under the Reagan administration, the USAID has been allocating significant technical and financial resources to PPPs. UK and Germany are other bilateral donors who are committed to promoting PPPs in reproductive health. Their efforts have been almost exclusively in the area of social marketing of contraceptives ((4, p.63). This is also the case in many Asian countries which have had a state-sponsored family planning programme.

As mentioned earlier, the World Bank has been among the most important promoters of PPPs in health at the country level. Public-private partnerships are a component of almost all World Bank funded health projects in the 1990s. The Bank influences the public sector to actively promote PPPs as part of the activities of health system reforms projects. The bank’s private investment arm, the International Finance Corporation (IFC) has increased its lending for commercial health activities (4, p. 64).

For example, a 1998 World Bank sector report has discussed extensively the scope for public-private partnerships in health in Pakistan. A large section of private practitioners in Pakistan are people with little or no formal training, and trained health professionals are concentrated in the urban sector. Public-private partnership initiatives recommended by the report include:

- Continuing education programmes for public and private providers to be run by professional associations e.g. the association of family physicians
- Extending social insurance schemes to include self-employed persons, and registering private clinics and practitioners as service providers to be reimbursed from insurance funds.
- Developing a pilot project for provincial governments to contract with an association of private physicians, for the provision of basic services to a targeted urban slum population on a prepaid capitation basis.
- Developing modalities for public sector contracting with private maternity homes (17).
The following are examples from select South and South East Asian countries of PPPs in the health sector, usually introduced as part of the HSR initiatives backed by the World Bank, with the involvement of USAID and a few other bilateral donors such as DFID.

**Contracting out primary care services**
The Urban Primary Health Care Project in **Bangladesh** operational in four city corporations is an example of public-private partnership financed by the Asian Development Bank and implemented in 1998 by the Ministry of Local Government, Rural Development and Co-operatives. Donor funding will support the construction of 190 new primary health care centres near low-income areas, each having a catchment area of about 50,000 people.

Competitive bidding is to be used to select an organisation with which to enter into a partnership contract to delivery the basic package of services. Included in the package are immunisations, Vitamin A supplementation, family planning services, antenatal, and postnatal care; case management of pneumonia and diarrhoea in children, case-management of tuberculosis and reproductive tract infections in adults, basic first aid and psychological support for women affected by violence, and health education. Some of the facilities will provide obstetric services for normal deliveries and all emergency obstetric care barring c-sections (18).

In Tamil Nadu, **India**, the state government has involved private-for-profit organisations in construction, maintenance and provision of equipment in public hospitals and health centres. The government provides staff and drugs and manages the facilities. As many as 100 primary health centres (PHCs) in Tamil Nadu are to be maintained through various private companies and industrial houses (19). Karnataka proposed to engage NGOs to operate some of the government facilities in remote tribal and backward districts, in an attempt to enhance coverage (20). This has also been attempted in Maharashtra for several years even before the World Bank project (19).

**Private participation in public hospitals**
One of the more prevalent forms of country-level public-private partnerships has been the involvement of the private sector in public hospitals. The following table describes the various options for private participation in public hospitals:
### Table 2: Options for private participation in public hospitals (15)

<table>
<thead>
<tr>
<th>Option</th>
<th>Private sector responsibility</th>
<th>Public sector responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-location of private wing within or beside a public hospital</td>
<td>Operates private wing for private patients. May provide only accommodation services or clinical services as well</td>
<td>Manages public hospitals for public patients and contracts with private wing for sharing joint costs, staff and equipment</td>
</tr>
<tr>
<td>Outsourcing nonclinical support services</td>
<td>Provides nonclinical services (Cleaning, catering, laundry, security, building maintenance) and employs staff for these services</td>
<td>Provides all clinical services and staff and hospital management</td>
</tr>
<tr>
<td>Outsourcing clinical support services</td>
<td>Provides clinical support services such as radiology and laboratory services</td>
<td>Manages hospital and provides clinical (and non-clinical) services</td>
</tr>
<tr>
<td>Outsourcing specialised clinical services</td>
<td>Provides specialised clinical services (such as lithotripsy) or routine procedures (cataract removal)</td>
<td>Manages hospital and provides most clinical (and non-clinical) services</td>
</tr>
<tr>
<td>Private management of public hospital</td>
<td>Manages public hospital under contract with government or public insurance fund and provides clinical and non-clinical services. May employ all staff. May also be responsible for new capital investment, depending on terms of contract.</td>
<td>Contracts with private firm for provision of public hospital services, pays private operator for services provided, and monitors and regulates services and contract compliance</td>
</tr>
<tr>
<td>Private financing, construction and leaseback of new public hospital</td>
<td>Finances, constructs, and owns new public hospital and leases it back to government</td>
<td>Manages hospital and makes phased lease payments to private developer.</td>
</tr>
<tr>
<td>Private financing, construction and operation of new public hospital</td>
<td>Finances, constructs, and operates new public hospital and provides non-clinical or clinical services, or both.</td>
<td>Reimburses operator annually for capital costs and recurrent costs for services provided.</td>
</tr>
<tr>
<td>Sale of public hospital as going concern</td>
<td>Purchases facility and continues to operate it as a public hospital under contract</td>
<td>Pays operator for clinical services and monitors and regulates services and contract compliance.</td>
</tr>
<tr>
<td>Sale of public hospital for alternative use</td>
<td>Purchases facility and converts it for alternative use, depending on sales agreement</td>
<td>Monitors conversion to ensure adherence to contract obligations.</td>
</tr>
</tbody>
</table>


In **India**, Contracting out of non-clinical services in hospitals - e.g. laundry, cleaning services, drivers, dietary services - is a feature of state-level HSR projects in all the seven World Bank funded State Health Systems Development Projects (20-24). In 2002, in four of the states of these seven states there were at least 500 hospitals contracting non-clinical services ranging from ambulance services and maintenance of medical equipments to cleaning and laundry and catering services (25). In Uttar Pradesh, space in public hospitals was to be
leased out to private diagnostic services (24). In Maharashtra, a joint venture company including the government and the private commercial sector has been launched to set up a super-specialty hospital (25).

Besides these, which are a part of the ‘reform’ packages, there have been public private partnerships initiated in these and other states through the independent initiatives state governments in the face of resource constraints. In Kerala and Rajasthan, hospital development committees have been set up to mobilise private resources in addition to charging fee for services (19,26).

A similar attempt in Indonesia was made in the early 1990s. The ‘Unit Swadana’ scheme was introduced to make public hospitals self-sustaining by encouraging them to raise and retain their own revenue. The main source of revenue raised was user fees, but there were also many instances of private sector investment in these hospitals. Investments were usually for capital expenditure in the form of purchase of new equipment or construction of new wards (27).

In the NorthWest Frontier Province of Pakistan, PPP between a privately owned medical college and the district headquarters hospital consists of the following. The medical college charges high capitation fees from its students, which is then channelled to the district hospital to upgrade its facilities to meet the requirements for a teaching hospital (13).

The Phya Thai Group in Thailand, which runs a private hospital chain, has recently entered into a partnership with the Ministry of Public Health (MOPH). The Group's Rangsit University and MOPH have come together in the establishment of the first private medical school in Bangkok. The medical school's clinical training is conducted in the public sector Rajvithi Hospital with Rangsit support in funding and erecting school buildings and dormitories for the hospital. Another area of partnership between Phya Thai and MOPH is to unite government-run provincial hospitals with private hospitals in the same locality. The director of the provincial hospital directs the co-opted model. The state-of-the-art Phya-Thai Heart Centre has recruited the Director and consulting cardiologists from government hospitals on a part-time basis (28).

Production of drugs and supplies
The government of Thailand has entered into partnerships with the private sector for the production of medical supplies and drugs. For example, the Government Pharmaceutical Organisation (GPO) holds a large share in the Thai Herbal Products Co. Ltd, producing herbal medicines for local consumption and export. The GPO provides technical support and maintains quality control, and also earns a share of the profit. The GPO has established the General Hospital products Public Company with a group of private investors, which produces and distributes IV solutions and sets and various bottles for use in both public and private sector health facilities (28).
**Social insurance**
Public-private partnerships have existed for some time in **Thailand** in the form of some of its social insurance schemes, which involve an arrangement between the public social insurance fund and private sector providers. For example, the insurance for government workers – Civil Servant Medical Benefit Scheme (CSMBS), the Thai Social Security Act (SSA) and the Workmen Compensation Scheme (WCS) allow insurees a choice of public or private providers (29,30,31).

**Managed care organisations**
In **Indonesia**, an example of a broad public-private partnership in the health sector is ‘managed care’ introduced in 1992 through the National Health Law. Early experiments were not very successful in enrolling insurees. In 2001, when the government of Indonesia introduced the most recent wave of health sector reforms with the support of the World Bank, a large-scale expansion of ‘managed care’ to one-third of Indonesia was also being planned. Based on models operating in the US, this would encourage private ‘managed care’ or ‘health maintenance’ organisations (HMO) to enter the market. These HMOs would be intermediaries between the ‘buyers’ – households and enterprises – and ‘sellers’ – public sector as well as private sector health provider/ facility networks. Buyers would enrol with these HMOs and pay a regular premium, and providers will be reimbursed by the HMO on a capitation basis for the number of patients enrolled with them. The poorer sections may be subsidised by the government to enrol in such schemes. Whether this proposal has been implemented is not clear at the time of writing this (32).

2. Public-private partnerships in sexual and reproductive health services in Asia

2.1 Public private partnerships in sexual and reproductive health services

Public private partnerships are thought to be particularly relevant for the promotion of sexual and reproductive health services, for a number of reasons. A UNFPA document cites paragraph 15.5 of the ICPD Programme of Action as the rationale for involving the private sector in reproductive health services:

“To strengthen the partnership between governments, international organizations and the private sector in identifying new areas of co-operation;

“To promote the role of the private sector in service delivery and in the production and distribution, within each region of the world, of high-quality reproductive health and family planning commodities and contraceptives, which are accessible and affordable to low-income sectors of the population.” (33)

Berg (2000) outlines some of the reasons why public-private partnerships are important for the development of SRH services. To begin with, SRH services
have to ‘do more with less’. The ICPD mandate requires governments to provide an expanding array of high quality services. Demand for SRH services is rising also because of the increasing number of people in the reproductive age, rising need for preventive services increasing education and awareness and the growing HIV/AIDS epidemic. At the same time, donors are phasing out of several developing countries and providing substantially decreased support to others for a variety of reasons. The resulting financial crunch has created the imperative to explore alternative ways of mobilising financial and non-financial resources to meet health goals (34).

PPPs are also considered important for the effective management of sexually transmitted infections, because a large majority of STI patients in many parts of the world seek care from the private sector, perhaps more so than for other health problems. The private sector offers more personalised services, is more sympathetic and is often more convenient in location and timing. Privacy and confidentiality are other important considerations for STI patients. However, the private sector may not comply with nationally approved protocols for STI treatment and control, follow-up the patient, provide counselling for safer sex practices and partner notification. They may also adhere to standard recording and reporting procedures required by the national programme. For all these reasons, a partnership between the public and private sectors may offer the best of both worlds and help make the control and management of STIs more effective. The public sector would play a monitoring and technical support role and provide drug supply, and the private sector would be involved in service delivery (14).

A large number of global PPPs exist in specific areas of sexual and reproductive health. The following are some examples.

The Accelerating Access Initiative mentioned earlier is an initiative to provide HIV/AIDS related care and treatment in low-income countries. The Global Fund to fight AIDS, TB and Malaria is another Global Public Private Partnerships. The Fund has been established to support interventions for the prevention, treatment, care and support of people with AIDS, TB and malaria (2).

Efforts are underway to constitute a global public-private partnership – the International Partnership for Microbicides (IPM) to accelerate microbicide development for the prevention of HIV infection (35).

The Global Initiative on Reproductive Health Commodity Management initiated by the UNFPA and including manufacturers of several contraceptives seeks to increase access to reproductive health commodities (36).

The Global Partnership for Youth Development is a partnership between an international NGO – the International Youth Foundation (IYF), the World Bank,
the Kellogg Company, and many other companies and organisations which works for the promotion of young people’s health and development (37).

Public-private partnerships in sexual and reproductive health services share most of the characteristics of PPPs in any health service, but also have some unique features. For many decades, family planning programmes in many developing countries have had PPP arrangements such as social marketing of contraceptives and franchising for service delivery. These may be considered as older forms of PPPs, because they involve a partnership between government or bilateral donor and the commercial sector. These older forms of partnerships have been joined by more recent arrangements that came with the emergence of global PPPs and health sector reforms, which include contractual arrangements between the two sectors for direct involvement in service delivery, distribution of products or provision of technical support.

In the next section, we examine country case examples of public private partnerships specific to sexual and reproductive health services: social marketing, social franchising and other forms of PPPs. The following countries have been included: Bangladesh, India, Indonesia, Nepal, Pakistan, Philippines and Thailand. The choice of countries for case studies is pragmatic, based on availability of published information.

2.2. PPPs in sexual and reproductive health in select Asian countries

Social marketing programmes
‘Social marketing’ may be described as the application of market tools concepts and resources to effectively deliver health products and services and motivate the use of those products and services. Products are charged subsidised prices and distributed by commercial distribution systems to retail outlets. Behaviour change strategy seeks to promote access to and demand for goods and services by integrating health education with commercial brand advertising (38). The subsidy may be provided by the government, or by a bilateral donor.

Many social marketing programmes begin with donor subsidies for covering costs, and eventually become self-supporting through full cost recovery. However, if low-income populations are to be reached, then cost-recovery may have to be subordinated to achieving the social goals, and this means that ongoing donor support will be needed.

Programmes providing subsidies for the delivery of contraceptives through commercial distribution systems began as early as in the 1960s, but became widespread in many parts of the world in 1981 with USAID’s first world-wide Contraceptive Social Marketing (CSM) technical assistance effort. A second programme – the Social Marketing for Change (SOMARC) was launched in 1984, also by USAID. This project solicited the active collaboration of the commercial sector not only to distribute products but also to contribute financial
and in-kind resources. The prices were set at levels affordable to low-income groups. Other well known international Social marketing organisation include the TIPPS Project, the PROFIT project, and the Commercial Markets Projects, all funded by the USAID (39).

Social marketing of condoms has become an important component of AIDS control programmes since the mid 1980s. By 1999, at least 71 different social marketing programmes for male and female condoms were active in 59 developing countries as part of HIV/AIDS prevention efforts (40).

Many new health products are also being distributed through this channel. Pre-packaged therapy (PPT), a package of standard medication, which can effectively treat STI and the clean delivery kit for home births are among recent products being marketed by Population Services International (PSI), a Washington DC based non-profit organisation working in more than 50 developing countries (41).

Contraceptive social marketing programmes have been operational in many South and South East Asian countries for several decades, and these have now been joined by condom social marketing efforts aimed at HIV/AIDS prevention.

**Bangladesh**

Bangladesh has had a social marketing project for distribution of contraceptives since 1976. This project has been funded liberally by USAID ever since its inception. It is now considered the second largest contraceptive social marketing effort in the world (after India). The project was later constituted into SMC- Social Marketing Company. SMC’s condoms, pills and other health products are estimated to be available in about 20,000 sales outlets all over Bangladesh (42). Its well known brand names include Raja condoms and Femicon oral pills. As early as in 1993, SMC was reported to be providing 2.2 million couple-years of contraceptive protection, 60% through condom sales and 40% through sales of oral pills (43).

More recently, SMC has initiated condom social marketing for HIV/AIDS and prevention of sexually transmitted infections, with clients of sex workers as principal audience. There is also a plan to promote female condoms among sex workers (44).

**India**

India has a long history of a condom social marketing programme sponsored by the government. Operative since 1968, this scheme includes three different qualities of condoms called Nirodih, procured from Indian condom manufacturers and supplied to marketing companies and NGOs called Social Marketing Organisations (SMOs). SMOs get a promotional incentive per condom sold.
A similar social marketing programme for Oral contraceptive pills was launched in 1987. Since 1988, the government of India has also provided funding to specific commercial organisations and NGOs to implement social marketing ‘Area Projects’ in specific geographic locations (45).

In Uttar Pradesh, an extensive social marketing programme was started in 1997, designed and managed by the State Innovations in Family Planning Services Agency (SIFPSA), constituted jointly by USAID, the government of India and the government of Uttar Pradesh (34).

There is a large oral pill social marketing project, also funded by USAID, operating in eight Indian states: Madhya Pradesh, Bihar, Rajasthan, Jharkhand, Uttaranchal, Uttar Pradesh, Chattisgarh and Delhi. The private sector partner for this project is the Indian owned Industrial Credit and Investment Corporation of India (ICICI) bank. Technical support is provided by Commercial Market Strategies (CMS), and PATH (Programme for Alternative Technology in Health), both US-based consultancy organisations. This social marketing programme called ‘friends of the pill’ (Goli ke humjoli) is based on extensive qualitative research among current and potential OC users, their spouses and key household decision-makers. The programme uses mass media advertisements, and celebrity endorsements to raise awareness about oral contraceptives and to address concerns related to side effects. Over 30,000 pharmacists and 22,000 traditional doctors have been trained on issues related to oral contraceptives, and briefing sessions have been held for medical associations and other civic groups. Information is disseminated by mail to over 27,500 doctors, and there have been over 300 newspaper and magazine articles on to programme (46).

Population Services International (PSI), a US based social marketing firm, is another player in the social marketing field in India. A more recent addition of PSI products is the clean delivery kit which includes tetracycline eye drops to treat chlamydia, Vitamin A megadose capsules, soap, a plastic sheet, a new razor blade, clean cord ties, pair of gloves and pictorial illustration of correct use of the kit (47).

In the 1990s, condom social marketing programmes have been initiated also as part of the HIV/AIDS prevention strategy in many parts of the country. An innovative project in Chennai, Tamil Nadu, is a community-based social marketing project "aXess". This project recruits and trains IEC and sales agents from among members of the community, exclusively or in addition to members of specific risk groups. These agents are financially rewarded not only for sales of condoms but also for recruiting other sales agents and educators, so that the network expands, creates a high demand for information and products and gets the community increasingly involved.

This project differs from other social marketing projects in that it relies exclusively on one-to-one dissemination of products and information, rather than use
advertisement and mass media. The project’s pilot phase was 1997-99, which is reported to have been successfully completed (40).

Indonesia

Like other Asian countries with a state-sponsored family planning programme, Indonesia has for long had a contraceptive social marketing programme. A contraceptive social marketing project, Kondom Dua Lima was first launched by the National Family Planning Board (BKKBN) in 1974. This effort was a failure. The project was broadened in 1988 from its initial emphasis on condoms to include a complete social marketing cum social franchising programme, called the Blue Circle Campaign (48), which will be discussed in the next section on social franchising

The USAID supports a condom social marketing programme in Indonesia as part of its HIV/AIDS prevention activities. The 'expanded access to and promotion of preventive devices' component of USAID funded HIV/AIDS Prevention Project (HAPP), is aimed specifically at involving the private sector. The Futures Group International, the US-based social marketing organisation was engaged by USAID to provide technical support to this component. The Futures Group created a Consortium of Concerned Condom Manufacturers (CCCM) consisting of two Indonesian and one international condom manufacturers. CCCM and Futures jointly implemented the HAPP condom social marketing programme (49,50).

The main objectives of this condom social marketing programme was to increase condom use among sex workers and their clients, increase access through a variety of outlets, increase sales of commercial condoms and increase commercial sector investment in condom promotion. In one year (1998-99), condom use among sex workers rose 30 per cent, according to an annual behaviour surveillance survey. The programme has increased condom visibility and availability in neighbourhoods of red-light areas, removing lack of access as a barrier to condom use. However, there were difficulties in penetrating the market with this commercial brand of condom, which was sold without any price subsidy. This was because of market leadership by another socially marketed condom brand that was heavily subsidised (49,50).

Nepal

The Contraceptive Retail Sales Company (CRS), originally established as a pilot project of the Ministry of Health, is now a non-profit corporate entity distributing condoms, oral pills, IUDs, Norplant, Injectable contraceptives and more recently, clean delivery kit (51). In 1994, with USAID support, CRS began to market Depo-Provera under the brand name Sangini (woman's close friend). CRS has trained pharmacy staff to provide Sangini across the counter.
PSI is a new entrant in Nepal’s social marketing scene, opening its office in Nepal in 2002. It launched a condom social marketing programme in early 2003, targeted at sexually active youth for HIV/AIDS prevention (52).

Pakistan

The Population Welfare Program implemented since 1995 with funding from the World Bank included also a large-scale social marketing component. This was implemented through commercial and non-governmental organisations. The social marketing component included not only the distribution of contraceptives at subsidised prices but also trained retailers, wholesalers, and medical practitioners in contraceptive service delivery. The social marketing programme has involved traditional birth attendants, hakeems and homeopaths and Registered Medical Practitioners (RMP) as family planning agents distributing contraceptives and referring for clinical contraception (53).

The Philippines

The Philippines Contraceptive Social Marketing Program was implemented through the Futures Group International. ‘Trust’ condoms were marketed by DKT-Philippines which started operations in 1990-91. This project did not do very well in its first three years in terms of sales and market share (54). A complete overhaul of the project in 1994 was accompanied by a well-thought out advertising campaign which dealt with issues such as embarrassment in buying condoms. By 2000, the programme was reported to have sold more than 103 million condoms nationwide since its inception. In 1997, DKT introduced TRUST oral contraceptive pills as well (55).

Thailand

Thailand, like India, launched one of the earliest social marketing programmes in Asia through its Community-based Family Planning Services (CBFPS). This was part of the Population and Community Development Association (PDA). The programme established the need for family planning and motivated people to use contraceptives which were distributed through community based volunteers. Contraceptives were priced at affordable costs and made widely available. Behaviour change communication efforts were kept up continuously at the community level (56). Thailand’s successful contraceptive social marketing programme is seen as a major contributor to the country’s success in achieving high levels of condom and oral pill use.

The One condom brand is being distributed through a recently (April 2003) launched social marketing programme of the PSI as part of its HIV/AIDS and STI prevention initiative (57).
**Social franchising**  
This is a variant of social marketing, involving services rather than products being marketed. Most of the experience with social franchising has been in relation to family planning services, although areas such as voluntary counselling and testing are now being covered.

In the early 1990s, USAID funded the first social franchising projects to expand the market for clinical family planning services. Social franchising projects for family planning and reproductive health services now exist in more than ten developing countries (58).

Social franchise programmes consist of creating networks of private medical practitioners or other health providers offering a standard set of services under a shared brand. The brand name serves as a guarantee of the availability of a defined package of services that are high quality, at clearly determined prices. Some remain as networks, and may evolve into ‘franchising’ programmes in which there is a controlling organisation, the ‘franchiser’ who provides ongoing monitoring and technical support to the franchised providers (58).

Benefits to franchise members include training programmes, brand and commodity advertising, and a range of other services such as inter-franchise referrals, technical support, opportunities for professional networking, subsidised equipment, drugs and contraceptives. Family planning franchises are usually ‘fractional’ franchises, which means that an additional product or service is added to an existing business, rather than a new business being set up from scratch. (58).

According to one report, social franchising ‘lends itself’ to the promotion and expansion of SRH services. Key advantages of social franchising for SRH services include:
- The possibility of tapping on under-utilised private sector capacity
- Improving access to services even for poorer clients by increasing the number of providers
- Availability of a wide range of SRH products and procedures available, through multiple complementary franchises.
- Assurance of quality provided by the franchise’s brand name
- Financial and institutional sustainability, a very important consideration in the present environment of inadequate funding for SRH (59).

Other benefits are that the services will be sustainable, and the shift of users who can pay to the private sector will relieve the burden of the public sector (60).

Social franchising programmes in reproductive health are now found in several Asian countries. Examples from India, Indonesia, Pakistan, Nepal and The Philippines are described below.
India

A small number of social franchising projects for the delivery of reproductive and sexual health services are also found in the country. Among the best known efforts in this respect is the JANANI programme operational in the poverty-stricken Northern state of Bihar (61). JANANI was set up by the US based NGO, DKT, in 1995. Financial support for DKT is from USAID.

Starting off as a conventional social marketing programme with subsidised products from the Government of India, JANANI has now established a social franchising programme for the provision of contraceptive services. The programme receives funding support from OECD. The franchising brand is 'Titli' or butterfly, and franchisees are Registered Medical Practitioners (RMPs), a group comparable to Vietnam's assistant doctors and China's Village doctors. The RMPs are provided with training in primary care for reproductive and sexual health. All RMPs are selected by the organisation, and are required to have literate wives (they are almost all men), who also receive training alongside their husbands. The women are trained to diagnose reproductive tract infections using WHO protocol for syndromic management. Strict quality control is maintained through supervision of the facilities at regular intervals.

This RMP network is linked to a franchise of MD and MBBS doctors in urban areas, called the 'Surya' network. Titli franchisees can refer patients to members of the Surya network, for IUD insertion, abortion and voluntary sterilisation, for which they receive a referral fee. There are six training centres located throughout Bihar, and operated as independent businesses, and provide free training to Surya members in IUD insertion and manual vacuum aspiration. As of November 2000, there were 140 Surya Clinics and 12,000 Titli Centres in Bihar (61).

Another social franchising scheme operates sexual health clinics for inter-city truckers. The funding is from DFID, and a pilot project is ongoing. The package includes treatment for STIs based on syndromic approach which requires only one visit, condoms and educational materials. Five million truck drivers and their assistants are targeted. Sexual partners are also supposed to be included in the target group, though it is not clear how they will be reached. Doctors in private practice at or near truck halt points are being included, and the franchise may expand to include paramedics. Where necessary, doctors may be identified and helped to establish a practice. Franchisers are being sought from among pharmaceutical companies, trucking companies or NGOs with commercial expertise. This scheme appears to be financially sustainable – franchiser can cover the costs, give a margin to the franchisee and keep the package affordable (59).
Indonesia

The Blue Circle Campaign is a social franchising programme supported by the USAID as part of the 'Private sector participation in Family planning' project (48). It has a network of 13,000 private physicians and midwives in 31 cities of the country, whose services are marketed as part of the BKKBN’s social marketing programme. The physicians and midwives are the main distributors of subsidised contraceptives procured through Jalur Swasta, a private-sector network. A network of 1600 pharmacies is also part of the network (49).

According to one account, there was a seven-fold increase between 1989 and 1994 in sales of oral contraceptives marketed under the Blue Circle logo, and the for-profit sector’s share of the family planning market increased from 12 to 40 per cent between 1987 and 1997 (4, p.58).

Nepal

A USAID funded social franchising network led by Commercial Market Strategy (CMS) is forming a network of private nurses, midwives and paramedics in a rural district in Nepal. The project provides clinical training to franchisees and markets their clinics through radio, print media, posters and door-to-door promotion. CMS is also developing a social marketing campaign for HIV prevention, and family planning and maternal and child health products and services (62,63).

Pakistan

Pakistan has one of the major and perhaps, to date most successful social franchising projects for the delivery of reproductive health services. This is the Green Star Network - for the provision of contraceptive services, initiated by Population Services International (PSI). Green Star Network started as a contraceptive social marketing project in 1986, with USAID support. In 1991, PSI founded a non-profit local NGO called Social Marketing Pakistan (SMP), for marketing condoms. When USAID support was withdrawn in 1993 because Pakistan refused to sign the nuclear non-proliferation treaty, PSI continued to operate using its own reserves. Since 1995, the German Government, through Kreditanstalt fur Wiederaufbau (KfW) has provided substantial funding to continue with the condom social marketing, and to design and launch the social franchising programme, Green Star Network (64).

This social franchising programme is comprehensive, with five components: medical training, reliable supply, public education, technical support and quality control, and ongoing monitoring. Four types of franchisees are included in the Green Star Network, all of whom receive contraceptives at subsidised costs and training from SMP. The contraceptives are imported by PSI, through SMP, which
also packages and markets the contraceptives at subsidised costs to the franchisees of this Network (64).

Green Star #1 is comprised of 2000 female doctors, all private practitioners, in the network, who receive a 40 hour intensive course on all contraceptive methods, including IUD insertion, hormonal contraceptive prescription, management of side effects and counselling.

Green Star #2 has 4250 private doctors, mostly men. They receive a one-day training in reproductive health and all contraceptive methods except IUD insertion. The male doctors are expected to motivate men to talk with their wives about contraception, to take responsibility for family planning and to support their wives when they choose to adopt a method.

Green Star #3 has 2580 pharmacists who receive half-a-day training in all contraceptive methods, counselling and reproductive health. This group is likely to be able to serve many low-income people who tend to consult a pharmacist before visiting a physician.

Green Star #4 comprises of about 2200 female health visitors – women who make home calls or run small clinics. They receive a day’s training in reproductive health, counselling and non-clinical methods of contraception. They usually serve the poorest neighbourhoods and also refer women to the female doctors who are part of the network.

The Green Star Network has increased sales of contraceptives and number of clients and improved the quality of family planning services. Independent research has shown that 74% of Green Star clients are from low income groups. The Network has grown to over 11,000 private sector providers in 40 cities throughout Pakistan (64).

Yet another social franchising initiative - the Key Social Marketing (KSM) Programme- is funded by DFID through the Futures Group International, a US based Social Marketing organisation. This programme is also aimed at promoting contraceptives, but is limited to oral and injectable contraceptives. The Futures Group has joined with two pharmaceutical companies to market their oral and injectable brands under a social marketing logo – the Key – but at commercial (non-subsidised) prices (65).

Franchisees of KSM include doctors, female health visitors, pharmacists, and select NGOs. This social franchising programme involves a very large network, with 10,000 doctors in private practice, 25,000 pharmacists and 1000 female health visitors, selected NGOs (60). This project is said to ‘assist the Government of Pakistan achieve its demographic goals as set forth in its Five-Year Plan. The Pakistan Medical Association has endorsed the KSM.
An innovation is the Key audiocassette. The Key audiocassette delivers accurate information about birth spacing and Key hormonal products to the client in the privacy of their homes. The audiocassette contains a doctor’s advice on how to choose and use an appropriate contraceptive method. The audiocassette is also a valuable counselling tool used by Key providers. The KSM reports that in 2000, 90% of its clientele were low-income women (65).

The Philippines

John Snow Inc. Research and Training Institute, USA is implementing a social franchising programme for providing maternal and child health care. When donor funding for an NGO-funded and operated MCH/FP clinic network ceased, John Snow developed this into a social franchising initiative. The franchiser is the Integrated Maternal ChildCare Services and Development Inc. known popularly as SDI. The franchisees are midwives, either existing SDI employees or independent midwives. This network now has 49 franchisees, providing an agreed package of MCH/FP services through Well Family Midwife Clinics (54,60).

The Well-Family Midwife Clinic Network provide family planning and maternal and child health services, including delivery services. The franchise focuses on urban areas and on clients who are able to pay a small fee for services but cannot afford the fees charged by most private practitioners. As of October 2002, there were 205 franchised clinics in the network. The franchiser provides equipment and instruments and offers supplies in wholesale rates, and also advertises the Network on television and radio, helping to build up a market for the services of the clinics. In addition, training is provided to midwives on family planning, counselling and communication skills (66, p.3-4).

A relatively smaller scale social franchising programme provides female sterilisation. This programme is funded by DFID and implemented with technical support from Marie Stopes International (MSI). The local franchiser is the Population Services Pilipinas Inc., an established NGO with experience in providing tubal ligation services through static and mobile clinics. The franchisees are private doctors already established in their practice. The pilot project has a network of 12 doctors (60).

Manufacture of reproductive health products

Of the countries examined for the purpose of this paper, public-private partnership for production of contraceptives was unique to India. All the partnerships involve the Indian manufacturing firm Hindustan Latex Limited (HLL). A partnership between the UNFPA, Government of India (GOI) and HLL has resulted in the local manufacture of high quality IUDs, which is supplied to the National Family Planning Programme. Condom quality upgradation was made possible through a similar partnership involving the UNFPA, KfW, GOI and
HLL. Condoms manufactured are now supplied not only to the national programme but is procured by UNFPA for global distribution and also sold commercially in India, Europe and US. The HLL is also involved in a number of social marketing programmes to distribute its own as well as other contraceptive products. These are again, partnerships involving a donor, HLL and GOI (67).

**Other PPPs in sexual and reproductive health services introduced as part of HSR**

As mentioned earlier, a number of country-level health sector reform projects seek to foster and promote PPPs, usually for the delivery of all health services, but sometimes for the provision of specific services related to sexual and reproductive health. These may take the form of contracting with NGOs or for-profit organisations for the delivery of services, mobilising resources from the private sector for specific projects, forming joint public-private institutions for implementing programmes, constituting new entities with public-private participation for the financing and management of health facilities, bringing together various international and national actors to promote providers’ networks or help providers establish private practice, to mention only a few.

**Bangladesh**

The National Integrated Population and Health Programme (NIPHP) operational since 1997 and funded by USAID is a partnership in the populations sector. It involves the USAID, the Ministry of Health and Family Welfare, two service delivery entities, one for rural and one for urban areas, and five other supporting entities. Pathfinder International directs the Rural Service Delivery Partnership and the Urban Family Health Partnership by John Snow Inc in collaboration with Concerned Women for Family Planning and the Population Services training Centre (18).

The Rural Service Delivery Partnership supports twenty NGOs working in 171 of rural Bangladesh's 460 thanas. The urban service delivery partnership supports 25 NGOs in four city corporations and 67 smaller municipalities. The service delivery package includes a range of reproductive and child health services beyond antenatal care and family planning, and includes services for RTIs and STIs including HIV (18).

The HIV/AIDS Prevention Project, a part of the Health and Population Sector Programme (HPSP) also involves contractual arrangements between the government and the for-profit and/or not-for-profit sectors for the delivery of a basic package of services. In this instance, the private sector is to work with high-risk groups. Services to be provided include behaviour change communication, condom promotion, prevention and treatment of STIs and 'empowerment' of the
high-risk groups. Sex workers and their clients, injection drug users (IDUs) and men having sex with men are the high-risk groups targeted (68).

**India**

A recent World Bank publication ‘Better health for India’s poor’ has proposed a number of strategies for the promotion of PPPs for improvement of maternal health in India. Muraleedharan et al (2002) suggest that the PPP arrangement that is most feasible is one where prenatal care is provided by the public and private health sectors, and there is insurance coverage for institutional deliveries. Coverage of the poor through insurance may be subsidised or met fully from government or donor sources. The authors suggest that emergency obstetric care also be covered by insurance and provided in both public and private hospitals. These strategies are yet to be implemented, but may represent the shape of things to come (25).

**Indonesia**

The 1997 Safe Motherhood project supported by the World Bank comprised many elements of public-private partnership. The BDD or village midwife was given only a three year contract, paid by government for delivering a basic package of services to the poor, and a ‘private’ practitioner charging fees as far as other services were concerned. Another initiative was a scheme to reimburse private as well as public health facilities for the provision of emergency obstetric care to women from low-income groups (69).

A major public-private partnership established as part of the Safe Motherhood project was for the setting up of the Midwives Loan Fund. This was a successful ‘public-private’ partnership. It helped midwives with some years of experience to set up or expand their private clinics for provision of delivery care as well as contraceptive services. The partners involved were the US-based SUMMA Foundation, the Indonesia Midwives Association (IBI), and Bank Rakyat Indonesia (BRI), one of Indonesia’s leading national banks. The project was financially supported by USAID. The total loan fund was US$ 1 million, of which 500,000 were the contribution of BRI and 500,000 channelled by the SUMMA Foundation. The IBI, which is highly respected by Indonesian midwives, played an important role in marketing the loan fund, selecting potential borrowers and ensuring that they set up private practice and used the loan funds appropriately. BRI, a state owned commercial bank, had much experience with micro-lending and also high lending standards. Between 1995 and 1999, 1113 midwives were helped by the loan to establish or improve their private practice. Performance indicators used to assess their contribution to reproductive health showed that they were reaching new family planning clients, and also clients who previously used public sector services. The loan fund continued to operate even after the SUMMA project ended in 1997, and BRI and IBI took on all management responsibilities, and lending rates have remained high (70).
One major limitation of the Fund was that although it was meant to include at least 20% of 'village midwives' among its beneficiaries, only 5.6% were in fact from this category. ‘Village midwives’ are a new category of health workers that the government of Indonesia had trained and deployed in order to increase the coverage of deliveries attended by skilled health workers. The Midwives Loan Fund was seen as one means of sustaining their continued presence in the villages where they worked without swelling up the government’s salary budget. As mentioned above, the 1997 Safe Motherhood project had already introduced short-term contracts for village midwives and required them to raise part of their income from user fees for services rendered. The role of the Loan Fund in helping them set up in private practice was therefore crucial for the sustenance of this category of workers (70).

Another public-private partnership initiative, which preceded the 1997 Safe Motherhood project involved the Ministry of Health and MotherCare, a US based consultancy organisation. MotherCare helped the MOH develop a package of interventions to enhance the government’s Safe Motherhood initiatives in three districts of Indonesia. The package included in-service training to improve the knowledge, skills and confidence of midwives to perform not only within a health facility setting but also in a community setting; a supervisory system with peer-review and continuing education, a maternal and perinatal audit system and an IEC strategy aimed at the community. The project helped increase skilled attendance at birth from 37% in 1994-95 to 59% in 1998-99. However, the proportion admitted to a hospital for a complication requiring a life-saving intervention did not increase, and in fact, declined. This was attributable to the high cost of seeking emergency obstetric care (71).

The World Bank supported HIV/AIDS and STDs Prevention and Management Project, implemented since 1996, has NGO involvement in implementation as a defining feature. NGOs are contracted to carry out behaviour change communication, service delivery, training, monitoring and evaluation through a competitive bidding process. Joint NGO-MOH training activities and workshops and seconding MOH staff to NGOs are among various collaborative activities that were planned as part of the project (49).

Currently (through 2002), the USAID supports a project to strengthen government commitment for reproductive and child health and improving access to and quality of services. The project description mentions that the USAID will seek public-private partnerships to share fiscal responsibility for health and family planning services where feasible. It further notes that these partnerships are being forged because a new generation of Indonesians sees 'protecting social welfare as a corporate responsibility' (72).
Nepal

The US based and USAID supported NGO 'EngenderHealth' has for several years worked with the Ministry of Health and with a number of NGOs to increase access to contraceptive services. In 1996, the organisation assisted the Ministry of Health to establish the Quality of Care Management Centre (QOCMC) in association with the Nepal Fertility Care Centre (NFCC), a local NGO. The QOCMC, with technical support from Engender Health provided training and supervision to every government health site providing contraceptive services in 21 districts. A model Family Welfare Clinic was set up in 1994 by the government with the assistance -technical and financial - from EngenderHealth. This clinic provides a full range of contraceptive services, antenatal care, obstetric and gynaecological services and treatment for sexually transmitted infection (62).

More recently, EngenderHealth and John Snow Inc. have launched with the government the Nepal family Planning Program (NFPP) a five-year family planning and maternal and child health project. This programme aims to make a basic package of maternal and child health and family planning services available at each level of the health system - district hospitals, primary health centres, health posts and the community - in 17 districts of Nepal (62).

Pakistan

A World Bank funded HIV/AIDS prevention project was scheduled to be implemented in Pakistan starting November 2002. This project has involved consultations with NGOs even at the stage of project preparation. On the basis of an analysis of the strengths and limitations of various categories of NGOs, the project proposes to enter into call for bids from medium to large NGOs with established management capacity and a track record of work in the field. NGO partnerships are to work with vulnerable population at greatest risk of HIV – including sex workers, intravenous drug users, migrant workers including truck drivers and prisoners. NGOs selected on the basis of competitive bidding will enter into a contract with the government. The contract will require NGOs to provide a service package which includes behaviour change communication, promotion of effective condom use, voluntary counselling and HIV testing, proper management of STIs, needle exchange programmes for IDUs and empowerment activities. The World Bank supports all project components except those involving IDU users. DFID is funding the IDU package of services (73).

The HIV prevention project also has a small grants component for capacity building among small NGOs to undertake HIV/AIDS prevention activities, and especially to experiment with innovative new approaches (17).
The Philippines

The USAID has played a significant role in the promotion of public-private partnerships in family planning programmes in the Philippines. The USAID funded ‘Integrated Family Planning Maternal Health Program (IFPMHP) implemented during 1994-2001 has as an intermediate result (IR 3) 'increased private sector provision of family planning’ (54).

IR 3 provided assistance for
- Strengthening non-governmental organisations’ capability for MCH/FP service delivery
- Expanding industry based FP/MCH programmes
- Developing private sector channels for services and commodities through social marketing, and
- Achieving policy reforms that will shift public sector users who can afford to pay to the private sector

Several US-based organisations were funded to implement interventions to achieve these objectives in partnership with NGOs and the commercial sector. These were John Snow Inc, CARE, EngenderHealth (previously AVSC international) and The Futures Group International (54).

EngenderHealth has been working with the DOH to provide technical and financial support to training regional health offices for voluntary surgical sterilisation. Twenty-two DOH regional hospitals and medical centres have been developed as training sites for voluntary surgical sterilisation, and three hospitals as centres for postabortion care training. Training is provided through these training centres to private as well as government health providers. EngenderHealth has also been working with hospitals to develop effective infection control programmes. Similar initiatives for training in sterilisation, postabortion care and infection prevention has also been undertaken in private hospitals (74).

Partnership between the USAID and the National AIDS Prevention and Control Organisation of Philippines (NAPCP) aims to promote private (and public) sector mechanisms for monitoring HIV prevalence, and through behaviour change communication, to reduce HIV risk (54).

Thailand

International organisations and local business houses have come together to initiate behaviour change communication programmes for prevention of HIV. Shell/Thailand launched a programme with UNICEF called 'Peer education at the pump' which provided AIDS education to more than 800 young people working as service station attendants. In Phayao province, a coalition of small businesses, NGOs and government has been formed, known as the Business
AIDS Network for Development (BAND). BAND helps youth who have HIV infection or whose parents have been affected by AIDS through a referral network that includes technical training, scholarships, social support for people living with HIV/AIDS and their families (75).

3. Discussion and conclusions
Public-private partnerships are clearly a phenomenon on the rise in the present geopolitical environment. In examining their implications for health services in general and sexual and reproductive health services in particular, it is important to distinguish global public private partnerships from those operating at the national level. The two are very different in nature, scope and activities.

Global public private partnerships involving the UN and the WHO on the one hand and the corporate sector on the other, raise some important issues for global public health. How compatible is a partnership between the UN system - meant to be on the side of the marginalised and dispossessed, the WHO - which has in the past acted as the world’s 'health conscience' with organisations whose bottom-line is the generation of profit? The former is accountable to its Member States, while the latter is accountable only to its shareholders. What happens when there is a conflict of interest? Dependence on private foundations set up by business interests such as the Gates Foundation, which require 'partnerships' as a condition for financial support to the UN system may shift the balance in favour of the private sector partner. Further, such partnerships may have the insidious effect of shifting priority setting more in line with the interests of the private partner, with efficiency and cost-effectiveness dominating all else. This is because the private sector has less to lose from not entering into a partnership, or walking out of it, than do WHO or the UN with their severe resource crunches (6).

Legitimacy is an issue too. The WHO is accountable to its member states that have equal voting rights. Few partnerships include low-income country representation, and not all of them have WHO in their governing board or technical committees. And yet, decisions are made by the global partnership that are implemented by WHO, and through it, in its Member states (6).

In the area of sexual and reproductive health services, the role of global public-private partnerships is likely to be felt most in HIV/AIDS prevention, treatment and care. By 2001, global partnerships mainly focused on infectious diseases including HIV/AIDS, and within it, on vaccine development and on anti-retroviral drugs for HIV. The enormous amounts being invested on infectious diseases has meant less resources for other areas of health, including sexual and reproductive health, with the exception of HIV/AIDS. Within HIV/AIDS related services, again, the focus is now firmly on drugs, and to a lesser extent, on commercial marketing of condoms. The 'Bridging the Gap' partnership between Bristol-Myers Squib and UNAIDS and a variety of actors in Southern Africa has been cited as one way of
working around compulsory licensing, which will permit countries of this region to produce and market anti-retroviral drugs without reference to the patent regulations. In other words, the partnership, with its limited commitment to make the drug available, has substituted widespread production and availability at affordable costs of the drug to Southern African countries with high levels of HIV prevalence (6).

While it may be argued that the global public private partnerships have also brought with them the opportunity for additional resources, one may question why the same amount of donor funding may not be channelled into the public sector for the same purposes.

Country level public private partnerships in health and especially in sexual and reproductive health services exist in many countries of the region. For the most part, the USAID, and more recently national governments have initiated them as part of the health sector reform projects supported by the World Bank. There have also been more indigenous attempts to involve the private sector, prompted by the economic crises in the 1980s following economic liberalisation.

As part of health sector reforms, these partnerships consist in the main of contracting out non-clinical services to the private sector, and in some countries like Bangladesh, clinical services are also contracted out. Investments from the private sector into public hospitals are another common form of partnership. In the area of sexual and reproductive health, all the countries examined in this paper have had contraceptive and condom social marketing programmes, and social franchising programmes for the delivery of family planning services. As Partnerships with the private sector are also commonly sought in HIV/AIDS project sub-components of Health sector reform projects, and that, specifically to cater to so-called 'high-risk' groups.

Compared to the scale of these programmes, public-private partnership efforts to provide pregnancy related care, and especially services for childbirth are minuscule. There are very few examples of RTI/STI services for the general population, with only 'high-risk' groups being provided even STI services.

In other words, country level public-private partnerships have not mobilised resources to provide additional services as mandated by the ICPD Programme of Action. Rather, they have increasingly been used to channel donor funds into the development of a 'market' for traditional family planning services. Not even childbirth services have received much attention, leave alone services for infertility or reproductive tract infections for the general population.

One fallout of this, as already mentioned, is that donor funds are being utilised more for market creation, and through it, catering to those who can afford to pay, rather than meeting the needs of low-income groups, as used to be the case traditionally. The usual argument made in the literature is that by shifting the
demand for public sector services by the relatively better off to the private sector, these programme 'free-up' government resources to be invested in programmes for the poor and vulnerable groups. The little information available to date suggests that this rarely ever happens. It is not as if the public sector's resources remain constant, so that 'freeing' up some part of it makes resources available for other purposes. The reality is one of shrinking resources. The private sector caters to those who can pay, while the public sector remains as it was - under-resourced and steadily deteriorating.

Where public-sector hospitals and health facilities are contracted out to the private sector, either fully, or for specific services, as for example diagnostic services which operate for profit, there may be consequences for quality of care. The 'paying' clients may receive better services in the 'private' wards, while those who cannot afford to pay will have to make do with limited care. They may also have to make do without diagnostic services or drugs priced at 'market' rates. The rise in health expenditure, and in unnecessary tests, drugs and procedures that accompanies social insurance scheme's contracting with private providers, and more often, the entry of managed care organisations and private insurance is well documented in many Asian countries.

The efficiency of the private sector appears to be another myth that is propagated as a 'generic' truth without any evidence to substantiate it for specific contexts. A study from China on the quality of services in public and private sector health facilities shows that there was no difference between them, in that services in both were of a comparably low quality (76).

Community participation in priority setting and planning programmes features nowhere in the literature on public-private partnerships within countries. The public or users of health services are viewed as consumers and customers in a market place and not so much as citizens of a nation state. Their right to expect a range of choices of services is recognised, but not their right to participate in the collective decisions related to the menu of services available overall.

A related issue is the significant role played by US-based consultancy agencies in policy making, priority setting and programme designing which comes with the donor funding of these initiatives. In-country researchers and health-related organisations are sometimes part of a 'consultative process' initiated and controlled by external actors. This has implications for availability of research funding for country-based institutions and researchers who may have no options except to be collaborators in agendas and processes set by external organisations. There is no room for 'partnership' here. One who pays the piper calls the tune.

Social marketing schemes and social franchising programmes raise additional concerns. To begin with, it is not clear that unless subsidised, social marketing programmes are able to increase sales significantly and make an impact on
contraceptive use. Secondly, they appear to skew contraceptive method mix in favour of hormonal contraceptives and to a lesser extent, condoms (which seem to be used much more for STI prevention than as a contraceptive).

When imported contraceptives are sold at subsidised rates as part of the social marketing programme, this could crowd-out production by local manufacturers. Once the subsidy is withdrawn, the programme may fall apart because users can no longer afford it, and there are no comparable low-cost products.

This was indeed the case in Bangladesh when the Bangladesh social marketing project increased the prices of contraceptives it sold by an average of about 60 per cent. In the following year, condom sales dropped by 29% and oral pill sales by 12%. Sales did not recover till two years later, when the prices were lowered once again. The price increases were at the behest of USAID, the donor, who was greatly concerned about the increasing amount of subsidy. Each sales costs the donor a fixed amount for procuring and shipping the product plus a subsidy, which means that as the sales increases, the costs also rise (43).

Social marketing also has equity implications. These products are usually targeted at those who can afford to pay at least part of the cost. They are also usually marketed through commercial outlets, which may be expected to be located only in places where there is adequate purchasing power, and places connected adequately by roads and transportation. This selection bias will leave out those in poorer areas and also in scattered and smaller population settlements.

Quality of care is a major issue. Prescription of the oral contraceptive pill and the injectable requires screening for certain medical conditions, which the social marketing programme is usually not able to provide. There is also no follow-up care possible for side effects from use of these contraceptives. Commercial interests and profit-motive may in fact lead the agent to underplay risks of the method.

Like social marketing, social franchising in the health sector is fraught with some innate problems (66, p.2). For example, successful franchising requires that the products are well-defined, enabling the franchisee to mass produce and the franchiser to monitor quality. The nature and quality of health care services needed vary with every individual, making it difficult for products to the standardised and for quality to be monitored.

Also, franchising usually offers entrepreneurs with limited experience the opportunity to launch a successful business. This is indeed one of the features of franchising which makes it attractive to the franchisee. For a health franchise to be of high quality may therefore require a large number of underemployed qualified health professionals (66, p.2).
In their present form in the countries examined, large numbers of physicians, paramedics and pharmacists are recruited into networks and provided brief training. Although there is mention of quality control and supervision in some of these, it is not clear how the franchise will be able to control unnecessary prescriptions and procedures, especially in settings where the patients may view these as indicative of 'high-quality' care. User-perspective studies as well as independent assessments of the technical quality of care are needed to ascertain the relative costs of such an approach when weighed against the potential benefits of expanded coverage.

Especially puzzling in the case of social franchising is the non-inclusion of childbirth services in the package of services, especially given that midwives and female physicians are part of many networks, and that high levels of maternal mortality are a major issue in many countries.

Despite claims to the contrary, public-private partnerships may undermine the limited public sector sexual and reproductive health services that exist, and further exclude low-income populations, causing a wider chasm in health status across income groups. The ray of hope in this bleak scenario is that there are examples of countries such as Thailand, which have fashioned their own national reform agenda, including the kind of public-private partnerships that would best serve the interests of its population. Countries in the region could perhaps learn better from such examples than from champions of free-market orthodoxy.
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