Scaling-up proven public private partnership models to achieve family planning equity goals in India

Author: Dr. Suneeta Sharma
Presenter: Ashutosh Kandwal

International Conference on Family Planning, SENEGAL
November 29 –December 2, 2011
Outline

• Context: challenges and opportunities
• Building public private partnerships: a policy approach
• Three examples
  • Voucher system
  • Mobile health clinic
  • ASHA Plus scheme
Challenges

• High maternal mortality, infant mortality, and total fertility rates
• Use of FP methods and institutional facilities for deliveries is the lowest among poor
• Out of pocket expenditure on RCH services in both government and private facilities is high
• Health system imposes enormous barriers to the poor
• Health expenditure is one of the major causes of poverty
• Staff vacancies and lack of trained staff in public health system
• Difficult geographic terrain and sparsely populated areas
Opportunities

• Enabling environment under National Rural Health Mission
• Increased emphasis on reducing inequities and improving access to maternal health and family planning services
• Capitalize on market presence of viable private sector
• Private sector is preferred provider choice in both urban and rural areas
• Increased demand for high-quality health care services
Both Public and Private Sectors Have Important Roles to Play

Public-private partnerships provide opportunities for:

- Creating competition
- Mobilizing resources
- Capitalizing on strengths
- Achieving economies of scale
- Using existing capacity
- Targeting the poor
- Expanding service delivery network
Building Public-Private Partnerships: A Policy Framework

- Understand the market and policy environment
- Share information, foster dialogue, and develop a common understanding of health system goals
- Create an enabling environment
- Balance public-private sector roles
- Build public-private partnerships
Using a Systematic Process of Building PPP Models

- Prioritize needs
- Determine shared goals
- Engage right partners
- Develop strategic options
- Design and test appropriate models
- Develop costed scale up strategy
- Establish links with policy framework
- Ensure sustainable financing
- Evaluate impact

Government Leadership and Ownership
Effective Public-Private Models to Achieve Health Equity Goals

✓ Voucher system
  • Social marketing
  • Social franchising
✓ Mobile health vans
  • ASHA Plus program
  • Contracting out
Voucher System: Demand-side Financing

To reduce inequities in reproductive health care by enabling access to services, while empowering the below poverty line population to choose their own provider.
Piloting (in two blocks)
- Inaugurated in May 2007
- Continued till March 2009
- Eight Nursing Homes
- Services – Maternal, New Born, Family Planning
- 0.45 m individuals in 199 villages - BPL population
Model – Voucher Scheme

Project Advisory Group

District Quality Assurance Group

Voucher Management Agency

Accredited Private Nursing Homes

Auxiliary Nurse Midwife

ASHA (Community Health Volunteer)

BPL Beneficiary

Vouchers/Bills

Reimbursements

Maternal, Child Health and FP

SERVICES

Beneficiary

Accreditation of PNH and its Quality Check
Voucher System: Highlights

• Provided excellent private sector services at deep discount rates
• Expanded services efficiently in light of the understaffing at government facilities
• Relieved pressure on government in certain areas
• Enabled clients to save money
• Provided services to poor clients that they otherwise would not have received
Reducing inequities between Poor and Non-poor

**End line 2009 data for Non-Poor**

| Institutional Delivery | 47 |

Institutional delivery

- **Baseline - 2006**: 28.9
- **Endline - 2009**: 47
Reducing Inequities in Use of Modern Contraceptives Between the Poor and Non-poor

Baseline 2006
- All: 44.9
- BPL: 42.2

Endline 2009
- All: 47.1
- BPL: 46.4
- Non-BPL: 47.2
Sustainable Financing and Scaling Up of Voucher Scheme in Uttarakhand

Total population coverage in pilot: 0.15 million
Total population coverage in scale up: approx. 2.54 million

USAID contribution in demonstration: USD 170,666 for 12 months
GoUK funds for scale up: USD 1,045,000 for 12 months
Mobile Health Clinic: Reaching the Underserved in Uttarakhand

A fixed day, fixed time, and fixed place approach to provide primary healthcare services in remote rural areas
Route Map of Mobile Health Clinic

RAMNAGAR
- Thari (20 km)
- Maldhanchour (33 km)
- Total 8 sites
- Visit every 15 days
- Camps in a month 16

HALDWANI
- Amgarhi (25 km)
- Kamola (25 km)
- Dhamola (60 km)
- Kotabagh (35 km)
- BHIMTAL-BISR (30 km)
- Jamrani (18 km)

Locations:
- Thari
- Amgarhi
- Kotabagh
- Ramnagar
- Bhimtal-Bisr
- Jamrani
- Maldhanchour
- Kamola
- Dhamola
- Chorgalia
- Bindukhatta
Performance Statistics
(JAN 09 – DEC 09)

- 195 Camps held
- 11,352 out-patients registered
- Average patients per camp – 59.1
- IUD insertions – 189
- Pills distributed – 1,292 cycles
- Condoms distributed (packs of 10)– 411,00 pieces
Scaling up Mobile Health Clinic Coverage & Funding

Total population coverage in pilot: 0.5 million
Total population coverage in scale up: 10 million

USAID contribution in demonstration:
Capital Costs: Nil
Operating Costs: USD 186,000

GoUK funds for scale up:
Capital costs: USD 1.97 million
Operating Costs: USD 580,000
Thank You

For more information on the project visit www.futuresgroup.com