Public Private Partnerships formed by SNEHA: City Initiative For Newborn Health, ASK partnership, Arogya Sarita

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Introduction

Public-private partnership is prevalent in almost all sectors in India. Over the last three decades the health sector has experimented with public-private partnership in a number of ways, such as contracting out medical services or maintenance of health infrastructure, involving non-government organizations (NGOs) in awareness generation programmes, and pooling technical resources from the not-for-profit sector for training and research purposes. Private players have also been brought in in order to benefit from their updated technical skills, implementation experience and risk taking capacity.

This paper summarises one NGO’s experience in building partnerships with the public sector health system, the outcomes achieved so far and lessons learnt. It also describes the role of each partner and sustainability issues involved.

Perspective on public-private partnership

A common definition of public-private partnership (PPP) is that it involves a contractual agreement between the public and the private sectors, whereby the private operator provides services that have traditionally been executed or financed by a public institution. The ultimate goal of PPP is to obtain more ‘value for money’ than traditional public procurement options would deliver. Some of the ways in which this might be achieved are reduced life-cycle costs, more efficient allocation of risk, faster implementation, improved service quality and additional revenue.

PPPs in the health sector in India are now being looked at The goal of the emerging National Urban Health Mission is to address the health concerns of the community by facilitating equitable access to the available health facilities by rationalizing and strengthening the capacity of the existing health care delivery system. It proposes to address the gaps with the support of non governmental organizations. One of the key strategies that the NUHM1 is looking to adopt is that of facilitating Public – Private partnerships in all spheres of the public health system.

The Society for Nutrition, Education and Health Action (SNEHA) is an NGO working for the health of women and children, primarily in communities living in Mumbai’s slums. As such, it represents the third sector. Our operational definition of PPP must, therefore, involve a loose conception of private provision that includes the possibility of partnership between the public sector, private for-profit, private not-for-profit, and third sector organizations. We see PPP within the operational terms of our project cycle as an agreement between multiple partners – in this case initiated and facilitated by SNEHA – in which a specific and mutually agreeable role was envisioned for each partner in order to achieve the goal of the City Initiative for Newborn Health. The City Initiative is an unusual

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collaboration in which four types of organization are represented: an NGO (SNEHA), a public sector provider (the Municipal Corporation of Greater Mumbai; MCGM), a private sector organization (the Social Initiatives Group of ICICI Bank, now the ICICI Centre for Child Health and Nutrition; ICCHN), and a public sector educational institution (University College London Centre for International Health and Development; UCL CIHD). Conceptually, the only type of partner missing from this PPP is a private organization that is purely for-profit. Each partner has a different role. The MCGM role is service provision and to take a lead on the integration of activities within the public sector ambit; SNEHA’s role is to coordinate the City Initiative, broker communication between the partners and implement some of the third sector activities, all of which are designed to integrate with existing MCGM services; ICCHN’s role is to advise on and discuss strategic approaches and provide financial support; the UCL’s role is as an advisor on monitoring and evaluation.

Characteristically, PPP initiated by the government tends to involve time-bound project-level activities in which the other partner provides a service or fulfills a role, and which end at the close of the funding term. The model that SNEHA tried to develop in the City Initiative is based on an organizational belief that the public sector system can deliver if supported by a participatory facilitation process which leads to sensitive supervision and change in individuals and groups.

**Case study: City Initiative for Newborn Health**

Mumbai’s healthcare system has witnessed significant developments since independence. The Mumbai municipal public health care system is regarded as one of the most extensive and multilayered in the country. However, it still lags significantly behind some of its international counterparts. Despite being the economic and financial centre of the country, there is a shortage of qualified healthcare professionals alongside shortfalls in hard infrastructure. There is also a widespread mismatch between infrastructure, equipment and human resources, which leads to under-utilization of resources and sub-optimal outcomes.

In Mumbai’s urban slums, many vulnerable infants, pregnant women and new mothers are unable to access early and appropriate medical care for a variety of reasons. To address this issue, in 2004, SNEHA and the partnership already mentioned began work on the City Initiative for Newborn Health. The goal of the initiative is to improve the health of mothers and newborn babies by reducing neonatal and maternal morbidity and mortality through a series of planned sustainable interventions at public health facilities and in communities. It has two major components: working with health facilities and working with communities. The first component aims to work with the public health system to achieve continuous quality improvement in maternal and neonatal services at health posts, maternity homes, and hospitals. The second component aims to work with community groups in slum areas to improve maternal and newborn-care practices and care seeking. The initiative’s pioneering effort, therefore, is to simultaneously affect providers and users, working at a scale sufficient to test the models it develops in terms of potential for rollout. Now in its fifth year of implementation, the City Initiative has been built and implemented on a foundation of strong partnerships between the public and private sectors. For the purposes of this paper we limit our discussion to work done so far with MCGM health facilities.
Emergence of action groups
The project was launched in February 2004. The first phase began with consultation meetings at various levels within the administration of the MCGM health system. These meetings were instrumental in building good will and buy-in for the project, but also helped the non-MCGM partners to understand the many issues involved in providing healthcare to Mumbai’s public sector clients. The meetings were augmented with informal interviews and discussions with providers at all levels. The data gathered in the process were used in designing a series of participatory workshops involving all levels and cadres of municipal health care providers. These workshops were well received by participants, who expressed satisfaction that they had been able to share their opinions and ideas about the changes that would be necessary to improve access to and quality of maternal and newborn services. A key outcome of the workshops was a project design for the City Initiative and the coalescence of action groups. Gaps were identified at each level of the health system, among them a lack of written guidelines or clinical protocols for management of clients at a given level of facility, a lack of guidelines on when, where and how to arrange referral or transfer (including a lack of formalisation in the referral system overall), and a need to strengthen health post capacity. Five such action groups were formed: for training, information, education and communication; for facility upgrading; for the design and implementation of clinical protocols; for the refinement of administrative protocols; and for nurses working within the system. Action groups drew members from MCGM facilities at health posts, maternity homes, peripheral hospitals and tertiary hospitals, as well as from administration departments. The groups met regularly to work on problem analysis and identification of strategies, and prepared plans of action for each level. Particular tasks were the design of clinical protocols and facility assessment tools, identification of training needs at each level, and identification of IEC messages.

Action arising
It was agreed that the first phase of the City Initiative (2004–2007) would cover a third of Mumbai’s public health system. The project design and interventions were discussed and finalized by action group members through a series of participatory workshops, which SNEHA played a facilitatory role in convening. Following the workshops, SNEHA took a lead partner role in implementing agreed interventions at each level of the health system and monitoring progress. All the recommendations of action groups were taken up by SNEHA for implementation. This process was simultaneously supported by capacity building of municipal health care providers to sustain the interventions within the system. As well as providing financial support, ICCHN actively contributed to the conceptualization of the project and provided regular review and input. UCL CIHD worked with the other partners to develop robust monitoring systems and a strong research and documentation component. It also engaged in capacity building research skills at SNEHA.

Case study: ASK partnership
Identified need
The need for facility upgrading was identified as one of the major gaps by the facility upgrading action group in the MCGM. The group identified ‘vital’, ‘essential’ and ‘desirable’ standards for human resources, equipment, drugs and consumables to enable facilities at each level to provide a designated level of quality care. Specific items of equipment were vital at each of the four levels of health facility (health posts, maternity homes, peripheral hospitals and tertiary hospitals). We realized that the present system of administrative procedures would take some while to make vital equipment level available in all facilities. At the same time, the nature of administrative policies was that reform was unlikely to be
possible in the short term. The PPP decided to work towards enhancing the quality of care by supporting the provision of vital equipment.

PPP activities
The support for PPP evidenced in the government’s Health Policy (2000) paved the way for a partnership between the MCGM, SNEHA and ASK Foundation, a private sector partner. ASK Foundation was enthusiastic about the idea of upgrading public health facilities. Particular needs were identified with the help of medical offices and sisters—in-charge and a team of two facilitators, one from ASK Foundation and one from SNEHA. A proposal was put to the ASK Foundation with the understanding that improved infrastructure would increase the availability of services and thus reduce inappropriate transfers to the already overcrowded higher level facilities. Three maternity homes and one peripheral hospital were selected based on their performance and their association with a developing regional referral system. Equipment specifications were sought from the MGCM, and the process of procurement and supply was coordinated by SNEHA and ASK Foundation. Vital equipment needs have been addressed in all four facilities through the partnership. Monitoring is currently underway to assess utilization and further needs assessment is being undertaken. Impact evaluation will happen in due course, but testing the effect of equipment upgrades on quality of care would not have been possible without collaboration and support from the ASK Foundation.

Achievements of City Initiative for Newborn Health and ASK partnership
Health posts
• 8 fully-functioning antenatal clinics with staff trained on antenatal, postnatal, and neonatal care.
• Earlier registration: 20% women register in the first trimester.
• 551 antenatal clients.
• Increase in health care-seeking: 20% make two or more visits.
• More than 1629 neonates have been brought in for normal neonatal care.
• Clinically trained staff across 14 health posts.
• Improvements in motivation and attitude through communication training/

Maternity homes
• Standardized evidence-based clinical protocols.
• Clinical training: 20 modules in obstetrics and neonatology.
• Maintenance of partograph by 60% of maternity homes.
• Dedicated hotline connectivity established from maternity homes to peripheral and tertiary hospitals.
• ‘Vital’ level of equipment installed and functional at three maternity homes.
• Appreciative Inquiry training and communication trainings extended by MCGM across all maternity homes in the city.
• Initiation and maintenance of recording systems for transfers in and out of seven maternity homes.

Peripheral hospitals
• Regional referral links established between three maternity homes and two peripheral hospitals.
• Hotline connectivity established and functional.
• ‘Vital’ level of equipment installed and functional at one peripheral hospital.
• Initiation and maintenance of recording systems for transfers in and out of four peripheral hospitals.
New partnerships

During project roll-out, a number of other partnerships were formed beyond the core group. New partners included Inner Wheel, the National Neonatology Forum (NNF), the Federation of Obstetric and Gynecological Societies of India (FOGSI), and MTNL. Each of these partners made a particular contribution based on its skillset. Inner Wheel helped to upgrade health posts; the NNF and FOGSI helped action groups to draft clinical protocols and also supported efforts to improve coverage of maternity homes by specialist clinicians; MTNL helped to create and install a Centrax system through which facilities could communicate about client transfer and referral.

Conclusion

One of the challenges of partnership is that, despite the equal status of partners, one partner tends to drive the initiative. Indeed, it is possible that individual partners’ involvement may be more passive than active. For example, since the City Initiative was conceived by SNEHA, which had the commitment and human resources, SNEHA at times became the de facto executor, taking a lead role in implementation, monitoring and evaluation of the project. This may occasionally have reduced the effectiveness of the initiative. For example, when partography was introduced at maternity homes, although part of the MCGM mandate, staff may have seen it as an externally driven activity, and there was some reluctance to participate. This would probably have been reduced if the activities had come with the firmer instruction of the MCGM. We had a similar experience with the re-introduction of antenatal care at health posts. This had earlier been part of the MCGM service provision framework, but there was reluctance on the part of overburdened health post staff to introduce what were seen as new activities. Nevertheless, the officials of the MCGM are to be commended for their active engagement in the process of change, instituting regular clinical training across the city, introducing partography at maternity hospitals, and sanctioning the establishment of more clinics at health posts. Partnerships take time to mature. It took over two years until ground-level activities were established. Impact evaluation is underway, but the novel PPP seems to be sustainable in the medium term. Sustained partnerships lead to further partnerships and the involvement of organizations in new activities. For example, our experience in urban health partnership helped leverage funding for further work in Ghatkopar under the Sure Start programme. SNEHA has been invited as a member of the Integrated Health and Family Welfare Governing Council and as a consultant at a range of meetings, and new programmes are being planned with existing partners.

The Way Forward – SNEHA’s new PPP Initiative Arogya Sarita – An Integrated Model of Primary Health Care

The Municipal Corporation of Greater Mumbai, SNEHA, and Mahindra &Mahindra (Private Corporation) have partnered to improve access and uptake of public health services in the vulnerable areas of the R/south Ward of Kandivali, specifically in the two health post areas of Hanuman Nagar and Damu Pada.

Rationale for partnership

The innovative model of integrating the private sector into the government’s health care delivery has encouraged enthusiastic participation by all the stakeholders - the public health system, private sector
and community. Once participation is catalysed, the role of the NGO is expected to become facilitative. It is an impractical expectation for the public health system to ensure 100% coverage and access – the community needs to meet the services midway and ensure uptake. This can be achieved through proven methodologies that facilitate interaction between the community and the system.

The goal of this project is to make quality health care accessible to all by building an integrated model of partnerships in the designated project areas. This pilot project will be implemented over an 18 month period, reaching out to a population of 150,000. While a Primary Health Center (Health Post) is supposed to cover a population of about 50,000, the density in the area is much more. Also, the population is spread over difficult geographical terrain with clusters of tribal areas in the remote hilly tracts with no access to health care. The important deliverables of the project include upgrading health care services, addition of specialist services by the private sector in the health posts, integration of all health care services under the health post, introduction of mobile health units by the private sector, staffed by the public sector to reach the currently inaccessible areas and the formation of Slum Health Action Committees to encourage community ownership of health care.

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