



Review of Public-Private Partnership Models



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Pakistan Initiative for
Mothers and Newborns

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The Pakistan initiative for Mothers and Newborns (PAIMAN) is a 6-year USAID funded project designed to reduce country's maternal and neonatal mortality by making sure that women have access to skilled birth attendants during childhood and throughout postpartum period. PAIMAN works at national, provincial and district levels to strengthen the capacity of public and private health care provider and improve health care system. The PAIMAN program is jointly implemented by John Snow Inc (JSI), the Contech International, Greenstar Social Marketing, Johns Hopkins University/CCP, PAVHNA, The Population Council, Save the Children USA.

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ACRONYMS

BCC	Behavioural Change Communication
BHU	Basic Health Unit
CFW	Commissioner of Family Welfare
DHMT	District Health Management Team
DOTS	Directly Observed Treatment
HLFPPT	Hindustan Latex Family Planning Promotion Trust
IUD	Intrauterine Device
JSI	John Snow Incorporation
MNH	Maternal and Neonatal Health
NGO	Non-Governmental Organizations
PAIMAN	Pakistan Initiative for Mothers and New Borns
PHC	Primary Health Care
PPP	Public Private Partnership
PRSP	Provincial Rural Support Program
PSI	Population Services International
RCH	Reproductive and Child Health
SIFPSA	State Innovations in Family Planning Services Project Agency
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing

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1. INTRODUCTION

1.1. About Public Private Partnerships (PPPs)

Public private partnerships (PPPs) are arrangements between government and private sector entities for the purpose of providing public infrastructure, community facilities and health services. Such partnerships are characterized by the sharing of investment, risk, responsibility and reward between the partners. The reasons for establishing such partnerships vary but generally involve the financing, design, construction, operation and maintenance of public infrastructure and services.

The underlying logic for establishing partnerships is that both the public and the private sector have unique characteristics that provide them with advantages in specific aspects of service or project delivery. The most successful partnership arrangements draw on the strengths of both the public and private sector to establish complementary relationships. The roles and responsibilities of the partners may vary from project to project. For example, in some projects, the private sector partner will have significant involvement in all aspects of service delivery, in others, only a minor role.

While the roles and responsibilities of the private and public sector partners may differ on individual servicing initiatives, the overall role and responsibilities of government do not change. Public private partnership is one of a number of ways of delivering public infrastructure including health services. It is not a substitute for strong and effective governance and decision making by government. In all cases, government remains responsible and accountable for delivering health services and projects in a manner that protects and furthers the public interest.

1.2. About Pakistan Initiative for Mothers and Newborn Health (PAIMAN)

PAIMAN is a five-year project funded by the United State Agency for International Development (USAID). PAIMAN is committed to assist the Government of Pakistan to implement essential and effective interventions to improve the service delivery to ensure better health status of mothers and newborns. A consortium led by JSI is responsible for

designing and implementing the project. Other members of consortium include Aga Khan University, Contech International Health Consultants, Greenstar, John Hopkins University Centre for Communication Program, PAVHNA, Population council and Save the Children USA. Main objective of the project is to reduce maternal, neonatal and children morbidity and mortality in the selected Districts of the country. One of the project components is to improve service delivery through better planning and management. District Health Management Teams (DHMTs) will be used as management tool in the project districts. Initially the project will be implemented in 10 districts of the country i.e. Rawalpindi, Jhelum, Khanewal & DG Khan in Punjab; Upper Dir and Buner in NWFP; Jaffarabad and Lasbella in Balochistan; Sukkur and Dadu in Sindh PAIMAN is targeting the decentralized units as focal point of their intervention.

1.3. Rationale

Along with multilateral intervention there is a need to develop various models of Public-private Partnership to deliver MNH services. PAIMAN will assist the District governments to pilot the proposed models and there will be an evaluation of scaling up of these models for implementation of PPP strategies for delivery of MNH services in other districts. The overview of existing models which are being implemented or under the piloting will help to understand the strengths, weaknesses of existing models, so that the deficiency can be minimized in the proposed PPP models for MNH service delivery.

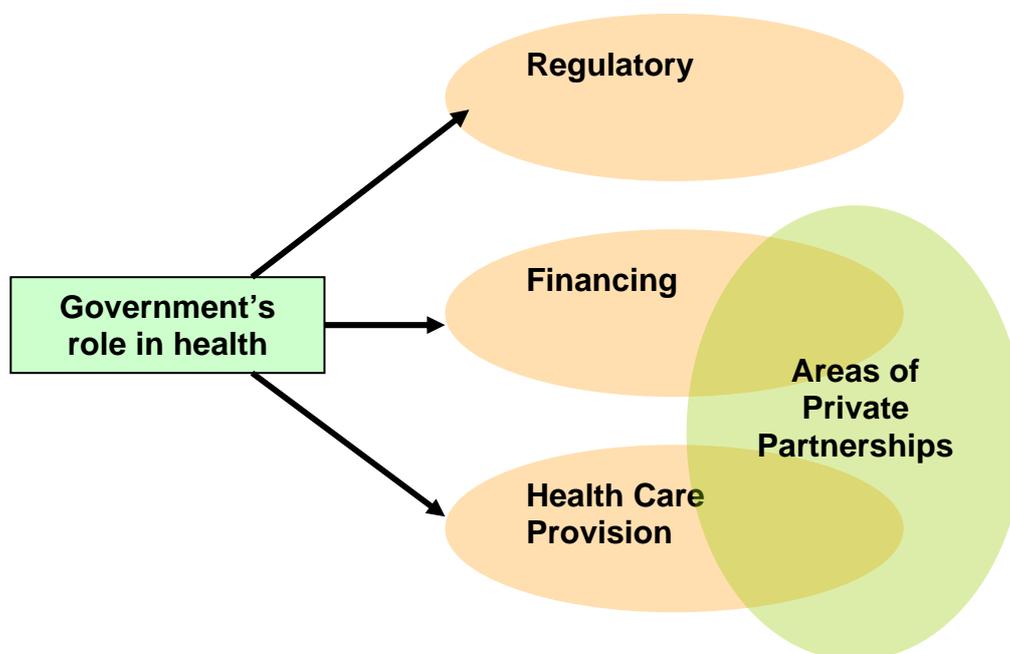
1.4. Objectives

- To study the existing models of PPP which are implemented, being implemented or under piloting at National and International levels.
- To study the strength and weakness of the existing models.

2. PPPs – A General Overview

There are variations in the socioeconomic infrastructure among the developing and developed countries. The nature and degree of PPPs vary according to the political, socio-cultural and the administrative infrastructures of the government. Generally in industrialized countries, private institutions, insurance industries, marketing cultures are well developed and the governments are in open competition with the markets. Therefore there is more liberty to develop an effective and an efficient PPP. In contrary in developing countries the communities are dependent on public sector for financing and provision of social services especially in health and education and the private institutions are not well established in these countries.

2.1. Nature of Collaboration



OPTIONS FOR PPP

1. Public sector retains regulatory and financing roles and partially share health services provision with private entities
2. Public sector completely handover service provision role
3. Public sector partially shares both service provision financing with private entities
4. Public sector only retain regulatory control

The government may collaborate with the private developer/service provider in any one of the following ways:

- a) **As a funding agency:** providing grant/capital/asset support to the private sector engaged in provision of public service, *on a contractual/non-contractual basis*.
- b) **As a buyer:** buying services on a long term basis.
- c) **As a coordinator:** specifying various sectors/forums in which participation by the private sector would be welcome.

The funding pattern and collaboration between the public sector and the private sector could take any one of the following forms:

- a) Public funding with private service delivery and private management.
- b) Public as well as private funding with private service delivery and private management.
- c) Public as well as private funding with public/private service delivery and public/private/joint management.

2.2. Types of PPPs

a) Operations and Maintenance

The District government contracts with a private partner to operate and maintain a publicly owned facility.

b) Turnkey Operations

The District government provides the financing for the project but engages a private partner to design, construct and operate the facility for a specified period of time. Performance objectives are established by the public sector and the public partner maintains ownership of the facility.

c) Wrap Around Additions

A private partner finances and constructs an addition to an existing public facility. The private partner may then operate the addition to the facility for a specified period of time or until the partner recovers the investment plus a reasonable return on the investment.

d) Lease-Purchase

The District government contracts with the private partner to design finance and build a facility to provide a public service. The private partner then leases the facility to the District government for a specified period after which ownership vests with the District government. This approach can be taken where District government requires a new facility or service but may not be in a position to provide financing.

e) Lease-Develop Operate or Buy-Develop Operate

The private partner leases or buys a facility from the District government, expands or modernizes it, then operates the facility under a contract with the District government. The private partner is expected to invest in facility expansion or improvement and is given a specified period of time in which to recover the investment and realize a return.

f) Build-Transfer-Operate

The District government contracts with a private partner to finance and build a facility. Once completed, the private partner transfers ownership of the facility to the District government. The District government then leases the facility back to the private partner under a long-term lease during which the private partner has an opportunity to recover its investment and a reasonable rate of return.

g) Build-Own-Operate

The District government either transfers ownership and responsibility for an existing facility or contracts with a private partner to build, own and operate a new facility in perpetuity. The private partner generally provides the financing.

2.3. Potential Benefits of PPPs

PPPs are not the solution for the delivery of all services. There are risks in proceeding with PPPs without critically examining their suitability to specific circumstances. However, District government can realize important benefits when public private partnerships are used in the appropriate context.

Potential Benefits

a) Cost Savings

With PPPs, District government may be able to realize cost savings for the construction of capital projects as well as the operation and maintenance of services. Cost savings can also be realized by District government in the operation and maintenance of facilities and service systems. Private partners may be able to reduce the cost of operating or maintaining facilities by applying economies of scale, innovative technologies, more flexible procurement and compensation arrangements, or by reducing overhead.

b) Risk Sharing

With PPPs, District government can share the risks with a private partner. Risks could include cost overruns, inability to meet

schedules for service delivery, or the risk that revenues may not be sufficient to pay operating and capital costs.

c) Improved Level of Services or Maintaining Existing Level of Services

PPPs can introduce innovation in how service delivery is organized and carried out. It can also introduce new technologies and economies of scale that often reduce the cost or improve the quality and level of services.

d) Enhancement of Revenues

PPPs may set user fees that reflect the true cost of delivering a particular service. PPPs also offer the opportunity to introduce more innovative revenue sources that would not be possible under conventional methods of service delivery.

e) Economic Benefits

Increased involvement of District government in PPPs can help to stimulate the private sector and contribute to increased employment and economic growth.

2.4. Potential Risks of PPPs

As with conventional forms of service delivery, there are risks as well as potential benefits associated with PPPs. District governments can reduce or eliminate the risks by understanding what they are and addressing them through well-conceived negotiations and contractual arrangements, and the involvement of stakeholder groups.

Potential Risks

a) Loss of Control by District Government

PPPs by their nature, involve a sharing of risks, benefits and decision making between the partners. PPPs that involve significant investments and risks by the private partner often provide for greater involvement of the private partner in decisions concerning how services are delivered and priced. This often leads to concerns about who controls the delivery of services. The issue of control needs to be addressed at the time the project is defined and kept in mind when the contract is negotiated.

b) Increased Costs

Not all District governments consider the true costs of providing services when establishing their pricing policies for fees for services. In some cases, there are explicit subsidies for specific services. The delivery of services through PPPs requires pricing policies and fees to reflect all relevant costs. This can have the

effect of increasing user fees for specific services. The cost of managing public controversy over increased fees or developing complex policies for staging fee increases can often negate the value of PPPs for specific services.

c) Political Risks

The combination of inexperience by District Government and stakeholder unfamiliarity with PPPs may result in higher political risks.

d) Unreliable Services

Private partners may be prone to labour disputes, financial problems or other circumstances that may prevent them from honouring their commitments.

e) Inability to Benefit from Competition

Competition among private partners to secure the right to enter into a PPP is an important benefit for District government. Competition leads to innovation, efficiency and lower costs. District governments may not be able to benefit from PPPs if there are only a limited number of potential private partners with the expertise or ability to respond to a request for proposals.

f) Reduced Quality or Efficiency of Service

If not properly structured, PPP contracts can result in a reduction in service quality, inefficient service delivery or a lack of proper facility maintenance.

g) Bias in Selection Process

As with conventional forms of service delivery, there is always the potential for District government to be accused of bias in selecting proponents. This may be more prevalent with PPPs given that “low bid” may not always win the contract if the District government has established other criteria (e.g., value for money). The potential for accusation of bias can be reduced through well developed policy and procedures, and by ensuring transparency in dealing with potential private partners.

h) Labour Issues

There could be adverse reaction from labour unions or District government staff.

3. REVIEW OF EXISTING PPP MODELS & INTERNATIONAL EXPERIENCES

PPPs have become prominent over the last decade. It is estimated by the World Bank that an investment of US \$ 890 billion was made globally in public – private infrastructure projects during 1990-2003. The leading sectors have been telecom (47 per cent) and energy (33 per cent), followed by toll-roads (8 per cent), water and sanitation (5 per cent), railways (3 per cent), seaports (2 per cent) and airports (2 per cent).

The share of South Asia in this investment (6 per cent) has remained low and there is considerable potential for an increase in the region. Between 3-6 per cent of the infrastructure PPP projects have either been cancelled or investments have been under stress due to a variety of reasons including inexperience, incomplete contracts and risk allocations, inadequate capacity of institutions, factors affecting investment climate, issues relating to cost recovery and affordability, and regulatory framework.

3.1. Uttar Pradesh, State Innovations in Family Planning Services Project Agency (SIFPSA) (India) : Clinical Contraception through Private Providers - Model 1

- **Reproductive and Child Health (RCH) Problem:** Need for increase in voluntary sterilization and Intrauterine device (IUDs) to achieve population stabilization
- **Service Delivery Problem:** Inadequate involvement of the private sector in providing sterilization and IUDs.
- **Public Entities:** District Government, Uttar Pradesh State Department of Health and Family Welfare.
- **Private Entities:** Private hospitals and nursing homes.
- **Modus Operandi:** The government reimburses private hospitals and nursing homes that provide sterilization and IUD services. The district government establishes the need for training. The private hospital and nursing homes provide free sterilization and IUD services, including pre-operative investigations, post-operative medicines, follow-up visits, management of complications and reporting to the district society. The district government pays upon verification to the private hospitals and nursing homes. District government also pays additional amounts for women who do not get pregnant for up to five years.
- **Comments:** The model is suitable to increase the coverage and accessibility for IUD services. It shares the services provision role but not the financing of the government sector. This partnership protects the poor as the services are 100% subsidized by the government. This

model unable to address the accessibility to remote areas where the suitable private hospitals and maternity homes were not available.

- **Strengths:** The program is straight forward covers the entire state and has increased sterilizations significantly. Monitoring and management are decentralized to the districts.
- **Weaknesses:** Private hospitals and nursing homes are facing problems due to delay in payments from the government. Older women and women who have more than three children are not eligible.

3.2. Andhra Pradesh: Urban Slum Health Centers (India) – Model 2

- **RCH Problem:** Poor health outcomes among urban poor.
- **Service Delivery Problem:** About 6 million urban slum dwellers had little access to primary health care (PHC) services and could not afford private care. The government of Andhra Pradesh built 192 urban slum health centres with aid from World Bank. After the end of project state is running the centres with its own finances.
- **Public Entity:** Andhra Pradesh Commissioner of Family Welfare (CFW).
- **Private Entities:** Non-Governmental Organizations (NGOs)
- **Modus Operandi:** The CFW provides NGOs with a fixed annual budget that covers salaries, operational expenses, equipment, furniture and pharmaceuticals. NGO provides basic RCH preventive care, services for childhood diseases, referrals and outreach. It does not provide inpatient care such as deliveries, sterilization and abortions. The project has three components: service delivery, community mobilization and behavioural change communication (BCC). There are no fees or registration charges.
- **Comments:** The model protects the poor but there is no financial sharing from the private sector and it partially shares services provision role with the government sector.
- **Strengths:** There was no significant opposition to contracting NGOs to operate these clinics, apparently because these were new facilities and NGOs are non-profit making concerns. Demand has been high. The structure, service package, staffing patterns all seem to be well designed and implemented. The government provides a rigorous training program for NGOs.
- **Weaknesses:** Payments from the Government are often late. There is a lack of basic laboratory equipment. User fees have been prohibited due to political opposition.

3.3. Bihar: The Kurji Holy Family Hospital and Health Centers (India) – Model 3

- **RCH Problem:** Unacceptably high infant and maternal morbidity and mortality.
- **Service Delivery Problem:** Unmet need for RCH services among the poor in the hospital's catchment areas.
- **Public Entity:** State and District Governments
- **Private Entities:** Kurji Hospital
- **Modus Operandi:** The hospital has established partnerships with the Government to provide immunizations and to host and manage and HIV/AIDS voluntary counselling and testing (VCT) centre; tuberculosis directly observed treatment (DOTS) centre; and a leprosy detection and treatment centre. It also provides family planning counselling (but no contraceptives). In each case government has provided drugs and reagents. The hospital receives no subsidy from the government. The user charges to the poor are 30% less than other private providers in that area.
- **Comments:** The model is helpful to increase the coverage of services to only a limited area. The model provides protection to poor but the financial load of the government is not shared. The partnership has limitation of accessibility to remote areas.
- **Strengths:** Major strength of the program is that it provides comprehensive RCH and other care services at very low prices. Another strength is the commodities partnership which makes the provision of key services possible.
- **Weaknesses:** The program is dependent on a reliable supply of commodities from the Government. The supply chain often breaks down and immunization for example cannot be given due to shortage of vaccines.

3.4. Uttar Pradesh : Social Marketing (India) – Model 4

- **RCH Problem:** Low adoption of contraceptives in rural areas.
- **Service Delivery Problem:** Lack of availability of good quality contraceptives at affordable prices.
- **Public Entity:** SIFPSA
- **Private Entities:** Hindustan Latex Ltd, Population Services International (PSI), DKT International and Hindustan Latex Family Planning Promotion Trust (HLFPPT)
- **Modus Operandi:** SIFPSA has awarded performance based contracts to several social marketing organizations for distribution support throughout the state of Uttar Pradesh. The government of India provides the contraceptives at subsidized rates to SIFPSA for distribution and sales. All of the private providers have created

standard sales distribution systems for supplying the contraceptives to their assigned areas through their field personnel.

- **Comments:** The model is good as it shares financing role but not the services provision role. It increases the coverage of product to remote areas. The project is only targeting the products it must be supplemented with contraceptive counselling outlets and reproductive health consultations.
- **Strengths:** This program improved the penetration and visibility of contraceptives in the state.
- **Weaknesses:** The social marketing organizations have been only engaged for distribution and sales not for fully integrated social marketing program that involves demand generation and impact analysis, which may have hampered the performance of the social marketing program.

3.5. Bangladesh : Obstetric and Pediatric Emergency Services – Model 5

- **Problem:** Access to emergency C-sections for poor women difficult.
- **Service Delivery Problem:** Lack of infrastructure in remote and rural areas.
- **Public Entity:** District Government
- **Private Entity:** NGO
- **Modus Operandi:** The District government loaned ambulances to an NGO which is responsible for operational costs (fuel, maintenance and driver etc) and which charges per k.m. (poor don't have to pay). The ambulances can be used for any emergencies to transport the patient to the nearest hospital.
- **Comments:** This model is very good to target remote and scattered populations. It provides opportunity to partially share the financing and services provision role. The model is able to protect the poor as subsidies are permissible to poor. The model is able to address the delay in obstetrical emergencies.
- **Strengths:** An attractive model well suited for rural and remote areas. It is simple fills an important gap and has saved lives.
- **Weaknesses:** Use of the ambulance solely for emergency obstetric care cannot be guaranteed.

3.6. Indonesia : Technical Training to Private Providers – Model 6

- **Problem:** Low interest of the trained doctors to work in rural and remote areas.
- **Service Delivery Problem:** No. of trained doctors is low.

- **Public Entity:** Medical School governed by the State
- **Private Entity:** Doctors
- **Modus Operandi:** The medical college developed a fellowship program recognizing the shortage of rural physicians. The recent graduates who are willing to work five years in a rural area are provided with small loan to build a clinic, buy a scooter and cover similar expenses. The program deposits and amount into the name of fellow in a bank account to given to the fellow with interest after five years and also provides free tuition for diploma studies. In return the physician must cover 8-10 villages and provide a fixed set of services at set fees, which he/she can retain.
- **Comments:** The model theoretically seems to be suitable for increase in coverage among the rural populations. The incentive of loan may be less attractive for the young doctors. The model has both financial and service provision roles of partnership.
- **Strengths:** Potential to provide services in the rural areas by qualified doctors with attraction of income generation to the doctors.
- **Weaknesses:** The model has not been able to deliver the desired results as most of the students prefer to go abroad for further studies. This can function better in an urban community where career expectations and aspirations are more modest.

Private-Public- Partnership Model in Pakistan

3.7. Land requisition from Village Head men (Community Leaders) for BHU and RHC in Pakistan: – Model 7

- **Problem:** The health budget for establishment of BHU and RHC in rural areas was insufficient to cover the land purchase and construction cost.
- **Service Delivery Problem:** The rural areas of the Pakistan were lacking basic infrastructure required to establish health services out-let in these areas. The primary health care services were inaccessible in rural areas.
- **Public Entity:** Provincial Health Department of the Provinces
- **Private Entity:** Community Leaders (Number Dar) or village head men. In some rural areas Village Welfare Committees.
- **Modus Operandi:** Provincial Health Departments had to bear the construction cost of BHU and RHC in rural areas while the land had to be donated by the community leaders or village head men free of cost. The representatives of health department from local DHO offices had negotiations with the village head men or “Number Dars”. The head men after consultation of local committee members specified the land for BHU / RHC. The health departments contracted for construction of facilities after completion of the land papers.
- **Comments:** This partnership is the first example of community participation for their health concerned. Some village head men donated their personal land and where the village common land was available that was denoted through consultations with local committee members.
- **Strengths:** The project was successful in sense that the government developed basic physical infrastructure for the delivery of primary health care to the rural community where the other health care providers (NGO or GP were not available)
- **Weaknesses:** The major weakness of this model was the lack of approach and geographic access to the health centres. Many BHUs and RHCs are located distant to the population dwelling near the graveyards. Although the residences of the doctors and paramedics available but no one is residing in these population isolated health centres. This factor has been the major cause of management failure in these health facilities.

3.8. Employees Social Security Institution (ESSI) in Pakistan (Model 8)

- **Problem:** Low income workers and their families were not having access to the health services.
- **Public Entity:** Ministry of Labour and Manpower
- **Private Entity:** Employers, Employees registered under the labour law. Organization having more than ten employees.
- **Modus Operandi:** The ESSIs are quasi-public, operate under government ordinances, and are managed as autonomous organizations at provincial level. They are funded entirely by contribution from the employers equal to 7% of the salaries. Government regulation required that establishment with more than 10 employees registered for ESSI coverage any worker earning less than Rs 3000 per month (about US\$50). The ESSIs have their own network of health facilities in major cities and industrial states. The health facilities provide basic and referral health services. They have accreditation system, in case of referral to accredited hospitals the charges are paid by the department. The employees and their families get an agreed package of services. The package of services includes, Medical Benefits, Sickness Benefits, Maternity Benefits, Disablement Benefits, Dependents Benefits, Funeral Expenses and Rehabilitation allowances under the insurance coverage.
- **Comments:** More than 5,000,000 employees (mostly urban) are registered (assuming six dependents per worker, this would give a total of about 3.5 million people covered or about 2.5% of the total population). This is a workable model but needs policy regulation if it has to be extended to self employees and farmers where the premium may be collected through some nominal percentage of crops or dairy products on bi-annually basis. In return all the family members must be covered for medical and extra benefits.
- **Strengths:** This model is running and most of the employees and their families get the agreed benefits from ESSIs. This model is successful to generate finance from the employers with nominal contribution from the employees. The services for the low income become affordable and accessible.
- **Weaknesses:** The major weakness in this model is its weak enforcement. Usually employers do not show the true strength of their employees to keep the premium as low as possible. If this law is enforced properly this model can be more workable.

3.9. Pakistan : Provincial Rural Support Program (PRSP) – Model 9

- **Problem:** Basic Health Units (BHUs) for PHC in rural areas are not working.
- **Service Delivery Problem:** Non-performance of staff, non-availability of essential medicines, supplies, equipment etc and the inability of the supervisory tiers to get the BHUs to deliver the assigned service.
- **Public Entity:** District Government, Government of Punjab
- **Private Entity:** NGO (Punjab Rural Support Program PRSP)
- **Modus Operandi:** PRSPs are using the existing budget and personnel to yield optimum output. All staff and physical assets are made available by the District government to the PRSP for the delivery of at least those services for which the District government has a responsibility. The Rahim Yar Khan (RYK) pilot used 3 BHUs-cluster approach, because of less number of doctors available. Medical officers were given fresh contracts with PRSP carrying a salary of Rs. 30,000 per month, with requirement to reside at focal BHU.
- **Comments:** There is no incentive in this model to attract the partner to remote areas. Although this model protects the poor with 100% subsidies but the quality of services can be compromised due to no profit margins. The model only shares services provision and has nothing to do with the finances.
- **Strengths:** The BHUs are able to provide a full range of services. Performance is good with constant monitoring.
- **Weaknesses:** The model inherits the problem of mistrust and resistance. The model is highly dependent on reputation of NGO and recruiting of quality doctors, who are willing to live in a rural community and be on a call 24 hours a day. This model is not addressing the provision of preventive services as was agreed.

3.10. Balochistan Safe Motherhood Initiative (BSMI) Khuzdar Pakistan – Model 10

- **Problem:** It was estimated that the maternal mortality ratio (MMR) was about 700 per 100,000 live births in Khuzdar (Maternal and Infant Mortality Survey, 1991), which was amongst the highest in the world. More than 90 percent of all deliveries were conducted by untrained traditional birth attendants (*dais*). Women seek medical care from a trained health professional only during life-threatening situations, but accessing emergency obstetric care proved difficult for a majority of rural women. This was attributed to the delays in decision-making to seek adequate medical care and in transporting women experiencing complications to the hospital. These delays too frequently result in maternal death.
- **Service Delivery Problem:** The population of Balochistan and Khuzdar is scattered on large areas. The health facilities and the

referral hospitals are inaccessible as there is no suitable communication and transportation system in that area.

- **Public Entity:** Government of Balochistan Health Department
- **Private Entity:** UNICEF and Asia Foundation
- **Modus Operandi:** The project uses the government owned health infrastructure for provision of health services. The project has five components.
 1. Information education and communication strategies aimed at women, families and traditional birth attendants.
 2. Streamlining the local transport system through training, motivation and monitoring of local owners to transport in need of emergencies obstetric care.
 3. Introduction of reliable communication system to connect traditional birth attendants and primary health facilities and transport system.
 4. Upgrading and strengthening reproductive health services provided at the government's primary health facilities and at the divisional (Khuzdar) and district (Kalat) hospitals
 5. Training of health care providers, including Lady Health Workers, working at the primary health facilities in order to motivate, sensitize and prepare the providers to appropriately manage common reproductive health problems in their communities. Continued training of TBAs.
- **Comments:** This model of partnership has multi-dimensional effects including coverage, accessibility, community mobilization, financing and reduction of delays in obstetrical emergencies. The organization involved in this project is non-profit earning and they are financing all the components of the project therefore after the expiry there may be issue of sustainability of the program like many other projects funded by these agencies.
- **Strengths:** The program is targeting and identifying population in remote areas. The program will increase the coverage and accessibility and can reduce the delayed referral.
- **Weaknesses:** The model indicates only the voluntary and ethical measures to be taken for obstetric emergencies, no formal responsibility of transport and communication sector is fixed on any agency.

3.11. Pakistan USAID Contraceptive Social Marketing (CSM) Project 1985 (Model-11)

- **Problem:** Inaccessibility to family planning and contraceptive counselling and quality products. Inadequate motivation to initiate contraception both in urban and rural areas.
- **Service Delivery Problem:** The Ministry of Population Welfare of Pakistan has inadequate infrastructure, trained health personnel's and

contraceptive product outlets in both urban and rural areas of Pakistan. Even the motivated couples don't have the access to quality product and counseling from trained health care providers. Availability of good quality and low-priced contraceptives in the market was very low.

- **Public Entity:** Representatives from the government's Ministries of Planning, Health and Education
- **Private Entity:** Resident advisor from USAID; and a local company responsible for products
- **Modus Operandi:** Initially the program started in 1984 operated by the Government of Pakistan (GoP). Sales of both condoms and low-dose oral contraceptives were planned for 1986. At this point, however, the social marketing project's implementation remained in doubt as a result of internal government opposition. The government planned to implement the project without an outside contractor, but this proved infeasible. The Request for Proposal (RFP) prepared by USAID outlined, 4-year involvement for a resident advisor. Funds flowed from a 5-year US\$20 million contract signed in 1984 by USAID and GoP.
- **Comments:** The project was unable to achieve its objectives and there was no appreciable increase in coverage of contraceptive use and social marketing until there were more liberal policies that came to open the new avenues of social marketing.
- **Weaknesses:** The model inherits management problems and inadequate involvement of private sector therefore it failed to achieve the set objectives.

3.12. Greenstar Social Marketing and Key Social Marketing in Pakistan (Model 12)

- **Problem:** Inaccessibility to family planning and contraceptive counselling and quality products. Inadequate motivation to initiate contraception both in urban and rural areas.
- **Service Delivery Problem:** The Ministry of Population Welfare of Pakistan has inadequate infrastructure, trained health personnel's and contraceptive product outlets in both urban and rural areas of Pakistan. Even the motivated couples don't have the access to quality product and counseling from trained health care providers. Availability of good quality and low-priced contraceptives in the market was very low.
- **Public Entity:** Government of Pakistan
- **Private Entity:** Greenstar Social Marketing and Key Social Marketing
- **Modus Operandi:** USAID supports Greenstar Social Marketing and Key Social Marketing in Pakistan to offer women a wide range of choices in health care, better information and more accessible facilities. The program focuses on both rural and urban areas, ensuring that reproductive health products and services are economically viable and accessible to the poor. It also encourages multiple commercial manufacturers to enter the market to improve the quality of the

products to help sustainability of the system. The GSM and KSM are executing social marketing program through advertisement, marketing, research, training and dispensation of contraceptive products. Their network includes, 47,500 retail outlets, over 12,500 medical doctors, 7000 paramedics and 9500 chemist/ druggist. They collectively claim to contribute 20% of couple years of protection to national program of population welfare.

- **Comments:** This partnership got immense popularity in community mobilization. The project has markedly increased the coverage of contraceptive counselling outlets through general practitioners and retail outlets for the provision of quality contraceptive products at subsidized rates. This model shares both service provision and financing role with the government. The project could be self sustainable as it involves financing component.
- **Strength:** The programme has impact on the accessibility and affordability to contraceptive counselling and products. The project has been able to demonstrate an appreciable decline in fertility indicators in Pakistan.
- **Weaknesses:** The model is successful in urban slums and larger towns but the accessibility in remote areas is still lacking. This model is manly targeting the availability of the products just near to open market prices. Some products are even cheaper in open market because the project is charging G.P consultation subsidies through the product retile prices.

3.13. Safe Motherhood Applied Research and Training Project (SMART) in D.G Khan and Layyah districts: Pakistan (Model 13)

- **Problem:** Inaccessibility and delay in Maternal and Neonatal Emergency handling
- **Service Delivery Problem:** DG khan and layyah district are remote districts of Southern Punjab Pakistan there is services delivery problem especially for maternal and neonatal emergencies due to lack of awareness and preparedness.
- **Public Entity:** District Government DG Khan and Layyah
- **Private Entity:** Population Council Pakistan
- **Modus Operandi:** The Safe Motherhood Applied Research and Training (SMART) project, funded by the European Union, is a three-year operations research project. The Population Council aims to reduce maternal and neonatal mortality in D.G. Khan District, Punjab, and to provide comprehensive analysis of the results. Program components include increasing community awareness about obstetric and neonatal danger signs; increasing preparedness for emergency care, including transport; improving the quality and accessibility of

basic and comprehensive emergency obstetric and neonatal care; and improving healthcare providers' interpersonal communication skills.

The research design involves three cells: health systems improvement (HSI) only, HSI plus community involvement, and a control (in Layyah district). A variety of quantitative and qualitative techniques are used to evaluate inputs, processes, outputs, and impact and to study in detail community and provider attitudes and responses regarding maternal and neonatal health. The project will provide solid research to inform programs of the potential to reduce maternal and neonatal mortality through community-based interventions in addition to health services interventions in a southern Punjab district.

- **Comments:** In this model the private partner is involved for community mobilization and IEC component. It is doubtful how the interpersonal communication will be achieved with out any binding force of some incentives. All activities seems to be voluntary there is no formal agreement between government and the NGO to share service provision or financial matters.
- **Strength:** This model is under the stage of implementation and the outcomes of the projected are still awaited.
- **Weaknesses:** It seems that the voluntary activity of an NGO can be taken as formal agreement involving PPP among the district government and the private partner.

3.14. Technical Assistance for Health Sector Reform In North-West Frontier Province Pakistan: (Model 14)

- **Problem:** The overall impact of the public and private health system on the health status of the Population of NWFP is unsatisfactory. NWFP's population is close to 20 million, including 2.5 million Afghans and is growing at 2.7 percent per annum. Due to the scarcity of arable land and employment opportunities, many families and men are forced to migrate in search of a living. The burden of disease reflects a transition pattern dominated by communicable diseases, complications of pregnancy and childbearing, and malnutrition. At the same time, there is an increasing demand for more costly health services for chronic health conditions and accidents associated with modern society. A 1996-1997 survey found a total fertility rate of more than six children per woman, and an infant mortality rate of 75 deaths per 1,000 live births in the first year of life (115 in the poorest quintile). The contraceptive prevalence rate was only 15 percent for any type of method, and only 45 percent of eligible children are fully immunized.
- **Public Entity:** Provincial Health Department
- **Private Entity:** Asian Development Bank

- **Modus Operandi:** Provincial Health Department was the Executing Agency for the TA. A steering committee, chaired by the provincial Secretary Health, NWFP, was established to guide TA implementation, and to ensure the continuity of the government's participation in the TA. The committee included representatives of PHD; the Provincial Planning, Environment, and Development Department; non-government organization and private sector representatives; and the team leader. A core HSR unit was established in the planning cell of PHD, with an Internet facility, to which the consultants and fulltime counterparts were attached. PHD made this unit available on commencement of the task, and that it nominated counterparts in public health, health systems management, statistics, and computer programming to work with the consultants. PHD facilitated the interaction of consultants with stakeholders. The consultants helped to develop policies and plans for HSR. They also assisted the unit in exchanging experiences and ideas with other HSR teams (including in Punjab).
- **Comments:** This type of partnership cannot be the true PPP because ADP is basically assisting the health department to implement health sector reforms. However the health sector reforms itself stress the development of PPP to involve private sector and assign it a definitive role in social services especially in health.
- **Strength:** The above assistance lead to decentralization and policy relaxation for the development of PPP in NWRP in the devolved districts.
- **Weaknesses:** The Provincial Health Department still need lot of assistance for planning and capacity building in the decentralized units. Most of the District Government are still following the incremental budgeting and DHMT are not functional in many districts. There is still inadequate financial authority delegated to the districts.

3.15. **Save the Children: District-level model for improving reproductive health (RH) care and awareness in Haripur District of North-West Frontier Province, Pakistan. (Model 15)**

- **Problem:** The population of the refugee camps in and around Haripur is estimated at 115,102. The current political, security and economic situation inside Afghanistan has not inspired many Afghans to return home. Very few people have any formal education, women live in strict purdah (isolation), and family incomes are small. There is little published data about this fairly unique refugee population. It was estimated that over half of the women did not receive antenatal care or increase their dietary intake during pregnancy. Alarmingly, although most women delivered at home (77%), few families knew the danger signs surrounding pregnancy or had considered how the mother would reach the hospital if complications arose. When the baby was delivered, 70% had their umbilical cords cut with a household utensil and 80% were bathed (usually in cold water or a in a cold room). It was

also discovered that most women exerted little influence over the decisions surrounding their delivery; only 35% decided where they would deliver.

- **Public Entity:** District and Provincial Health Department. District and Provincial Population Welfare Departments.
- **Private Entity:** Save the Children

Modus Operandi: Save the Children implements a district-level model for improving reproductive health (RH) care and awareness in Haripur District of North-West Frontier Province, Pakistan. This program focuses on the RH issues of safe motherhood, birth spacing, and management and treatment of sexually transmitted diseases/reproductive tract infections. Save the Children runs a primary health care and reproductive health program in these areas which aims to promote the well being of children, families, and communities by reducing morbidity and mortality rates, preventing and managing communicable diseases, promoting good health and protective behaviours, and promoting sustainability of good health behaviours. The program actively promotes and supports awareness and acceptance of preventive health strategies within the refugee community. A Family Health Clinic operates round the clock and provides basic emergency obstetric care to women referred from the Basic Health Units operating in the refugee villages. An ambulance is also available in the clinic to make supervised referrals to tertiary level hospitals in case of patients requiring further specialized care

- **Comments:** This model shares the service provision role of the Government by NGO. The health department is collaborating with international NGO to invest on health. This model is not true example of PPP as there is no risk or profit sharing among the partners.
- **Strength:** This model has successfully increased the coverage of the services to inaccessible areas. If the financial burden is considered this model involves no additional financial burden on community and protects the poor.
- **Weaknesses:** This model is not a sustainable PPP model as it does not involve any financial sharing by the community. It is a voluntary program run by an NGO. The program might end with the end of funding.

3.16. Delivery of PHC and Preventive Services for HIV/AIDS among FSW and MSM in Lahore

- **Problem:** The Punjab AIDS Control Program has to establish health out lets for PHC and Preventive Services for HIV / AIDS in specified areas of Lahore for Female Sex Workers and Men having sex with Men

- **Public Entity:** Punjab AIDS Control Program, World Bank.
- **Private Entity:** Contech International (Lead firm), NEHRI, Savior-Favoure

Modus Operandi: The Punjab AIDS Control Program is being executed through Government of the Punjab Health Department. The health department has to establish the centers for Primary Health Care Services and preventive services for HIV and AIDS. The Health Department has developed Public Private Partnership for the delivery of the Health Services with Contech International and their partner NGOs, (NEHRI and Savior-Favoure). The AIDS Control Program is paying to Contech and partner NGOs for provision of health services through their established centres in specified areas of Female Sex Workers (FSW) and Men having sex with Men (MSM) in Lahore. The AIDS Control Program is utilizing already establish infrastructure instead of developing new one.

- **Comments:** This model provides coverage to the areas where the government care providers are not committed to provide services. These difficult areas are accessed by the AIDS Control Program through their private partners. This model of PPP is also sharing some nominal financial contribution through fee for services that is Rs. 5 per visit. The services are free for non-affording and hence it protects the poor. This model can be workable for contracting the MNH services in remote areas to committed local NGOs.
- **Strength:** The project is efficiently working and successful in raising the awareness among the targets groups regarding HIV prevention.
- **Weaknesses:** The target groups in this model are highly stigmatized and marginalized. There is lot of suspicions among these groups especially towards the health care providers. Moreover location and tracing of target groups still a difficult job.

3.17. National Commission on Human Development Program in 16 Districts of Pakistan 4 in each Province (Pakistan Human Development Fund (PHDF) Established for PPP to fund NCHD Projects) (Model 16)

- **Problem:** Poor health indicator in terms of low utilization of ORS and Iodized salt. Low coverage of EPI vaccines and low contraceptive prevalence rates in the targeted districts. The low literacy rate amongst the females was also targeted though the project.
- **Public Entity:** Government of Pakistan (PHDF) and UNDP
- **Private Entity:** Private Philanthropists,



- Modus Operandi:** The project has five components that includes Education, Primary Health Care Extension, Community Development /Volunteerism, Micro Enterprise Development, Incubation (Capacity Building) and Global Resource Mobilization. The primary health care extension component is focused on training and health education of mothers for utilization of ORS, and use of Iodized salt. Motivation and counselling for birth spacing through use contraception is also included in this project. To increase the percentage of EPI vaccine coverage in children and TT immunization among women are also targeted through this program.
- Comments:** The model is suitable to increase the coverage in remote areas through participation of Philanthropic NGOs. This model shares only services provision while the financing is through PHDF and other donor agencies. This is not true PPP model it is donor dependent and the sustainability is doubtful.
- Strengths:** It has been claimed that over 650,000 mothers have been trained on the importance of making home-made ORS in 6 districts. (Cost Rs 1.50 / mother). Ninety percent of women in the target areas of PHCE Project are being continuously provided Health Education. Ninety percent of the children under 5 are being continuously monitored for their growth/nutrition. Mothers' health education has doubled iodized salt usage in Mardan. Percentage of eligible couples using child spacing methods has increased by increased by 500%. Percentage of women with 3 TT vaccinations has been increased by 65%. Percentages of children immunized with BCG, DPT and Measles have been increased to 67.6%, 38.5% and 27.6% respectively
- Weaknesses:** This model is not a sustainable PPP model. It does not involve any financial sharing from community side. It is voluntary program run by the international donor AID.

Discussion

In this review most of the PPP models included were practiced or are being practiced at regional level in South Asia and at national level in Pakistan. The socioeconomic problems, disease trends, populations, literacy issues and other factors are similar in the region and within the country therefore the review of closely related areas will be more helpful for developing the proposal for PPP rather than comparison with the PPP models in the developed countries. Health systems of the developing countries are historically reshaping and remolding under the influence of their internal political and managerial problems but the appreciable role had been played by international donor agencies and financial institutions. At this point of time the health systems in most of the developing countries are shifting from selective PHC to the comprehensive PHC implementation strategies through the principles of decentralization and community participation. In the last two or three decades all the developing countries were receiving the international assistance especially in health sector for selected health problems like control of communicable disease, maternal and child health, population control, dihedral disease, ARI and many other problems. Now the developing nations are passing through weaning phase of international donor dependency to self reliance and sustainability for their health systems. This is very tricky and difficult phase on one side health is accepted as “basic right of every individual irrespective of capacity to pay for it” on the other hand there are changing policies starting from decentralization / devolution to market oriented approach for health that means the end destination is provider-purchaser relationship between health care provider and the patients. The governments of the developing nations are now in search of the buffer phase in between the two extremes on one side there is total dependency for health on government and on the other side no shelter to the poor. The private public partnership is concept evolved in quest of the moderate policy for mutual sharing of health financing by the community, government and private stakeholders in the developing countries.

Regional PPP Models:

Among the regional models reviewed from India Utter Pardesh, Andhra Pardesh and Bihar all these model share some service provision role from the private sector but there is no /or negligible role in health financing. All these models are generally targeting the urban population and they are not workable in the remote areas. However these models have been successful to increase the coverage of the services through private sector participation. In Pakistan Greenstar and Key Social

Marketing are better models because they are sharing both service provision and financing roles and are more sustainable. Reference to MNH services the Bangladesh regional PPP model "Obstetric and Pediatrics Emergency Services" is workable because it addresses the access to remote areas through ambulances. It may be helpful to increase the accessibility to health facilities but it does not address the domiciliary services by trained health personals and social issues for decision making for institutional deliveries. Instead of using ambulances, the vehicles must be used as mobile MNH squads to serve both transport and services provision at domiciliary level. The regional PPP model of Indonesia "Technical Training to Private Providers" apparently seems to be addressing the remote areas but technically complicated and there are not enough incentives for ambitious young doctors to be settled in remote areas.

PPP Models in Pakistan:

The Employees Social Security Institutions (ESSI) is the true PPP model in Pakistan. It shares the service provision and financing role from private sector but as the management is quasi-governmental therefore it again can be considered as subsidiary body of the government. This model as such is not workable because it needs new regulation or change in existing regulation. If with change in regulation this model is implemented and extended to self employed rural population with payment of nominal proportion of crops yield on six monthly bases as premium for health insurance then this model could be sustainable true PPP model. (In Pakistan Kissan were paying Malia Rs. 2.00 per acre as Land Revenue Tax collected by the nominated Number Dar on six monthly bases). If we want to pilot similar insurance model that is possible without change in regulation. The voluntary health insurance through health card scheme for MNH services can also be introduced but it would be successful only in urban areas where the people are sensitized for health and willing to get insured.

The social marketing models are becoming popular in the South Asia as well as in Pakistan. The Greenstar and Key Social Marketing are targeting the family planning services and the products to make them socially and economically accessible to urban and larger rural towns. The other social marketing programs are underway for supply of Insecticide Treated Nets and Anti-malarial drugs on subsidized rate in Role Back Malaria (RBM), Supply of Anti-tuberculosis drug for TB. DOTS program and iron fortified wheat flour for pregnant and lactating ladies for nutritional supplementation. The stakeholders claim that they will encourage the social

mobilization for utility of these products through advertisement and they will launch the products on subsidized rate so that the products are economically accessible to the non-affording population. On the other hand such models are more attractive for donors as providing opportunity for negotiation directly with product launching firms where the accountability issues are undermined moreover the subsidized products are very closer to the open market rates. The family planning products through social marketing are retailed more than the open market as it also includes the consultation fee of the GP. Such social marketing models can be practiced in selected areas of services they are more of financial model rather than service provision. Reference to MNH services which is the need of every individual without his capability to pay for services such models of marketing may not be workable. These models are not addressing the issues of accessibility to remote scattered population for coverage. Another PPP model that has been recently piloted in rural areas of the province Punjab is “Contracting government owned BHU/RHC to an NGO (PRSP) along with salaries and maintenance budgets for management purpose.” This model has many weak points such as no incentive force to bind private sector for partnership and government has not taken enough grantees for quality of services from the PRSP. However this model can be workable if the private partners are paid by the government for package of services provided by them. In this contract government is 100% subsidizing all the services. There must be improved quality of services and the subsidies must be different for different services package. The differential subsidies will provide the opportunity of for the government to invest in those areas where the people are not willing to pay. On the other hand the non subsidized user charges for those services for that the people are willingly paying will provide the incentive to the private partner to attract in remote areas.

There is another category of PPP models in Pakistan like “Balochistan Safe Motherhood Initiative (BSMI) Khuzdar, by UNICEF and Asia Foundation, “SMART” Project by POP Council at D.G Khan, “District level model of improving RH care” at Haripur (NWFP) by Save the Children, “Delivery of preventive services for HIV/ AIDS among the FSW and MSM” at Lahore by Contech International and “PHC Extension” UNDP and PHDF (Pakistan Human Development Fund). In these models there is partnership for service provision and these models do increase the coverage and accessibility to the services. There is also protection of poor as most of the services are partially or totally subsidized. These models are specifically workable for MNH services in remote and scattered areas where the profit earning private sector cannot be attracted. The MNH service initially supported by the international donors will then

gradually be weaned off to sustainable internal financing system. There is one common weak point of all these models that they are donor dependent programs. In all these project there is heavy funding of one or more International Donor Agencies. These models are not playing any role for financing health services and there is no sharing of risk or benefits that is the essential component of true PPP. Although developing nations still need a lot of international assistance in the transient phase of health sector reforms for comprehensive PHC strategies but working on these models will not achieve the objective of weaning from donor dependency through Private Public Partnership.

In spite of many limitations, there are several advantages and achievements of having the private sector institutions to participate in health and education efforts in Pakistan. Effective and extensive outreach, community involvement, and "client-responsiveness" and accountability are the main positive attributes of this sector's experience. In terms of outreach, private sector institutions have been successful due to their diverse geographic and activity scope. Their presence of operations in local environments, balanced within a broader development perspective, has enabled the processes of development to reach the communities. This also relates to the attribute of community involvement. Non-profit enterprises particularly, work in collaboration with community-based institutions and with indigenous networks of community organizations, which makes them more responsive and accountable directly to the beneficiaries of their programs. It is these characteristics upon which the public sector can build for its wider efforts in improvement of health.

Given the non-systemic and unregulated nature of the diverse private sector institutions, there are many issues that the private sector institutions need to face and address in order to confront the challenges for optimizing their involvement in poverty reduction efforts. These include a combination of factors such as (i) balancing scale of operations with impact, (ii) sustainability of their development programs, and (iii) management and governance issues. A partnership which builds upon the successes and the comparative advantages of the private sector institutions, and which aims to reduce the friction arising because of some of the shortcomings of the sector, is required to ensure a concerted effort towards improvement of health indicators.

As key public services such as education and health are increasingly being delivered by the private sector institutions, the Government and the private sector institutions need to come to the table and bring options for viable models for PPP for the

delivery of social sector services and other sectors as well. There is a sense developing that options which include public sector financing of such services for implementation and management by the private sector need to be explored, and perhaps even pilot-tested. Some such efforts are already underway. Civil society needs to play a more proactive role by documenting its experiences, sharing best practice, and bringing viable options to the table for discussion. Given the Government's budget constraints, social sectors and other poverty reduction priority areas will need to be protected through innovative ways to implement cost-effective and efficient quality health programs. Enhanced community involvement and more institutional private sector participation can only help to ensure that there is a sense of accountability and responsibility present in all services and service providers directly to the beneficiaries.

4. CONCLUSIONS

PPP is a popular term in engaging the private sector for delivery of services. A true partnership requires shared objectives, shared risks, shared investment and shared rewards. The key points that have emerged from international experience for successful implementation of PPPs include the following:

- a) High level political and institutional support is critical for PPPs.
- b) Government has central role in defining what it wants and as the regulator.
- c) PPP deals must make sense in terms of delivering both the desired outcomes and commercial returns.
- d) Good PPPs involve optional risk allocation, demonstrable value for money clarity of affordability and certainty of public service payment obligations based on delivery of outputs.
- e) Output based techniques are important for targeted and efficient subsidy allocation.
- f) A well defined policy framework is required that (a) sets out clearly the processes, priorities and scope of PPP; (b) drives transparent procurement processes; (c) includes a communication strategy to improve public and private sector understanding of PPPs; (d) provides clarity of long term government obligations that work across federal and provincial levels; (e) includes mechanisms to recognize implicit/explicit government liabilities and public sector balance sheet requirements; and (f) includes mechanisms to deal with incumbents.
- g) A well defined legal framework is required that provides clarity, defines contracting authority powers, minimizes procurement costs and timetables, for example, through standard/model contracts, improves dispute reduction, and accommodates future development.
- h) Private sector/supply side issues should be addressed including availability of long term local currency finance, PPP bid capacity and financing skills, and building capacity of local skills.
- i) Early identification of projects and pre-feasibility studies for prospective investors is important.

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