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Reproductive health services for women: differences between public private partnership and government models

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A B S T R A C T

Under Public Private Partnership (PPP) the synergy between strengths of the public and the private sector is expected to be harnessed to provide accessible, efficient, accountable and good quality services to achieve good health of people. A study was conducted to examine the theme of PPPs as a way of providing good quality of reproductive health services to women. Interviews were conducted with select 320 women beneficiaries of three facilities operated as PPPs and three comparative government operated "Control" facilities in Gujarat, India. While choosing place for reproductive health care women gave weightage to proximity, familiarity and cost than to conventional indicators of quality of care. Their experiences of seeking care did not differ much in both types of facilities except on cost and waiting time, which were higher in facilities operated by PPPs. Their expectations of range of services from these facilities were more than what the mandate of the facilities allowed them to provide. Women's views and experiences have a bearing on the utilisation and effectiveness of the PPPs and the study suggests that to achieve the real potential of these partnerships the design needs to take these into consideration.

Introduction

Public private partnerships and women's reproductive health in India

In India, Public Private Partnerships (PPPs) were implemented in the health sector to improve service delivery. These are largely perceived to have succeeded in providing an efficient, flexible, equitable, cost effective and viable alternative for government service delivery. However, there are concerns about the cost of services, unreliable quality of care and lack of standardisation (Venkat Raman & Björkman, 2009). Where PPPs have been given the flexibility to charge user fees, it is feared that they may end up serving only

those who can pay, increasing inequity, making profits through supplying more health care than is required and providing low-quality health care (Mitchell-Weaver & Manning, 1992). The government policies do not provide the blueprint about how economically dis-empowered, traditionally subjugated women should go about exercising their reproductive rights in such a commercial approach adopted for viability of the PPPs (SID, 2006). Further, the effectiveness of PPPs is likely to be hamstrung by non-monetary factors such as illiteracy, low awareness, limited mobility, access to transport and women's beliefs and past experiences which are rarely taken into consideration while designing health service delivery (CEHAT, 2009).

In India informal partnership with private sector has existed in national programmes since the first five year plan (1951-56). However, with increasing importance of efficiency and quality in service delivery a more formal, equitable relationship between partners to deliver comprehensive services (Baru & Nundy, 2008) was envisaged and implemented. Despite impressive economic growth, progressive policies and five year plans, women in India continue to have unaddressed reproductive health needs. The last round of National Family Health Survey (NFHS 3 in 2005-2006) showed that only 51 percent of women had received the recommended three antenatal care visits, 41 percent had institutional births, and 39 percent received postnatal care within 2 days of delivery (IIPS, 2007). The Sample Registration System estimated the Maternal Mortality Rate at 212 per 100,000 live births (RGI, 2011). Studies have shown that as compared to men, women in the country are disadvantaged not only because of their gendered vulnerabilities but also because they belong to a specific caste, class or educational status (Chatterjee & Sheoran, 2007). There is a higher incidence of mortality and morbidity among women who are poor, less educated and socially disadvantaged.

Essential reproductive health services are not available to the majority (70%) of women in India through the public health system (IIPS, 2007). Though provision of health facilities is a constitutional obligation of the government, inadequacies in availability, accessibility, acceptability and quality of health services have affected health services, particularly to poor, rural women (The CRR, 2008). Health sector reforms have been proposed since 1992 to address these inadequacies of the public health system (Planning Commission, 1992). Public Private Partnerships (PPPs) are a core component of the reform strategies. The belief that locally available, easily accessible and acceptable and better managed private sector are better suited to provide efficient, cost effective and good quality services drives this proposed reform (Venkat Raman and Bjorkman, 2009).

Gujarat state has been at the forefront in implementing health sector reforms. The state has made rapid strides economically but lags behind on the human development index (HDI) that reflects the performance in social sector. Improvement of HDI is a priority of the State government. The PPPs have had a long history in the state beginning with the example of a primary health centre being managed by SEWA Rural in the 1980s to the Chiranjeevi yojana in the recent years. Despite their documented successes (UNNATI and Vadodara Medical College, 1999; Mavalankar *et al.,* 2009), implementation of these partnerships has not always benefited women. While the irregular and inadequate medicine supplies and over emphasis on target achievements affected SEWA Rural's

services to women (UNNATI and Vadodara Medical College, 1999; Annigeri *et al.*, 2004), under Chiranjeevi yojana empanelled obstetrician are known to divert women without documentary evidence like Below Poverty Line cards (issued by the government) and women with complications to the public hospitals due to cost considerations (Acharya and Mcnamee, 2009). Moreover, successes and achievements of these models have been largely assessed on the basis of performance on technical or health indicators. There is scant data on how women beneficiaries' view the quality of services being provided by PPPs. The state therefore offered an interesting context for conducting a study to fill this information gap. The purpose of the study was to examine the theme of PPP as a way of providing quality of reproductive health services to women, especially to under- privileged women. This paper tries to focus on quality of reproductive health services as perceived and experienced by women beneficiaries of these services.

Materials and Methods

The core objective of the study was to investigate women beneficiaries' perception and experiences about quality of reproductive health service delivery at select PPPs.

Operational terms

For the purpose of this study PPP was as defined by the government, a collaborative effort by public and private sectors for delivery of a set of services in a stipulated time period, wherein "Public" means Government or organizations functioning under State budgets and "Private" means the Profit/Non-profit/Voluntary sector. "Control" was defined as effort by the public sector alone for delivery of a set of services in a stipulated time. Beneficiaries were women in the reproductive age group (15 to 49 years) from the areas of the selected facilities and under- privileged beneficiaries were women in the reproductive age group from the poor and Scheduled Caste/Scheduled Tribe/ Other Backward Caste families. Quality of services was defined in terms of components such as adequacy of health facility (location, availability of medicines, supplies and staff and capability of doctors); efficiency in health care delivery (timing, waiting time and privacy) and inter-personal communication (friendliness and responsiveness of staff, explanations offered and comprehensibility of advice). Women's satisfaction with services was also taken as proxy of quality of services they availed of.

Study design

A case control design was adopted for the study. PPPs implementing the reproductive and child programme at the district, Community Health Centre (CHCs) and Primary Health Centre (PHCs) level[1] were selected. Focus on provision of services for women beneficiaries' reproductive health, documented successes, government's stated plans of up scaling, and feasibility of studying them determined the selection of PPPs. Three PPPs that met this requirement were selected in consultation with officials of the Government of Gujarat. These were the PHC at Dahej in Bharuch district run by a corporate body, CHC Shamlaji in Sabarkantha district run by an NGO and facilities of five private obstetricians empanelled under Chiranjeevi Yojana (CY, CY hospitals) in Surat district. "Control" facilities at same level of health service delivery in the same districts were selected

[1] The PHC serves a population of 30 to 50,000 and provides primary health care. The CHC or the first referral unit, serves a population of >1.2 lacs and provides secondary health care.

for comparative study. These were Tankari PHC in Bharuch, Prantij CHC in Sabarkantha and facilities of five private obstetricians not empanelled under CY (Non-CY hospitals) in Surat district.

Methods and Procedure

In the areas of the PPPs and their "Control" a survey was carried out among women beneficiaries in the reproductive age group who had used the reproductive health services in the year prior to the survey.

Sample Since aim of the study was not to look at prevalence of health needs or vital rates, but to examine women beneficiaries' perceptions about quality of care and satisfaction with services and the study was part of doctoral work with attendant limitations of budget and time, the sample size was kept small. Based on women seeking reproductive health services at government facilities at the primary and secondary care level, p= 0.5, margin of error 10%, with a confidence level of 90 percent and applying FPC i.e. finite population correction the required sample size for Dahej PHC was 50, for Shamlaji CHC it was 60 women and for CY facilities it was 50 women. An equivalent sample was estimated for the "Control" PHC and CHC and non-CY hospitals. Thus a total of 320 women beneficiaries were interviewed for this study.

Data collection and analysis In Dahej, Shamlaji and their respective "Control" areas 4 villages were selected randomly. The number of women beneficiaries who used Control / PPP facility in the last one year was proportionately allotted as per the population of the selected village, to the 4 villages. Within these villages, household list with the health worker was sought and required number of women beneficiaries selected randomly for visit. If no woman beneficiary of health services at either the PPP or the "Control" was found in the household, then next household was visited. If more than one woman was found in the household, both were interviewed. In Surat, 10 women beneficiaries each were interviewed at five CY and five non-CY hospitals.

Structured tool was used for data collection. The data collection tool focused on services sought, access, women's preference for place of services, quality of services and their satisfaction with service delivery. The data was collected after obtaining informed consent of women beneficiaries. The interviews were conducted in a private setting and the computerised data did not use or record the beneficiary's name. A study identification number was used in place of beneficiary's name. Ten percent of the data was reviewed in the field and cross checked with BPL and Mamata cards. Statistical Package for Social Sciences (IBM SPSS Statistics 22) was used for data entry and analysis. Data was analysed to explore trends and patterns in women's health seeking and their health seeking experiences. Chi square tests were used to test statistical significance of findings pertaining to Dahej and Shamlaji and their respective "Controls". Data related to CY and non-CY hospitals was not subjected to statistical tests as the sample was purposive.

Findings

Context

Dahej and Tankari PHC are both located in Bharuch district of Gujarat. The district has a population of 1,550,822 (Census of India, 2011) distributed across 8 blocks. Health facilities of Bharuch district comprise of 37 PHCs, 8 CHCs, 1 District hospital and a network of private hospitals and nursing homes. Since 2006, Dahej PHC is operated

by Reliance Industries (IPCL which was later acquired by Reliance) as a Corporate Social Responsibility initiative. The PHC with the government appointed staff and medical officer and a medical officer and few paramedics appointed by Reliance on contract basis is expected to provide the reproductive health services mandated by the government for a primary health care facility.

Shamlaji and Prantij CHC are located in Sabarkantha district in the tribal belt of Gujarat. The district has a population of about 24, 27, 346 distributed in 13 blocks. Health services to the district population are provided through 19 CHCs, 68 PHCs, 413 Subcentres and more than 276 private hospitals. Since 2002, Shamlaji CHC or Tribal Hospital is run by All India Movement for Seva (AIMS) a non-profit organisation established by a doctor couple. The CHC with the government appointed staff and specialists, medical officers and a few paramedics appointed by AIMS on contract basis is expected to provide the reproductive health services mandated for a secondary care facility. The CHC, located on the national highway also has a full-fledged trauma centre.

The Chiranjeevi hospitals and non – Chiranjeevi hospitals belonged to Surat district where Chiranjeevi yojana[2] was introduced in 2006. The district has a population of 6,079,231. Health services in the district are provide through a network of 13 CHCs, 47 PHCs, 343 Subcentres, civil hospital[3], municipal tertiary care hospital, urban health centres and a large number of private hospitals. About 56 Obstetricians with private practice were empanelled under Chiranjeevi yojana in 2009, with most of them located in urban areas around Surat city. The obstetricians had a post-graduate degree in Obstetrics, owned hospitals (if possible) with at least 15 beds, a labour room, an operation theatre and access to blood and anaesthetist in emergency situation. Obstetricians under CY are expected to provide antenatal care including routine and relevant investigations, ultrasound examination, delivery services for normal and complicated deliveries, blood transfusion when needed, Neonatal Intensive Care Unit, support, food and transport

Beneficiary profile

Barring Tankari, more than three fourths of the beneficiaries at all the facilities belonged to the socially and economically under-privileged strata of the society. The proportion of under- privileged women beneficiaries was particularly high in the areas of the PPPs. For instance, as compared to their "Control" facilities, significantly larger proportion of women beneficiaries at Dahej (38%) and Shamlaji (52%) belonged to Scheduled tribes and to households which had "Low" Standard of Living Index (SLI)[4] (Dahej: 44%, Shamlaji: 70%).

As compared to women beneficiaries at respective "Controls", relatively higher proportion i.e. more than half the women beneficiaries at the PPPs reported that they possessed BPL card which entitled them to government benefits. Health insurance of some kind was reported by a little more than one fourth of women beneficiaries at PPPs. In Sabarkantha district, almost half the women beneficiaries at Shamlaji CHC

[2] Scheme under which services providers are paid a fixed amount for providing cashless delivery services to women from BPL or scheduled tribe families.

[3] The Civil hospital is the referral hospital at the district level

[4] A standard of living (SLI) index, defined in terms of ownership of household goods used in NFHS II was adapted and scored as below:
House type: 4 for pucca, 2 for semi-pucca, 0 for kachha

reported health insurance as compared to only a tenth of the women beneficiaries of Prantij (Table 1: Profile of the Household)[5]

In terms of demographic profile, more women beneficiaries at Dahej and Shamlaji were younger and illiterate than their counterparts in the respective "Control" areas. Other than that the demographic and obstetric profile of women beneficiaries was similar for the PPP and their comparative "Control" (Table 2: Profile of the Women Beneficiaries).

Health seeking

Interviewed women beneficiaries who had availed of health services 12 months prior to the interview were asked about the reasons for seeking care and for choosing the place of care.

Services sought Women beneficiaries at the PPPs mainly sought reproductive health services, especially maternal health care. In addition, significantly more women beneficiaries in Dahej sought contraceptive services and in Chiranjeevi hospitals they sought services for gynaecological problems. Conversely, in Tankari and Prantij, as compared to their respective PPPs, more women sought services for general ailments such as fever, cough and cold.

The pattern of services sought was similar amongst under-privileged women, except that significantly more under-privileged women beneficiaries at Dahej also sought pregnancy test for confirmation of pregnancy and at Shamlaji also sought care for general ailments.

Choice of place Proximity, followed by familiarity with the facility were the main reasons for choosing the PPPs as well as their "Control" facilities as places for seeking care. As compared to Dahej PHC, significantly more women beneficiaries at Tankari said that low cost of services and availability of care for all health problems were the reasons that made them opt for services at Tankari. Yet, significantly more of these women beneficiaries also sought care at the parent First Referral Unit (FRU).

At Shamlaji CHC, as compared to Prantij CHC, significantly more women beneficiaries resorted to care because of presence of friendly staff and reputed doctors at the facility. On the other hand, women beneficiaries at Prantij listed inexpensive care and ASHAs personally escorting them to the CHC as reasons for seeking care.

Amongst the women beneficiaries of CY and non-CY hospitals, while more women beneficiaries listed presence of friendly staff as reason for choosing CY hospitals, a substantially large proportion of women beneficiaries at non-CY hospitals opted for those facilities because of reputation of the obstetrician (Table 3: Reasons for Choosing the Health Facility).

Reasons offered by under-privileged women beneficiaries for choosing the place of care were similar except that significantly higher proportion at Tankari opted for services here because of familiarity with the facility.

[5] Toilet facility: 4 for flush toilet, 2 for pit toilet, 0 for no facility; Electricity: 2 for electricity, 0 for no electricity Source of drinking water: 2 for pipe, hand pump, 1 for public tap, 0 for other source Ownership of house: 2 for yes, 0 for no; Ownership of land: 2 for yes, 0 for no; Ownership of durable goods: 4 each for a car or tractor, 3 each for a moped/scooter/motorcycle, telephone, refrigerator, or television, 2 each for a bicycle, electric fan, radio/transistor and cart Cumulative score ranged from 1 to 44. Categories were: Low SLI: 1 to 14 score, Medium: 15 to 28 score, High SLI: 29 to 44

Quality of services Women beneficiaries' views were sought on indicators reflecting quality of care. Most women beneficiaries at all the three PPPs and their respective "Control" facilities said that the facilities were conveniently located, well equipped with medicines and staff, the staff was friendly, took care to maintain their privacy and provided advice that was easy to follow. About two thirds or more also said that staff was responsive to their needs, explained about examination and its results and that the waiting time was acceptable. Experiences of the under-privileged women were on similar lines.

There were however some differences between facilities. As many as 82 percent of women beneficiaries at Dahej said that the staff was available, but the proportion was still lower than the Tankari PHC. Women beneficiaries at Dahej also revealed that though they were not charged anything except Rs. 5 for registration, they paid the Ayahs and nursing staff out of their own choice, "Khushi se dete hain". Most women beneficiaries from industrial workers' families from outside the district or state mentioned that they preferred this PHC as they did not have to spend any of their own money on medical care. They said that in other centres, including those operated run the government, they had to pay for services from their own pocket, as they were considered as "migrants".

Significantly less women beneficiaries at Shamlaji CHC were happy with the OPD timings, waiting time and cost of services. Despite their complaints about cost of care, these women said that the expenditure was acceptable and did not come in the way of their seeking services at Shamlaji CHC. Similarly, though more women beneficiaries of non-CY hospitals labelled the services as costly, they too were quick to admit that these costs were acceptable to them. Interestingly, more women beneficiaries at non-CY hospitals said that they had opted for the facility because of the doctor's reputation, yet fewer women viewed the obstetricians as capable of providing services (82%) they needed (Table 4: Experiences of women).

Satisfaction with services Most women beneficiaries (>=80%) at all the three PPP health facilities said that they had received the treatment/ care they wanted, it was effective and that they were willing to repeat visits in future in case of need. At both Dahej and Shamlaji, though fewer women beneficiaries as compared to those at their respective "Control" facilities said that they received the services they sought, more of them said that they would still come back for services in case of need. Barring Dahej, more than three fourths of the women beneficiaries were also satisfied with the services. In Dahej, significantly less women beneficiaries were satisfied with the care. It was therefore not surprising that 20 out of its 50 interviewed women had availed of services at more than one place (Table 5: Women's Satisfaction with Services).

Irrespective of facilities, very few women beneficiaries actually reported being dissatisfied with care received. Dissatisfaction was reported by five women beneficiaries at Dahej and two at the Tankari PHC. The main reason for dissatisfaction in both places was availability of fewer services. Women beneficiaries at Dahej wanted a systematic follow up from the staff and Caesarean operation facilities at the PHC. They did not like being referred to private or district level hospitals for care as it cost them anywhere from Rs. 10,000 to 15,000 for Caesarean operation. Likewise in Shamlaji, women beneficiaries expected that a facility of repute should be in a position to provide all the necessary services to them and not refer them to other institutions. They

were disappointed when they were referred further.

The six women beneficiaries who reported dissatisfaction with the services also complained about crowding of the OPDs and long waiting time. They talked about the need for starting the OPD earlier and keeping it open for a longer duration as the crowds at the OPD and inadequate waiting area made the wait for consultation very distressing. There were no complaints against the Chiranjeevi hospitals. Three women beneficiaries of non-CY hospitals were dissatisfied on account of distance to the hospital and a sense of discomfort at the hospital. Only one woman complained about the cost of services at the hospital.

Summary and Conclusions

The study data at Dahej indicates that women beneficiaries value proximity of and familiarity with health facility and low cost of services. At Shamlaji, women beneficiaries while acknowledging reputation of the service providers and the facility talked about proximity and convenient location of the facility too. Similarly those using services of Chiranjeevi obstetricians also voted in favour of proximity of health facilities. However, both at CHC and Chiranjeevi obstetricians' women beneficiaries seemed to give weightage also to their experience of interaction with the staff.

Friendly behaviour of staff compensated for the cost of services at both these places. Women beneficiaries' experiences across the PPPs and government run facilities differed very little. While the issue of cost was mentioned in relation to services at Shamlaji and non-CY facilities, women also clarified that this did not deter them from choosing a facility if their other expectations from the facility were largely going to be met. Women beneficiaries at all the facilities were by and large satisfied with the services.

On another note, where the facilities were crowded because of their convenience, reputation or popularity, women beneficiaries had to wait longer and in discomfort to seek care. This made them dissatisfied with the services available. Further, the efforts of the PPPs to implement the mandated services with fidelity were neither well received nor appreciated by the women beneficiaries. They expected these facilities by virtue of their special nature to be more prolific in services they offered and as a result were sometimes disappointed when referred further for care. Though they bore the costs, women beneficiaries did complaint about the cost of services at the PPs and of any further referrals from the PPPs.

A major justification for seeking private participation and partnership in health service delivery has been that the private sector health services are better managed, efficiently delivered and of good quality. The study data seems to suggest that women valued 3 Cs, comfort, convenience and cost over the conventional quality measures and reputation of services providers. None of the conventional quality of care aspects such as technical quality, infrastructure and efficiency of service delivery were articulated by women beneficiaries as reasons for choosing the place of care. In fact, the government managed facilities and PPPs did not differ much in women's perceptions and experiences thus raising questions about one of the very premises on which private involvement is based.

Table.1 Profile of the Household (In %)

		PHC		CHC		Private hospitals	
		Dahej	Tankari	Shamlaji	Prantij	CY	Non-CY
Indicator	**N=**	**50**	**50**	**60**	**60**	**50**	**50**
Caste	SC	36	14	5	72	4	8
	ST	38	22	52	7	48	32
	OBC	10	49	42	15	32	24
	General	16	14	1	6	16	36
SLI	High	0	4	2	2	0	0
	Medium	56	71	28	53	70	72
	Low	44	25	70	45	30	28
BPL family	Yes	58	49	85	38	52	50
	No	42	51	15	62	48	50
Health insurance	Yes	26	27	48	10	28	28
	No	74	73	52	90	72	72

Toilet facility: 4 for flush toilet, 2 for pit toilet, 0 for no facility;
Electricity: 2 for electricity, 0 for no electricity
Source of drinking water: 2 for pipe, hand pump, 1 for public tap, 0 for other source
Ownership of house: 2 for yes, 0 for no;
Ownership of land: 2 for yes, 0 for no;
Ownership of durable goods: 4 each for a car or tractor, 3 each for a moped/scooter/motorcycle, telephone, refrigerator, or television, 2 each for a bicycle, electric fan, radio/transistor and cart
Cumulative score ranged from 1 to 44.
Categories were: Low SLI: 1 to 14 score, Medium: 15 to 28 score, High SLI: 29 to 44

Table.2 Profile of the Women Beneficiaries (In %)

		PHC		CHC		Private hospitals	
		Dahej	Tankari	Shamlaji	Prantij	CY	Non-CY
Indicator	**N=**	**50**	**50**	**60**	**60**	**50**	**50**
Age	15-19 years	2	0	3	2	4	4
	20-24 years	42	20	33	22	58	52
	25-29 years	46	27	18	35	24	30
	>=30 years	10	53	46	41	14	14
Education	Illiterate	34	25	38	27	14	20
	Primary	20	31	13	22	24	18
	Secondary	36	39	25	33	30	36
	>=HSSC	10	5	24	18	32	26
Occupation	Farm labourer	98	98	100	98	100	96
	Other	2	2	0	2	0	4

Table.3 Reasons for Choosing the Health Facility (In %)

Indicator	PHC		CHC		Private hospitals	
	Dahej	Tankari	Shamlaji	Prantij	CY	Non-CY
N=	50	50	60	60	50	50
Near by	92	87	68**	43*	54*	32
Always come here	36	45	50	40	68*	40
Inexpensive	16	30*	22	38*	20	12
Friendly staff	6	1	38**	5	58	38
Tt for all problems	2	16*	25	22	16	12
ASHA escorted	30	28	0	17**	6	2
Doctor reputation	2	4	30**	3	14	52**
No other option	6	0	3	3	2	0
Convenient timing	4	4	20*	7	32*	12

*: Significant; **: Highly significant

Table.4 Experiences of Women (In %)

Indicator	PHC		CHC		Private hospitals	
	Dahej	Tankari	Shamlaji	Prantij	CY	Non-CY
N=	50	50	60	60	50	50
Convenient location	94	98	98	100	98	94
Convenient timing	100	96	85	98*	100	98
Staff available	82	94	98	92	100	98
Staff friendly	90	89	98	93	98	96
Acceptable wait time	74	76	67	90*	94	94
Privacy maintained	100	64	98	92	98	98
Exam explained	64	71	88	85	94	90
Results explained	60	82*	97	95	98	92
Responsive to needs	72	77	100	97	98	96
Medicines available	84	89	100	98	96	92
Advise easy to follow	92	89	100	98	98	94
Doctor capable	86	87	78	80	92	84
Expenditure						
Free	92	89	53	75**	72	30
Acceptable	4	2	47	15	28	58
Expensive	4	9	0	10	0	12

Table.5 Women's Satisfaction with Services (In %)

		PHC		CHC		Private Obstetricians	
		Dahej	Tankari	Shamlaji	Prantij	Chiranjeevi	Other
Indicator	N=	50	50	60	60	50	50
Satisfaction	Happy & satisfied	54	77*	78	80	96	82
	Received services	84	94	93	100	100	98
	Treatment effective	80	83	92	95	98	96
	Will repeat visit	88	95	95	88	98	90

Given the government's intent of implementing models, women beneficiaries resorting to services offered under PPPs should be out of active preference guided by the quality of care offered and not out of lack of alternatives nearby as the study seems to suggest. The Institute of Medicines (IOM) framework of quality of care articulated the need to prioritise patient centered and timely care i.e. care which is responsive, respectful and timely. A study by PHFI reported that patient's experiences emerged as the dominant theme in its analysis. Given the growing recognition of centrality of patient's experiences it is appropriate and pragmatic to explore these in the context of PPPs.

The study focused on effect of select reproductive health PPPs, particularly amongst under- privileged women beneficiaries. Inherent in the restricted focus of the design is the difficulty in generalizing the findings to other PPPs addressing other health issues. The study also dealt with a select population with unique socio-cultural context and therefore has limited generalisability to PPPs in a different context. Nevertheless, the findings highlight the need to explore the involvement and utility of PPPs when the functioning of these are perceived by women beneficiaries to be as good as the existing government sector run facilities.

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