cities that provide short courses for public-health workers with supervision provided by Chinese trainees and graduates of the training programme in field epidemiology. These provincial programmes had trained over 200 public-health workers by the start of 2008.

There is new funding for categorical programmes to combat priority diseases, including the US President’s Emergency Plan for AIDS Relief, the Global Fund to Fight Tuberculosis, AIDS and Malaria, and the GAVI Alliance. Historically, creating a legacy of health systems that sustain their goals has been difficult for categorical programmes. These programmes might now increase contributions to public health and strengthen human capacity by supporting initiatives such as training programmes in field epidemiology. Thus, the training programmes can meet and sustain their goals with an added positive effect on countries’ abilities to improve health in many areas. The resulting public-health systems, led by competentely trained public-health workers, will increase the host country’s ability to fight AIDS, tuberculosis, and malaria—as well as diarrhoeal diseases, maternal mortality, and chronic diseases, and to address the International Health Regulations and other disease priorities of the ministries of health.

*Peter Nsubuga, Mark White, Robert Fontaine, Patricia Simone
Coordinating Office for Global Health, US Centers for Disease Control and Prevention, Atlanta, GA 30333, USA
pcnO@cdc.gov

The views in this Comment are those of the authors and do not necessarily reflect those of the US Centers for Disease Control and Prevention. We declare that we have no conflict of interest.


Indian public-private partnership for skilled birth-attendance

The provision of emergency obstetric care was recognised as vital to the reduction of maternal mortality back in 1991. However, India faced a shortage of obstetricians to provide comprehensive emergency obstetric care in rural areas. One solution proposed by national government was to train basic doctors to provide such care. Unfortunately, this strategy was not well implemented and could not succeed. India has more than 20,000 obstetricians, of whom only 780 work in the public-health system at subdistrict level in rural India. Even in a developed state such as Gujarat the situation is no better, with only eight obstetricians in the public service for a rural population of 30 million. Various governmental efforts to install and retain obstetricians in rural areas have not succeeded.

Maternal mortality remains high in India—about 300–450 per 100,000 livebirths—because of the dearth of obstetricians in rural areas and unclear policies for and practice of delegation of lifesaving functions. Access to skilled care, institutional delivery, and emergency life-saving surgery, such as caesarean section, is very limited for poor people in India. Due to gross underfunding of public-health services in India, ill health is a financial burden for people. 25% of people admitted to hospital become poor because of treatment costs. To decrease maternal mortality, the Gujarat Government, in consultation with the Indian Institute of Management in Ahmedabad, the Society for Education Welfare and Action—Rural (a well-known non-governmental organisation) and local obstetric societies, developed a scheme to provide free birth care to poor families through contracts with private obstetricians practising in rural areas. This innovative public-private partnership was called the Chiranjeevi Yojana, which means a scheme to provide long life to mothers.

The pilot study started in December, 2005, in five districts. The health department contracted more than 170 of about 200 private obstetricians in these districts to provide skilled birth-attendance, including required emergency services to poor women. The Government would pay the obstetricians Rs1795 (about US$45) per delivery...
irrespective of the type of delivery. This per-head mechanism ensured that there is no financial incentive for unnecessary caesarean sections. The cost of this scheme is small compared with the state’s health budget, and the scheme was widely promoted by governmental health workers.

Despite the fact that the pilot districts were some of the least developed in the region, many poor women took advantage of the scheme. On the basis of the positive performance, the Government decided to scale up this scheme to all 25 districts of the State in January, 2007. Under this scheme more than 840 private obstetricians are now enrolled and access to skilled birth-attendance and emergency obstetric care for poor women has substantially improved.

As of November, 2007, there have been more than 131,000 deliveries, with a mean rate of caesarean section of 6%. About 40% of eligible poor pregnant women benefited from the scheme in just 2 years. Available data show that the proportion of deliveries in institutions has risen to 76% in November, 2008, from 54% in 2005. This increase is partly due to the scheme, which could prevent a substantial number of maternal and neonatal deaths. The *Wall Street Journal* presented the Asian Innovation Award to the Gujarat Government health department, and other states and the central government seem interested in replicating the scheme.

With proper institutional arrangements, private practitioners can be motivated to provide skilled birth-attendance and emergency obstetric care to poor women at a fair cost. The experience of this scheme suggests that decentralisation, an enabling environment, an assured payment mechanism, and capacity to foster collaboration are pivotal to the success of such public-private partnerships.

The scheme could also enlist midwives and basic doctors to provide skilled birth-attendance and link up with obstetricians to provide comprehensive emergency obstetric care. Public-private partnership can rapidly scale up the availability of human resources for skilled birth-attendance and emergency obstetric care to the poor in a very short time and thus make achieving Millennium Development Goal 5 possible.

*Dileep Mavalankar, Amarjit Singh, Ramesh Bhat, Ajesh Desai, SR Patel*

Indian Institute of Management, Vastrapur, Ahmedabad, 380015 India (DM, RB, SRP); Government of Gujarat, India (AS, AD) dileep@iimahd.ernet.in

We declare that we have no conflict of interest. All authors have been involved in designing the scheme and AS, AD, and SP were also involved in implementation.