**Original Article:**

**Improving Access to Sterilization Services through Public Private Partnership: Cases from Rajasthan.**

**Author:**
Susrita Neogi, Ph.D. Scholar, Centre of Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi - 110067.

**Address for Correspondence**
Susrita Neogi,
Ph.D. Scholar,
Centre of Social Medicine and Community Health,
Jawaharlal Nehru University,
New Delhi - 110067.
E-mail: susrita.roy@gmail.com.

**Citation**

Submitted: Jan 15, 2020; Revised: May 19, 2020; Accepted: May 21, 2020; Published: May 31, 2020

**Abstract:**
Introduction: Under the National Rural Health Mission, the government has promoted several Public Private Partnership schemes to extend health services to the rural populations; sterilization is one such service. Rajasthan, one of its high focus districts, has adopted the scheme. Objective: Examine the capacity and perception of the private providers to reduce barriers to accessing sterilization services in Rajasthan. Methodology: Case study design is adopted in the study with purposively selected private providers from two districts of Rajasthan. Results: There is diversity in the capacity of different providers, in the scheme, to deliver accessible services. Besides, their perceptions about barriers to access also vary. Discussion: Three broad phenomena emerge: first, the role of the private sector in bridging the barriers to access is limited; second, their role is shaped by their perceptions about barriers to access; and third, the emphasis of the scheme is more towards the promotion of private facilities than ensuring accessible services. Key Words: Public Private Partnership, Reproductive Health, Sterilization, Access, Capacity, Perception, NRHM, Mission Parivar Vikas

**Introduction:**
India embarked on the mission to ‘reform’ its public health sector, according to the neoliberal paradigm, since the 1990s. The process, initiated by the World Bank, aimed to reduce government expenditure in the health sector as well as to introduce market-oriented principles in public services. (1) Public Private Partnership (PPP) originated as a strategy that was an alternative to full privatization. (2) As defined by the World Health Organization (WHO), PPP is a “means to bring together a set of actors for the common goal of improving the health of a population-based on the mutually agreed roles and principles” (3). The two important actors are the public sector represented by the government staff, while the private is divided into for-profit and not-for-profit/ non-profit organizations (commonly referred to as Non-Government Organizations).

In agreement with the World Bank’s prescription for reform, the Indian policymakers introduced PPP in many national health programmes in India; the Reproductive and Child Health (RCH) programme was one of them. (4) The programme was subsumed into the National Rural Health Mission (NRHM) launched in 2005. Mapping of PPP arrangement, under the programme, identify three schemes, Chiranjeevi Yojana in Gujarat, Mamta Friendly Hospital Initiative in Delhi and Janani Sahyogi Yojana in Madhya Pradesh, in which private facilities were contracted to deliver pregnancy and childbirth services to women from a household below poverty line (BPL). Assessments of these schemes, across states, highlight some common gaps emanating from both the design as well as the implementation. (5) (Box 1)

Under the RCH programme, followed by NRHM, sterilization service was also contracted out to both types of private sector mentioned above (4, 6). The justification for engaging the private sector is two folds. On one hand, non-profit organizations have a good rapport with the community and flexibility to design strategies according to the local conditions, unlike the government machinery, which can facilitate better uptake of family planning services. (7) On the other hand, the for-profit private sector medical care facilities can provide clinical contraceptive services like sterilization and insertion of the intra-uterine device because most of the gynecologists and surgeons were working in that sector. (8) However both these had some problems; while most non-profit institutions could not provide clinical services, the doctors in the for-profit sector did not show much interest to take part in these schemes. (7, 8)

In 2016, the Mission Parivar Vikas was launched with the focused agenda for improved access to contraceptive and family planning services in selected high fertility districts (HFD). (9) A five-pronged approach is adopted in the scheme, of which the first and foremost is the delivery of assured services. Under this approach, the augmentation of sterilization services through the HFD Compensation Scheme proposes a financial package to accredited private and NGO facilities. This centrally designed scheme is launched in 14 districts of Rajasthan which has Total Fertility Rate (TFR) more than 3. In the context of Rajasthan, the importance of the scheme is more for rural areas because though the average TFR in urban areas of the state is 2.3 that in the rural areas is 3. (10)
Objective of the Study

To understand the potential contribution of private providers, in the new scheme, to improve the access, it is important to examine the earlier scheme. The specific objectives of this paper are to study the following aspects in the context of private providers already partnering with the government to provide sterilization:

- The capacity of private sectors for service delivery
- Perceptions about barriers to access sterilization services and approaches adopted to address these barriers
- Advantages and disadvantages of the PPP strategy to address the barriers

In this paper, Aday and Anderson’s framework to examine access shall be adopted to understand the capacity of the service provider. Service delivery characteristic, according to the framework, is one of the two broad determinants for access; the other is population characteristics. This paper focuses on the former, which can be further divided into resources and organizations, of the private sector. (11) Besides, the perception of the private providers as well as their opinion about the scheme to address the barriers will also be included as the determinants of access.

Methodology

The data used in this paper were generated and collected as a part of doctoral research on the role of PPP in the delivery of health services in Rajasthan. Udaipur and Sirohi were selected as study districts as they were predominantly rural (80.17% and 78.93% respectively) with a significant tribal population (49.71% and 28.58% respectively). (12) These two districts, with TFR around 3, are among the 145 districts selected for Mission Parivar Vikas. Thus the selection is relevant from the epidemiological as well as programmatic point of view.

Sterilization services in these two districts were delivered by both the public sector as well as private sector institutions. For this paper, only those private sector organizations contracted by the government for delivering sterilization services are being considered. There are 23 and 7 such private facilities empanelled in Udaipur and Sirohi respectively. These facilities can be classified into three categories based on the type of ownership and mode of service delivery. The categories are as follows:

- International Non-government organization (INGO) delivering both static and outreach facilities- only in Udaipur
- Small Nursing Home (SNH) owned by not more than 3 doctors with only static services – in Udaipur and Sirohi
- Multi-specialty hospital (MH) with only static services – only in Udaipur

In addition to the interviews, the contract document for these cases was also reviewed to understand the overall objective of this institutional arrangement as well as the expected role of the different actors for improving access to services. Before the interview, written consent was taken from all respondents. As none of the respondents agreed to record the interview, details notes were taken during the interview process which was then coded and analyzed.

A deductive approach was adopted for organizing the responses according to a priori themes based on the existing framework to examine barriers to access. While access is a multi-dimensional concept, only two key dimensions of access were identified for the study – availability and affordability. From the responses the broad themes were identified which captured the roles of the two sets of actors, public and private sector, relevant for addressing barriers to these two dimensions of access. Within the given themes, the similarities and dissimilarities across the different categories of the private sector were identified.

Results

Before presenting the current status, it is important to understand the design of the scheme, as is. This will serve two purposes; first, it will identify the merits and demerits of the scheme vis-à-vis addressing the barriers to access and second, it provides the basis for comparing actual and desired practice. In the context of NRHM, the key elements mentioned in scheme guidelines for PPP in sterilizations are – (i) selection criteria of private providers, (ii) payment to the private providers and (iii) regulation of the private providers. (14, 15) (Box 2)

A case study design was adopted for this research to get an in-depth understanding of these organizations. This research design is preferred because it emphasizes a detailed contextual analysis of complex issues. (13) For a selection of cases, a list of private facilities was obtained from the district offices of the two study districts along with the number of sterilization users attended by them. For categories that had the only institution empanelled was automatically selected one delivering the services. This includes the INGO and MH in Udaipur. While selecting the cases, in the SNH category, the focus was on block-level institutions as there was more than one such institution. The facility that performed the maximum number of sterilization in the last six months was then purposively selected. The selection was then confirmed by the district nodal officer-in-charge of the sterilization scheme.

For collection an interview schedule was drafted and piloted in a non-study district with private providers. Interviews were conducted with the head of these institutions. For public sector interviews were conducted with the state, district and block officials. A total of 37 interviews were conducted – 22 in Udaipur, 11 in Sirohi and 4 at the state level (Table 1). The data collection was done between April and June 2015.

<table>
<thead>
<tr>
<th>Category</th>
<th>Udaipur</th>
<th>Sirohi</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Sector – Head of the organization</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Private Sector – Staff</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Public Sector – District Officials</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Public Sector – Block Officials</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Public Sector – Community level workers</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Subtotal</td>
<td>22</td>
<td>11</td>
</tr>
<tr>
<td>Public Sector – State Officials</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

In addition to the interviews, the contract document for these cases was also reviewed to understand the overall objective of this institutional arrangement as well as the expected role of the different actors for improving access to services. Before the interview, written consent was taken from all respondents. As none of the respondents agreed to record the interview, details notes were taken during the interview process which was then coded and analyzed.

A deductive approach was adopted for organizing the responses according to a priori themes based on the existing framework to examine barriers to access. While access is a multi-dimensional concept, only two key dimensions of access were identified for the study – availability and affordability. From the responses the broad themes were identified which captured the roles of the two sets of actors, public and private sector, relevant for addressing barriers to these two dimensions of access. Within the given themes, the similarities and dissimilarities across the different categories of the private sector were identified.

Results

Before presenting the current status, it is important to understand the design of the scheme, as is. This will serve two purposes; first, it will identify the merits and demerits of the scheme vis-à-vis addressing the barriers to access and second, it provides the basis for comparing actual and desired practice. In the context of NRHM, the key elements mentioned in scheme guidelines for PPP in sterilizations are – (i) selection criteria of private providers, (ii) payment to the private providers and (iii) regulation of the private providers. (14, 15) (Box 2)
Box 2: Design of PPP scheme for sterilization

- Selection Criteria
  - Facilities located in the block
  - Designated space for counseling and sterilization as well as Operation Theatre
  - Laboratory facilities
  - Adequate equipment and medicine

- Payment to Private Providers
  - 2000 rupees per case of vasectomy and tubectomy
  - 1000 rupees to the acceptor
  - Mode of payment is voucher
  - No payment for a motivator

- Regulation
- No user fee is charged

Status of implementation of the scheme, based on the interviews, is as follows:

The capacity of the private sector for service delivery:

Under the scheme, the private sector is responsible for service delivery. To examine the performance of the health system in service delivery two aspects are important – resources and organization. (11)

Resources: According to the scheme guidelines, for empanelment under the scheme there are some basic criteria that the private facilities must fulfill. This includes a trained doctor who is a surgeon or gynecologist, operation theatre and also paramedical staff for assistance. The NGOs also required to be registered under any of the Indian Acts like Societies Registration Act, Trust Act or Section. All the cases had met the basic criteria, but their capacities in terms of human resources and other facilities varied significantly (Table 2).

Table 2: Resource Profile of Private Partners

<table>
<thead>
<tr>
<th>Characteristic (as on April 2016)</th>
<th>INGO, Udaipur</th>
<th>SNH, Udaipur</th>
<th>SNH, Sirohi</th>
<th>MH, Udaipur</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Years of experience</td>
<td>Almost 7 years (Since 2009)</td>
<td>Completed 3 year (since 2012)</td>
<td>Completed 3 year (since 2013)</td>
<td>Almost 17 years</td>
</tr>
<tr>
<td>2. Infrastructure</td>
<td>Six beds, two operation theatres, Mobile Unit for outreach camps</td>
<td>10 beds, one operation theatre and one labor room, one small Operation theatre</td>
<td>3 beds, with one operation theatre cum labor room</td>
<td>100 beds with an economy ward, deluxe and AC rooms</td>
</tr>
<tr>
<td>3. Human Resources</td>
<td>20, include six surgeons and gynecologists, Remaining are nurses, paramedics, administrativ e staff and field workers for outreach.</td>
<td>10, include full-time gynecologist and obstetrician, Remaining are AMN and other housekeeping staff.</td>
<td>8 include 2 full-time doctors of which one is a gynecologist, Remaining are ANMs and housekeeping staff.</td>
<td>200 include 30 full-time doctors. Remaining are nurses and paramedics and other support staff.</td>
</tr>
<tr>
<td>4. Source of funds</td>
<td>Largely from international donors. User fees were also charged.</td>
<td>User fees</td>
<td>User fees</td>
<td>User fees</td>
</tr>
</tbody>
</table>

From the point of view of resources, the MH and the INGO are better equipped than the SNH, but across both the study districts only single cases of the first two categories were available. Most of the doctors in the cases were gynaecologist with experience in the public health system; some of them were retired and a few of them were engaged in the private sector while they were in-service. Except the MH, which had its own nursing college, staff nurse was rare in the SNH and also in the INGO. Due to non-availability of trained nurses, most of the private institutions hired the services of Auxiliary Nurse Midwives (ANMs) and General Nurse Midwives (GNMs). The infrastructure required for delivery of sterilization services was also more in case of MH. The two SNH and INGO had very basic infrastructure with bed strength of at the most 10. This in a way limited their capacity to provide sterilization services.

“Most of the small nursing homes applied to get empanelled in the scheme. There was very little interest from the big private hospitals. Most of NGOs in this district did community oriented activities but lacked technical capacity to deliver clinical services required for sterilization.” [District Health Official, Udaipur]

“There are 5 fulltime doctors in our organization who are mostly retired government surgeons and gynaecologists. We also have some on-call doctors, most of whom are currently working in district hospital. The nursing and paramedical staffs are full time employees. In addition, we also have bedded hospital with two operation theatres.” [District Representative, INGO]

“This is a relatively new institution so I do have very limited human resource and infrastructure. Currently I am the only full-time doctor.” [Owner and Gynecologist, SNH, Udaipur]

Organization

The other aspect of service deliver in the access framework is organization which comprise of entry and structure. This refers to the manner in which the resources are coordinated and controlled in the process of providing medical services. (11) In case of the organization engaged for sterilization, the ownership was private, so the government had very little influence on it. The only way that the government did play in service delivery was by empaneling the private sector. There was also scope for regulating the performance of these organizations and financing only vis-à-vis the sterilization, vide the contract. This is out of the purview of this paper. The determinants of organization of these private providers are vision, geographic location and approach to deliver services in general.

All the cases, except the INGO, involved in the scheme were providing all types of health care of which family planning was one. However, their vision, as expressed by the respondents across these categories, was to provide health services as per the felt need of the patients and not to generate demand for services. The patients who came to these centres were those who are self-motivated and have the ability to pay for healthcare; also, mostly from the urban area where these private facilities were located. Although the respondents mentioned that the cost of care was nominal, it did not take into account the expenditure on medicines, opportunity and travel cost. The patient load for these institutions varied from an average of 120 per day in MH, Udaipur to 5 per day in SNH, Sirohi.

The INGO was an exception from the other private institutions because its goal was to promote family planning services only. Hence the organization conducted special awareness generation activities. In addition, the organization employed community workers who visited the houses of the potential clients and counseled them for availing contraception. For these the organization invested its own resources. They also had mobile clinics which it organized in selected Community Health Centres allotted to them by the government. With these different modes of service delivery, the INGO was able to reach the services to the remote blocks of the district. However, given the technical requirement of sterilization camps these could be organized in block level facilities only. However, for the task of spreading information about the camps, the public frontline functionaries were engaged.

“This is a fairly new institution so many people are not aware of it. Most of the users come for ambulatory care and minor illnesses. The average patient load is 15 per day. These users are usually from the urban areas of the block. This is the only facility in the block with a gynaecologist, including the government community health centre, so we also get childbirth related cases. The charges of the services are nominal because most people who avail our service are poor.” [Gynaecologist, SNH, Sirohi]

“We have been providing a range of healthcare services, both inpatient and outpatient. On an average the patient load of the hospital is 120 per day. This hospital has a good reputation so people from all parts of Udaipur as well as those from adjoining districts like Banswara and Dungarpur come. We also try our level best to adjust the cost of treatment based on the patient’s ability to pay, without compromising on the quality.” [Owner and Gynaecologist, SNH, Udaipur]

“Our organization’s goal is to promote family planning practices, so we adopt different measures for that. There静态 clinic at Udaipur provide services five days a week while the mobile camp is organized based on the schedule prepared in consultation with the public sector officials. Most of the users of in static clinic are from Udaipur, that too from slums while those who attend the camps are from adjoining villages. The users of the services in the static clinic are expected to pay nominal fees which include consultation charges and the cost of medicines. On an average we get 35-50 cases per day for different types of maternity health related services” [Representative, INGO, Udaipur]

Perception about barriers to access to sterilization services and approaches to address them

The major barrier to access sterilization services, as expressed by the respondents, is lack of education among community. This resulted in limited and often faulty information about sterilization and its side-effects. The respondents from the SNH and MH were of the opinion that this required government interventions at the community level. The INGO representative, however, agreed that besides the lack of knowledge, lack of service delivery institutions was one of the reasons for unmet need for sterilization, especially in rural areas. They also felt that there is gender differential in the provisioning of services.

The perceptions about barriers to access determined the approaches adopted for addressing those. The respondent from MH, Udaipur and the SNH, Sirohi mentioned that there is no addition to what is already taken by them under the scheme. They only offered the service to the women who came to their institutions for childbirth. The owner of the SNH, Udaipur mentioned that he paid additional incentives to the frontline functionaries who referred cases to his facility. In case the patient was poor, he also reimbursed the cost of travel incurred the patients. According to him, these measures were adopted, even though it meant reduced profit, to lure more cases to his institutions which will help in establishing his practice. The INGOS was the only private provider who undertook additional activities for demand generation.

“When I enrolled for the scheme, I had just started this hospital after working for more than 20 years in the public health system. As I was posted in the adjoining blocks of Udaipur city, many of the frontline workers knew me. So I approached them to refer cases to my facility, in lieu of extra incentive. In case the patients belong to poor household, I also pay for their to and fro travel.” [Owner and Gynaecologist, SNH, Udaipur]

“As per contract, we are only required to deliver services and also pay the users their incentives. Almost all the cases of sterilization that have taken place in my institution are of women who came here for childbirth. The process was undertaken after they along with their family member are counseled about the benefits under the scheme. Beyond this we do not do much publicity of this scheme because it is the responsibility of the public sector. There are very few users who come to us only for sterilization, but when they do we give them the benefit of the scheme and also do not charge.” [Owner, MH, Udaipur]

“We have adopted multipronged approaches to deliver family planning services. For bridging the service delivery gaps in rural areas we organize camps. In order to improve male engagement, we have designed a new scheme where male members who have already undergone vasectomy are trained to motivate other men; and they are paid incentives. In addition, we conduct regular mass media campaigns on this topic.” [Representative, INGO, Udaipur]

Advantages and disadvantages of the PPP arrangements to address the barriers

According to the scheme guidelines empanelment of private facilities would help in increasing the access to sterilization services. The public sector officials felt that the role of private sector was negligible in this respect. In addition, they were of the opinion that some of private sector partners were new in the field and were using this scheme to establish their practice. They were less skeptical about the role played by the INGO mostly because their vision was aligned to objective of the government’s scheme.

The private sector respondents, on the other hand, pointed out that they were doing the best possible despite certain constraints in operationalization of the scheme. These were irregular release of funds and also inadequate publicity about engagement of private sector partners in the scheme, which were a part of the public sector’s role. They also attributed some of the problems in design of partnership strategy such as very low remuneration for their services, emphasis on one kind of family planning measure and no scope for negotiation in these contracts.

There were a few advantage identified by both sectors. First, they unanimously agreed that the scheme has potential to offer private sector services to poorer section as the cost of care was borne by the public sector. Second, it is able to fill the gaps in service delivery, especially in blocks where the public sector institutions did not have adequate human resource or institutional capacity. Third, such schemes could ensure legitimacy of private sector.

“We are aware that very few sterilization cases are conducted in the private institutions, especially those in the district headquarters. In my personal opinion, these private partners are only in the scheme to establish their practice.” [District officials, Udaipur]

“I applied to get empanelled in the scheme because it was a win-win opportunity for both my institution and also the users who deserve better service. But the way the scheme is being operationalized makes it difficult for me to continue delivering services. Although I have been felicitated by the department for record number of sterilization cases, my dues are still pending. Besides, the patients have also not received their incentives. This indirectly affects the reputation of my institution adversely” [Owner and Gynaecologist, SNH, Udaipur]

“We are committed to the cause, hence we partnered with the public sector, but we do not get adequate support from the public sector staff. Most of the expenditures for our services are from funds that are collected by the organization. The amount that the government pays does not cover it. Moreover, the amount that is paid to all private institutions per case is the same. This seems unfair, given that we undertake lot more activities compared to other private sectors empanelled under the scheme, but there is no flexibility in the scheme guidelines for additional payment.” [Representative, INGO, Udaipur]

Discussion

It is crucial that service delivery institution ensure access to care among all societal groups to reduce inequality and
maximum population coverage. In case of PPPs for sterilization while the government is overall in charge of the scheme, the private sectors also have a very important role because they are the service providers. Therefore, this paper focuses on the role of private providers in ensuring access. Before analyzing the data, it is important to take into account the context in which such a scheme was initiated. During health sector reforms in the 1990s, the government reduced its funding in healthcare which led to lack of adequate resources for service delivery in public sector. This is one of the reasons for the proliferation of the private sector. (16) There was plurality in the private sector that emerged, based on their capacity as well as intention to contribute to improving public health goals. The analysis tried to capture the differences among the private sector who are engaged in PPP for sterilization.

Out of the private sectors facilities, a small subset opted to partner with the public sector in provision of sterilization services. Based on the cases studies of such private partners from two districts in Rajasthan, Udaipur and Sirohi, it is evident that although most of them meet the basic requirement in terms of human resource and infrastructure, this does not automatically translate to addressing the barriers to access. Many of these institutions are small nursing homes hence their performance in the delivery is also limited to a very few cases. In relatively better developed districts, there are multi-speciality hospitals that have more resources, but very few of them collaborate with the public sector. While the other option is non-profit organizations, in reality very few of these can deliver clinical services. The second attribute is the way these different private partners organize their resources. Although this is linked to the resources that these institutions already have at their disposal, it is more to do with their respective goals. Majority of these institutions are geared to provide medical care, for which there is demand and to those who have the ability to pay for these services. As this is more in urban areas, majority of these private institutions are also in and around district and block headquarters. In addition, these organizations do not engage in much outreach services. There are however a few providers like the non-profit organizations whose main objective is to promote sterilization services. These organizations adopt outreach strategies. Similarly, some private hospitals also rope in public sector workers to lure cases to their institutions. Both these kinds of institutions incur the cost for such additional efforts. Based on this attribute the private partners could be classified into active and passive partners.

In general, the private sector considers lack of awareness among people as the main factor for not utilizing health care services. However, they were of the opinion that demand generation was the role for the public sector as it was a national goal. This view was expressed more by the passive partners while the active partners shared that there were some other factors, like cost of care and also lack of availability of services nearer to the villages, in which the private partners can contribute. This perspective was well reflected in the approaches that these two types of providers adopt under the scheme. While the public sector officials acknowledge that some private sectors are performing many cases, the rigid design of the scheme as well as operational bottlenecks impedes the sustainability of such additional activities conducted by the active private partners. This data has some limitation. First, the purposive selection of districts and cases limits its generalizability. Second, information about the private sector’s role was not easily available as many of them were reticent to share details. The problem was same with the public sector officials at all levels. Third is the time factor. The data was collected in 2015; situation in these two districts might have changed with respect to the profile of the private sector as well as the partnership arrangement, since then.

Notwithstanding these limitations, three phenomena that explains the scope of partnership with private sector in addressing the barriers to accessing sterilization services; some of these are consistent with the experience in case of PPP for EmOC. First, the private sector capacities in improving access are inadequate. This could be attributed to their individual limitation in human resources and infrastructure, their being located in the urban areas and also the limited efforts taken by them to promote the scheme. Second, the private providers who have a nuanced view about the barriers to access adopt some additional means in order to bridge that gap; the cost is borne by institution. Third, the scheme guidelines and its implementation are also one of the common factors, cited by the private partners, behind their dwindling commitment for this scheme.

Lessons from this study of private partners specific to sterilization services as well as those for other maternal health services can be taken into account by the designers of the new scheme and revisit some of its expectation of resources. The scheme implementers may get better results if they select private partner not only based the technical aspects, but also on their perception about access and also approaches that these institutions are already using to address them. However, it is certain that even if such private sectors are available in some districts or blocks, it will be not have the required capacity. Hence, there should be flexibility to alter and customize schemes guidelines in consultation with the private sector institutions. Till these changes are introduced in the Mission Parivar Vikas, the engagement of private sector will not make any contributions towards improving access, especially to those from rural areas with unmet needs for sterilization services.

Acknowledgments
This paper is based on doctoral thesis under the guidance of Prof. Ramav. Baru and Prof. Rajib Dasgupta, Centre of Social Medicine and Community Health. I sincerely thank my supervisors for their valuable comments in course of the thesis as well as in drafting this paper.

References