Working with the Non-State Sector to Achieve Public Health Goals
Consultation on Priorities and Actions

Château de Penthes, Pregny, Geneva
20-21 February 2006

Background paper

1. Introduction and background

In many low-income countries the private, or non-state, sector plays a very significant role in the health system, be it in the delivery of health services, commodities and non-clinical services; in the production of key resources such as drugs, equipment or health workers, or in health insurance and other financing mechanisms. Contrary to some perceptions, the poor may make extensive use of non-state service providers. There is increasing recognition that the health Millennium Development Goals (MDGs) are unlikely to be achieved without these providers' active engagement. At the same time, debates on the role of the non-state sector are often rooted in ideology or based upon the experience of other sectors or of richer countries.

At a meeting on health systems hosted by WHO in Montreux last year[i], participants suggested that while there is a need for engagement between state and non-state actors in all aspects of health systems operations in low-income countries, it would be particularly useful to bring together parties concerned with ***service provision***, to explore ways to promote more effective interaction. Non-state providers are defined here as "all those providers outside the public sector, whether philanthropic or commercial, whose aim is to treat illness or prevent disease". This includes private for-profit and private non-profit formal health care providers as well as informal practitioners, be they individuals, facilities or larger organizations.

The challenge of how to maximize coverage and quality of care through the non-state sector, and minimize unwanted side effects, therefore concerns many groups[ii]. Managing the opportunities and risks inherent in getting parties with multiple and sometimes competing goals to work together to a common end requires effective interaction between policy-makers, programmes, professional associations, regulatory bodies, and the wide range of service providers. Engaging communities to increase understanding and expectations of quality and access to services is also integral to achieving long term public health goals.

At Montreux, there was a call to focus on concrete actions that could be undertaken in the near term to inform country level dialogue and policy in this area. Since then a preliminary set of practical policy and operational challenges has been drawn up on the grounds that they are *important but neglected*, or *new and relatively uncharted*, and all of which need action. This paper expands on these challenges and is the basis for discussions on 20-21 February 2006.

2. February meeting objectives, scope and participants

This consultation is designed to get further insights and feedback on the set of policy and operational issues identified for service provision, and to help shape decisions on actions which would be feasible and useful in the short term. Specific meeting objectives are to:

1. Agree on three or four key policy or operational questions that can productively be addressed during the next 18 months.
2. Agree on deliverables which will be most useful in each of these areas.
3. Agree on strategies to ensure their production and use.

The meeting will be informal but structured to ensure discussions produce clear priorities for future work and agreement on how to proceed. Participants are people who could be users and/or producers of the 'deliverables': policy-makers, private providers, programme managers, international agencies, researchers. The meeting cannot discuss all issues related to the non-state sector, and hard choices have to be made: we recognize that some important aspects have already been excluded from the agenda. For example, we have set aside many important financing and health workforce production issues and are focusing primarily on service provision. Part of day 2 will consider how to deal with such excluded topics.

3. What are the main challenges for which new or different work is needed?

Non-state providers are a diverse group, subject to different market forces with different goals, incentives, levels of presence, political and economic leverage and sometimes - although not always - different target groups. And the countries they work in of course differ: in so-called 'fragile states'[iii], providers and governments may face bigger or different challenges in working to ensure equitable access to essential services. To ensure our discussions, *do* reflect real-life concerns and *don't* duplicate work already under way, we have interviewed a number of knowledgeable actors and reviewed some key web-sites and documents (Annexes 1, 2). We also asked some volunteers to think in more depth on a set of topics identified as important and neglected, or new and relatively uncharted, and to provide specific suggestions on useful and feasible work, with which the meeting could then agree or disagree, help shape and prioritize. Drawing on all these various inputs, topics for the meeting are grouped into three clusters:

- New entrants into service delivery - *companies, corporations, new NGOs*.
- Finding new approaches to old challenges - *developing and implementing policies, regulatory frameworks, oversight of performance.*
- Scaling up *successful small-scale or pilot strategies.*

1) New entrants into health service delivery

Issues and challenges

Two groups of non-state actors in particular appear to be becoming more important in health service delivery. First, an increasing number of ***companies and corporations*** are beginning to change the health services they offer to staff and local communities, moving beyond the traditional sphere of 'occupational health' into, for example, HIV/AIDS care. Many large mining companies have run health facilities for years in remote areas, but other corporations are now also getting involved. Corporate health clinics in some countries are extending services to families of employees and to nearby communities, both to foster positive public relations and because health problems faced by their staff require community-wide interventions. Service delivery models are also becoming more diverse with the arrival of health care companies - home-grown or international - that offer to contract with big employers or with government to provide services with high standards of care. International groups including the World Economic Forum and the Global Business Council on AIDS are becoming active in this area as well.

Questions raised by different stakeholders about new entrants into health services

By corporate and NGO entrants include:

- How much of a risk is it for us to provide services in unpredictable economic environments?
- What are the opportunities for co-investment projects with the public sector?
- Should we be targeting poor and/or middle-income groups?
- What conditions, subsidies, safeguards or benefits should we try and negotiate with government?
- For what aspects of our performance is it reasonable to be held accountable by the government, rather than our shareholders/communities?

By policy-makers:

- How long will they stay? Can we stop them? Do we want to? What appear to be the main reasons for their new/changed participation in service provision?
- How could they help to improve access to more excluded groups?
- How can we ensure they do not lead to escalation of health costs, or attract health workers away from stretched public services?
- How can we ensure they adhere to key aspects of national health policy; are held accountable for the care they provide? What conditions or incentives should we set for their entry? Could we enforce these?
- Are organizations providing equivalent services being regulated equivalently?

By other stakeholders:

- How will these new entrants affect the services we are providing?
- Is competition over funding sources benefiting health service recipients?

A second group comprises ***new NGOs.*** There is evidence from some countries that new NGOs are being created, or existing ones are entering health services for the first time with little experience, in response to new international sources of funding such as The Global Fund to Fight AIDS, TB and Malaria (GFATM) and PEPFAR. How widespread is this experience with what are sometimes called 'brief-case NGOs' which may lack the regulatory checks and balances that are usually in place for for-profit firms and more established NGOs. The issues of regulation, oversight, quality of care and accountability are not unique to new NGO providers, but are being brought to the fore by rapid increase in numbers and reports of behaviours counter to the public interest within this group.[iv]

Current suggestions on work/actions needed

- Map the scale, scope and target audience of services being provided by new actors.
- Catalytic work: explore mechanisms to promote more effective interaction between different stakeholders in countries, including policy-makers, funders, representatives of companies and corporations moving into health services.
- Analytic work: on changes in NGO funding, attitudes towards corporate health, effects of corporate or NGO provision on access and quality of care, etc.
- Policy briefs on specific sub-areas setting out issues for different stakeholders to consider.

Questions for the meeting to consider:

- How widespread are the challenges identified above? Which are the critical issues to focus upon in the first instance?
- Which of the suggested types of work would be most useful and feasible, given what others are already doing? Can we develop them further?

2) Finding new approaches to old challenges in harnessing potential of non-state providers

Issues and challenges

Current orthodoxy about the role of governments in health includes a responsibility to provide both public and private health system actors with overall policy direction; to create conditions that allow them to do their jobs; to ensure oversight across the whole system with particular attention to equity concerns; and to reconcile competing views and demands. Historically there has been a lack of dialogue, and sometimes a lack of trust, between the public and the non-state sector. Government capacity to interact with an increasing range of actors, to monitor their performance, and to take on sometimes new and unfamiliar roles as their health system changes, is often severely stretched. Better understanding is needed on all sides, so that strategies can be negotiated to encourage non-state providers to contribute to some common goals despite the competing demands they face, and with a mutually acceptable degree of accountability.

In some countries, at the same time as recognition of non-state providers is increasing, and new instruments for working with non-state providers are being tested, there are moves to decentralize responsibilities for health service delivery to lower levels of government. One consequence is that local health authorities may feel overwhelmed by the new and often unfamiliar managerial capabilities expected of them. These challenges are particularly acute where government policy is unclear, and where the legal status or professional standing of some providers is an impediment to dialogue.

From interviews, three ingredients were signalled as being particularly critical to advance equitable coverage and quality: the need for ***national policy frameworks*** to guide the provision of care by non-state as well as public providers; functional ***mechanisms*** for negotiation and dialogue between different stakeholders, and a need to look more creatively at incentives and ***approaches to regulation*** that are easier to implement than standard methodologies.

Developing national policy frameworks: Experience with developing, and subsequently implementing, policies towards the non-state sector is limited and poorly documented. The importance of policy guidelines for decision-makers at the local and district level was highlighted in a number of countries. For countries embarking on the task, there is little information on experience in other countries available. Once in place, translating policy to practice remains difficult. Some interviewees commented that in their view implementation of such policies was largely 'stuck'.

Mechanisms for dialogue: In many countries, business associations and umbrella organizations, such as the Christian Health Association of Zambia (CHAZ), provide a forum for engagement at multiple levels. In countries adopting sector-wide approaches (SWAps) to health development, specific platforms for dialogue among different interest groups do exist, though analyses suggest that these have been more successful at promoting interaction between government and external agencies than in bringing in other national constituencies. The Country Coordinating Mechanisms (CCMs) required by GFATM are designed to bring together all key stakeholders concerned with those three diseases.

Three important groups of providers tend to have fewer established mechanisms, and limited capacity, for active partnership with the public sector. These are small for-profit clinics and individual providers, small NGOs and informal providers. These providers can be a major source for health care for the poor. Professional associations, which can provide a vehicle for dialogue with government, communicate policies and standards of care, or take on a role in self-regulation, do exist for these groups in some countries but have been limited in their influence. Informal providers in particular are considered by some to be a major but wasted resource because engagement is politically and legally, as well as logistically, challenging. One interviewee referred to this group as the 'elephant in the room' that tends to get ignored.

More creative approaches to regulation: Interviews have identified two large questions regarding regulation: what approaches are most effective at differing levels of government with differing provider types, and how can governments best build regulatory capacity?

Alternative approaches to regulation of private providers

- Doing nothing
- Setting incentives
- Improving practice through provision of information and education
- Strengthening consumers through information and education
- Self-regulation including voluntary codes of practice
- Co-regulation

'Classic regulation', involving laws and enforcement agencies, is not the only approach to affecting the behaviour of private health care providers (see box). Moves to improve regulatory functions in industrialized countries are gaining momentum, epitomized by the UK Cabinet Office Better Regulation Task Force. An example of new initiatives being tested in the UK is the requirement that regulatory impact assessments be undertaken before new regulations are proposed. A sub-group of the Better Regulation Task Force is looking specifically at regulation of and by local authorities. Another sort of 'impact assessment' is illustrated by Uganda, where new public budget management regulations require that all new legislation is subject to a full economic impact assessment prior to adoption. This has encouraged the development of creative ways to work within existing laws to allow task-shifting - for example, by introducing amendments that redefine the term 'supervision by a professional', and which can be applied to both public and private para-professional providers.

Current suggestions on work/actions needed

- Develop and maintain a web-based inventory of work on public-private policies.
- Country case studies on development/implementation of national policies for non-state sectors.
- Map operational policies developed at district level and below; focusing on contracting, regulation and information, and local capacity in these areas.
- Help develop local level capacity to be more effective 'stewards'.
- Living database of technical experts to support development of public/public partnership policies.
- Explore ways to support strengthening of professional bodies for non-state groups.
- Support regulatory impact assessments; document costs/benefits of different approaches.
- Review papers, e.g. approaches to regulation in post conflict/fragile states, with multiple NGOs, or synthesis of experience with developing public/private partnership policies.
- Dissemination of information.

Questions for the meeting to consider:

- How widespread are the challenges identified above? Which are the critical issues to focus upon in the first instance?
- Which of the suggested types of work would be most useful and feasible, given what others are already doing? Can we develop them further?

3) Scaling up the contributions of non-state providers to meeting public health goals

Issues and challenges

The term 'scaling up' means different things to different people. Here it is used to refer to dramatically expanding coverage of priority health interventions. This is part of the rationale for many current global health initiatives (GHIs) such as those focused on HIV, TB, malaria, maternal and child health. To effectively 'scale up' - and sustain - services requires adequate human, financial and material resources, functioning management systems, possibly new models of service delivery, and institutions capable of effective oversight of different types of providers.

Most work to date on scaling up has focused on constraints facing public sector service delivery, and on demonstrating that it is possible to work with non-state providers through mechanisms such as contracting, franchising or social marketing, thus bypassing public sector constraints. The effectiveness and impact of many of these instruments is still little understood, and little attention has been paid to understanding the factors that influence taking them to scale. This is in part because, while there are examples of non-state engagement on a large scale - especially in relation to the delivery of specific products - much experience remains small-scale or as a 'pilot'. Pilots are undertaken for many different reasons but a common one seems to be to prove the feasibility of a particular mechanism in a particular setting, rather than its desirability or feasibility on a large scale.

A number of constraints to larger scale intervention have been suggested, apart from the lack of knowledge and experience (see box). One major question to consider is that if scaling up depends on 'managed networks' of private providers, can these work for general service provision as well as for very specific products?

Any strategy to expand coverage through non- state providers must also consider the implications for quality of care and equity of access. Quality of care is a challenge for all providers, but small for-profit and informal providers are often a particular cause for concern for a number of reasons including uneven application of appropriate treatment protocols[v,vi]. There is uncertainty about the ingredients of successful efforts to improve or assure quality in the non-state sector - 'control' measures such as regulation seem to have limited effect. Accreditation and other external quality assurance methods, contracting and techniques introduced within social franchising and social marketing programmes including supervision, have all

Constraints to scaling up

- Limited government capacity to manage changing roles vis-à-vis non-state sectors.
- Government ambivalence to or confusion surrounding an expanded non-state sector role in service provision.
- No plan to go to scale.
- Competition for funding.
- Conflicting messages regarding both desirability and effectiveness of non-state sector instruments.
- Limited private sector capacity for health care and/or management.
- Limited or weak non-state sector representative institutions.
- Legal framework issues preventing entry of different providers and/or functions.

shown some limited positive effects. In some instances, provider training and community education may work as well. Experience suggests that a package of interventions will need to be developed with the participation of the providers concerned, to manage quality concerns as programmes go to scale.

Current suggestions on work/action needed

- Database of private sector interventions and scale of operation across interventions.
- Review of studies of barriers/enablers to scale up.
- Evaluation of quality effect from private sector mechanisms.
- Case studies on attempts to overcome constraints to larger scale implementation.

Questions for the meeting to consider

- How widespread are the challenges above? Which are the critical issues to focus upon in the first instance?
- Which of the suggested types of work would be most useful and feasible, given what others are already doing? Can we develop them further?

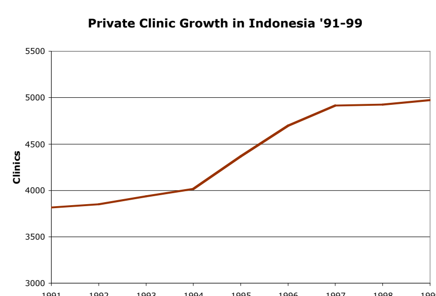
Cutting across all these topics, is the need to ensure 'ethical practice' and acknowledge potential conflicts of interest by all concerned - public policy-makers, private providers, and other partners - so that the public interest is protected.

4. What are current trends and changes in the non-state sector?

The challenges identified in the preceding section derive from interviews and from a review of some more formal data sources, summarized here. We were particularly interested to examine the recurring statement that the non-state sector was 'changing' in many countries. There are different ways of looking at changes: for example, by changes in size and economic importance; in composition; by changes in the extent to which the sector is recognized, and by rising efforts by health ministries to engage with the non-state sector. All are limited by data scarcity and publication bias: externally-supported programmes more commonly write up experience than do busy policy-makers or service providers. Since the mid 90's, there have been increasing efforts to systematically document the size and composition of the non-state sector in developing countries - for example, through national health accounts or private provider surveys. Data remain fractured and inconclusive, and this is not a complete review, but there appear to be some noteworthy changes.

Size and economic importance

In terms of changing size, the picture seems mixed. In Asia, there appears to be a gradually increasing non-state participation in health in many countries. In the two most populous countries, private expenditure on health as a percentage of total expenditures on health rose between 1998 and 2002, from 73.5% to 78.7% in India and 61% to 66.3% in China[vii]; an estimated 50% of rural health clinics in China are now privately owned versus none in 1980[viii]. In Indonesia, the number of for-profit hospitals have increased by one half during the decade from 1990 (Figure 1). During the same period, private-provider services rose from 48% to



54% of all ambulatory care[ix]. In Africa and Latin America, there is insufficient data to draw firm conclusions regarding the growth of the private sector overall, but there are indications of both relative growth and decline in differing countries.

Changes in composition
Even where the sector is not growing, the composition of the non-state sector in service provision does appear to be changing. The types of private for-profit actors are expanding, and in many instances the distinction between public and non-state providers is blurring.

The importance of faith-based organizations (FBOs), especially in Africa, is well documented and remains large. In many countries in South Asia and Africa, informal providers continue to play a very large role in health provision - for example, the number of informal or quasi-legal Rural Medical Practitioners in India is estimated at between 500 000 - 1.27 million[x]. In China and almost all South-East Asian countries, the number of private pharmacies, hospitals, clinics, providers, and a range of associated dual-employment practices has increased in the past decade. There are examples of increasing corporate participation in health service markets from countries in all geographic regions - in the form of health maintenance organizations (HMOs), joint-investment hospitals, and employer-supported clinics. There are examples of new NGOs are being created to deliver health services and established health NGOs taking on more complex clinical services.[xi]

Several factors seem to have contributed to changes in size and composition. The most prominent are changing ideologies and policies, unexpected shocks and new sources of funding. For example, corporate entry into health services has been spurred by at least three separate forces: opportunities presented by increasingly free markets for health service provision; government requests, and concerns to find ways to control rapidly rising health costs.[xii]

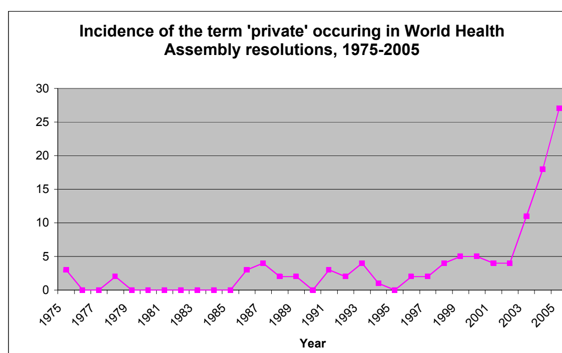
Changing ideologies, economic policies and labour markets
During the 1980's and 90's, shifts in international thinking and financing, and in more homegrown policies, resulted in many countries introducing general market liberalization policies, which in turn led to more open health markets: China, Tanzania and Viet Nam are just three examples.

Unexpected shocks
Economic shocks and civil conflicts can disrupt public services and may lead to an unplanned increase in private provision as was the case in Indonesia after the 1998 Asian Economic Crisis, and in Iraq just prior to the current Gulf War[xiii][xiv].

Changes in funding
Increasing GHIs and national government attention to NGOs have opened up new opportunities for support to NGOs and to a lesser extent to private enterprise. The addition of large new funding sources for HIV/AIDS and other priority diseases in recent years has accelerated this process.

Other ways to look at changes in the non-state sector include examining the evolution in recognition of the sector; in engagement by governments; in available instruments for engagement, in types of services delivered, and in allocation of external resources.

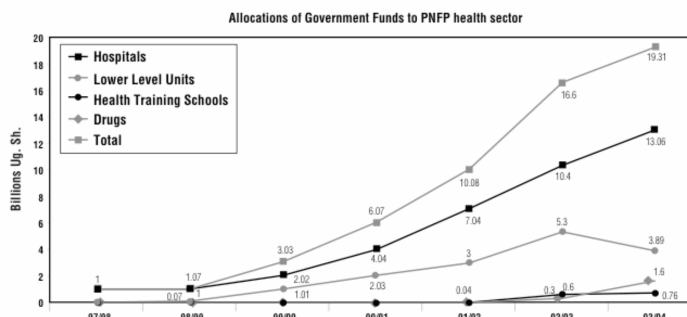
Recognition of its size and importance
Even in countries where there are few changes in size or composition, there seems to be growing acknowledgement of the size and importance of the non-state sector in health. As one interviewee put it, it is 'now accepted in polite company'. This is most evident in middle-income countries but can be seen across countries of all income levels, reflected in public discussions, newspapers, increased informal collaboration, rising numbers of formal research projects or access to government subsidies.



Recognition of the non-state sector by international agencies has also risen, as evidenced by the inclusion of private sites in demographic health surveys (DHS); the explicit intent to work with the private sector by many GHIs and Global Health Partnerships (GHPs), and by the increased frequency of references to "private" sector topics in WHO's World Health Assembly resolutions (see graph).

Engagement
By the mid-1990s, increasing emphasis on planning for non-state engagement was emerging for example as part of some countries 'SWAp' discussions. In Uganda, the government policy of actively collaborating with the non-state sector led to a dramatic increase in subcontracting to NGOs beginning in 1997. Ghana, South Africa, and Uganda have all developed national policies on engagement with the non-state sector with the stated aim of improving access to care and assure quality. Nigeria and the Indian state of Karnataka are currently developing similar policies.

Uganda's government financing to NGOs



Source: presentation by Dr. George Bagambisa, Coordinator of the PPP Unit, MOH, Uganda, on "PPP in Health: Uganda's Progress," PPP Workshop organized by the World Bank, Nairobi, Kenya, June 2004.

Instruments
Innovative instruments to engage non-state providers have grown in number and type, although the evidence for many of these instruments remains anecdotal. Columbia, Bangladesh, India, Pakistan and others have subcontracted parts of the normal package of government care (e.g. family planning) to NGOs. The growth of social marketing – whether donor or government sponsored – is indicated by the growing number of products delivered through these arrangements (condoms, bednets, antenatal vitamins, and water purification tablets to name only a few).

Clinical Services
Innovations in state/non-state cooperation for clinical services remains small, but is growing. Public/private mix (PPM), DOTS programmes for TB, new in 2000, are now part of all 22

high-burden country national tuberculosis programmes. Franchises and networks of private providers deliver one quarter of all clinical family planning in Pakistan; provide antiretrovirals to nearly 15 000 people in South Africa, and reach 30 000 shops in rural Bihar state in India.

Mobilization of External Resources
Unprecedented levels of external funds are available for health in poor countries, with a significant share being channelled through different forms of GHP. There are now nearly 100 public/private partnerships (PPPs) active in a wide range of health areas[xv]. The high-cost of AIDS treatment in particular has accelerated the inclusion of multinational companies as partners in targeted global collaborations.

For many GHPs, the non-state sector is a key partner in addressing health agendas too large for any single entity to tackle alone. Some, for example GTAFM, create explicit mechanisms for its engagement. There is evidence that the encouragement by such agencies to NGOs to apply for funds has led to an increase in the size and number of non-state actors engaged in health services in developing countries, for example, influencing the 250% increase in NGOs in Brazil between 1996 and 2002 and an increasing dependence of these NGOs on GHI funding for HIV/AIDS care.[xvi][xvii] Some bilateral agencies are also increasing financial support to working with private providers. For example, DfID funding of condom social marketing programmes rose between 1995-2002 from £3-30 million[xviii].

5. Strategies to ensure the production and use of agreed deliverables

The Montreux meeting set out some broad priorities for action on the non-state sector. Subsequent discussions reinforced the view that, while there is substantial activity in this area internationally and nationally, there seems to be a need for greater exchange between public and non-state sector actors in order to have better mutual understanding of the challenges in working together towards public health goals; a need to synthesize relevant experience across different disease and service specific initiatives; and a need to move beyond lesson learning towards putting knowledge into practice – particularly on a larger scale. This paper has added some specificity by providing a menu of 'hot topics' which have been identified as important but neglected, or new and relatively uncharted, and the meeting will help set priorities for action.

Having made some hard choices about which few things to focus upon in the first instance, and the type of work needed, the last task is to agree strategies for making sure deliverables are actually produced.

There are a number of options for taking the work forward ***over the next 18 months***. Different levels of commitment can be envisaged irrespective of the formality of working arrangements - from small to substantial. Work may be taken forward by single or several institutions. What are the advantages and disadvantages of different working arrangements in terms of getting the agreed work actually done? Three possible models are suggested here to get discussion going.

- *'Go away and get on with it'.*
- *Informal coalition.*
- *More formal 'working group'.*

Go away and get on with it. Individual pieces of work are taken forward by those who have agreed to a particular activity, and there is no further collective engagement.

Informal coalition. Composed of those who wish to continue as an informal group following this meeting, and to discuss progress and new developments together in some way periodically. Such a loose confederation of interested parties would rely on goodwill and 'gentleman's agreements' to do the work, within a specific time frame. WHO as secretariat could provide a role in facilitating communication, and in reminding people of their commitments, in addition to any specific pieces of work it has volunteered to do.

Advantages

- It is probably the quickest way to get started.
- Allows organizational arrangements to evolve more naturally
- It could make it easier to be more open and inclusive, as others want to engage

Potential disadvantages/things to address

- How binding can any commitment be made to do the agreed work in this model?
- Ensuring the credibility and legitimacy of products might be more difficult, because of their lack of association with a formally constituted group
- What sorts of review process would be appropriate and acceptable, to maintain inputs into the agreed work from different stakeholders, and to assure quality?

More formal model. Establish a properly constituted group, with formal rules and procedures, work plan, etc.

Advantages

- May help generate greater visibility for issues, and mobilize funds to address them.
- May make it easier to stimulate greater exchange of information as is a clear focal point doing that task.
- May provide some rigour and clarity, as are required to through issues such as credibility, legitimacy, governance of such a group.

Potential disadvantages/things to address

- It takes more than a physical body to gain credibility and legitimacy.
- High risk it will get paralysed by bureaucracy, and take 18 months to set up.
- Raises questions more explicitly of who is in and who is out.
- Introduces a new body in an overcrowded field of partnerships and initiatives.

Annex 1: List of People Interviewed in Preparation for the Meeting

Name	Institution/Department
Nel Druce	HLSP
Sarah Barber	UC Berkeley
David Peters	World Bank; Johns Hopkins
Sara Sulzbach	Abt Associates – PSP-One
Peter Berman	World Bank, India
Birger Forsberg	Karolinska Institute, Sweden
Karen Cavanaugh	USAID
Kara Hanson	LSHTM Health Policy Unit
Jonathan Broomberg	Praxis International; GFATM TRP
Deepak Gupta	MOH, India
Mushtaque Chowdhury	BRAC
Meng Qingyue	Shandong MU, China
Jessica Rich	UC Berkeley
April Harding	World Bank
Godfrey Biemba	CHAZ
Brian Brink	Anglo American
Tim Evans	WHO – EIP
David Evans, Jean Perrot	WHO – EIP/HSF
Patrick Kadama, Dominique Egger, Dela Dovlo	WHO – EIP/HDS
Shanti Noriega	WHO - EIP/MHI
Jeanette Vega	WHO - EIP/EQH
Manuel Dayrit	WHO – EIP/HRH
Precious Matsoso, Gilles Forte	WHO - HTP/TCM
Richard Laing	WHO - HTP/PSM
Alex Ross	WHO – HTM
Allan Schapira	WHO - HTM/ Roll Back Malaria
Mukund Uplekar, Knut Lonnroth, Leo Blanc, Mario Raviglione	WHO – HTM /StopTB
Sandra Black, Ted Karpf	WHO – HTM/HIV
Robert Scherpbier, V. Chandra-Mouli, Rajiv Bahl	WHO - FCH/CAH
Dale Huntington	WHO – FCH/RHR
Anjana Bhushan, Soe Nyunt-u	WHO – WPRO
Heather O'Donnell	WHO Country Office, Vietnam
Sameen Siddiqi	WHO - EMRO

Annex 2: The non-state sector in health service delivery in low-income countries: on-line sources of literature

I. Web sites / web pages specifically focused the non- state sector in health service delivery		
Web site	**What kind of materials?**	**URL**
Eldis/HRC Health Systems Resource Guide, Health Service Delivery	23 papers from multiple sources, with suggestions for of 'recommended reading'. No sub-division into topics. No grey literature.	http://www.eldis.org/healthsystems/delivery/index.htm#private
HLSP Institute - Private sector in health	4 papers, all published by IHSD (DfID).	http://www.hlspinstitute.org/projects/?mode=region&listId=18644
Harvard School of Public Health, International Health Systems	18 papers on NSS, all published by Harvard. No recommendations or divisions into topics.	http://www.hsph.harvard.edu/ihsg/topic.html#12
PSP-One (Abt & FHI / USAID)	449 documents. Mostly published by USAID contractors. Mixture of published and grey literature. Recommendations are indicated. No predefined subdivisions into topics but can search by topic. Only covers reproductive health.	http://www.psp-one.com/section/resource
DKT International	14 papers or short articles all published by DKT. Only covers social marketing.	http://www.dktinternational.org/article.htm
Population and Health InfoShare - Commercial Market Strategies (CMS)	20 papers all by CMS. Project is finished (followed by PSP-One above). Only covers reproductive health.	http://www.phishare.org/partners/CMSproject/
SOMARC (Social Marketing for Change)	20 papers all by SOMARC. Project is defunct (followed by CMS above). Only covers reproductive health.	http://198.93.224.40/overview.asp
Public-Private Mix for DOTS (PPM DOTS), Stop TB department, WHO	Summary of effects of PPM DOTS initiatives. 10 WHO reports and guiding documents on PPM. List of journal articles on private sector and TB control.	http://www.who.int/tb/dots/ppm/en/index.html
World Economic Forum Global Health Initiative	50 corporate social responsibility case studies - all health programmes to combat HIV/AIDS, TB and malaria. Guidelines for businesses.	http://www.weforum.org/site/homepublic.nsf/Content/Global+Health+Initiative

II. Useful general websites, that include publications on non-state sector in health services		
Web site	**What kind of materials?**	**URL**
World Bank - Knowledge Services for Private sector development	Web site on all aspects of the private sector. Searching under 'health' generates list of 72 resources - e.g. papers, links to web sites, case studies - from multiple sources. Searching under 'health services' generates 27 resources. Includes grey literature and many country case studies.	http://rru.worldbank.org/
World Bank	A search of 'private' and 'health services' in the documents and reports database generates 2127 papers. More refined searches can be done. Bank documents only - primarily country specific.	http://www-wds.worldbank.org/default.jsp?site=wds
id21 - Health, Health systems and economics	Search of 'private' in the id21 health database generates 212 papers from multiple sources, including grey literature.	http://www.id21.org/zinter/id21zinter.exe?a=l&w=b1
DfID - HSRC and HRC publications. Health Service delivery and financing	List of around 20 papers by HSRC many of which are about private sector issues.	http://www.dfidhealthrc.org/shared/know_the/publications.html#health2
Alliance for Health Systems and Policy Research	Search of 'private sector' in the database generates 4012 papers from multiple sources. Adding 'developing countries' reduces to 205. Links out to PubMed. No grey literature.	http://violet.collexis.net/evidenceBase/
USAID	The predefined search term 'private health care' in the database generates 346 USAID project documents by various contractors. To note that the 2005 Users' Guide to USAID/Washington Population, HIV/AIDS, Health and Nutrition Programs lists all of the current USAID projects and their websites. Many have produced documents on non state actors and methods, available from the individual contractor website	http://www.usaid.gov/ http://www.usaid.gov/our_work/global_health/home/Resources/users_guide.html
GTZ	211 GTZ project documents on health - no way of searching for private sector issues. Some private sector related documents	http://www.gtz.de/en/
European Observatory	Many publications discuss the private sector though dedicated publications on private sector are mostly on pharmaceuticals. No search function within the document list. Not specifically low-income country focused.	http://www.euro.who.int/observatory
LSHTM publications	Many LSHTM private sector publications listed but no search function within the document list.	http://www.lshtm.ac.uk/hpu/publications.htm
Management Sciences for Health	Lists MSH docs some of which are available online. Several are relevant. No searchable database	http://www.msh.org/
Futures Group	Search under 'private' generates a list of 54 documents all by FG. Some not specifically on private sector, but many seem relevant. Many country specific documents. Only covers reproductive health.	http://www.futuresgroup.com/Company.cfm

Web site	What kind of materials?	URL
PHRplus (Abt)	Search under 'private sector' generates a list of 381 doc from multiple sources. A variety of types of document, from grey literature to academic articles, but no recommendations or divisions into topics. Links to pdfs for some, but not all, documents.	http://www.dcdata.com/abt/abt.htm
John Snow International	No searchable database but lists JSI docs some of which are available online. Several of these are relevant.	http://www.jsi.com/JSIInternet/Publications/index.cfm
PSI	Search under 'social marketing' generates list of 37 working papers and published articles all published by PSI. Only covers reproductive health. Many country specific documents. Not possible to download documents - must be ordered.	http://www.psi.org/
PubMed	Definitive database of peer reviewed literature on health. No indications for recommended literature and no grey literature.	http://www.ncbi.nlm.nih.gov/entrez/query.fcgi
Non-State Provision of Basic Services Sub-Web	DfID project at Birmingham University covering non-state provision of education, WATSAN and health services. On health specifically, a bibliography of around 40 papers and literature review (academic sources, no grey literature). six detailed country studies which include health. Desk review of donor policies.	http://www.idd.bham.ac.uk/service-providers/
LSMS - World Bank	A search tool allows user to identify surveys with questions on 'use of health care'. Surveys include a question on use of private care. Some surveys have been analysed and written up as research papers - available online but only one or two relate to private sector issues.	http://www.worldbank.org/lsms/
Demographic and Health Surveys	Statistical data on use of private providers is available from household surveys. DHS surveys cover 70 countries over last 20 years.	http://www.measuredhs.com/

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