REPORT OF THE REGIONAL WORKSHOP ON BUILDING PUBLIC-PRIVATE LINKAGES TO ADVANCE PRIORITY HEALTH SERVICES IN AFRICA

MAY 7–10, 2008
ADDIS ABABA, ETHIOPIA

This publication was produced for review by the United States Agency for International Development and the World Health Organization. It was prepared and submitted by Barbara O’Hanlon of O’Hanlon Health Consulting LLC for the Private Sector Partnerships-One project.
Country Report

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Bureau for Global Programs, Field Support and Research

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In collaboration with:
Banyan Global ■ Dillon Allman and Partners ■ Family Health International ■ Forum One Communications ■ IntraHealth International ■ O’Hanlon Health Consulting LLC ■ Population Services International ■ Tulane University’s School of Public Health and Tropical Medicine
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CONTENTS

1.0 Introduction ........................................................................................................... 1
  1.1 Antecedents to Network for Africa and Addis Ababa Regional Workshop......................................................... 1
  1.2 Overview of Addis Ababa Regional Workshop ................................................................................................. 1

2.0 Overview of Technical Sessions ........................................................................ 3
  2.1 Why partner with the private health sector? ................................................................................................. 3
  2.2 Why the private health sector and RH/FP? .............................................................................................. 3
  2.3 Definitions of key concepts used in the workshop ................................................................................. 4
  2.4 Government as the steward of the private health sector .................................................................................. 4
  2.5 Range of policy instruments ......................................................................................................................... 4
  2.6 Why partnerships are important ................................................................................................................ 5
  2.7 Lessons from the field in working with the private sector ........................................................................ 5

3.0 Country Action Plans .......................................................................................... 9
  3.1 Methodology ................................................................................................................................................. 9
  3.2 Summary of country action plans .............................................................................................................. 9
  3.3 Country action plans ....................................................................................................................................... 11

4.0 Launch of the Network for Africa ...................................................................... 15

5.0 Private Sector Opportunities in Africa .................................................................. 17
  5.1 Deepen MOH skill base to work with the private health sector ................................................................. 17
  5.2 Build a knowledge base of private health sector approaches in Africa ...................................................... 18
  5.3 Invest in private sector innovations ........................................................................................................... 19

6.0 Conclusions and Next Steps ............................................................................. 21

Annexes
  Annex A: Participant directory ................................................................................................. 23
  Annex B: Workshop description and methodology ........................................................................ 27
  Annex C: Session overview on the case for working with the private health sector ........................................ 31
  Annex D: Definitions of key concepts for the workshop ............................................................................. 37
  Annex E: Government as the steward for the private health sector ....................................................... 41
  Annex F: Range of policy instruments ................................................................................................. 45
  Annex G: Session briefs .................................................................................................................... 47
  Annex H: Why partnerships are important ......................................................................................... 47
  Annex I: Private sector experiences in workshop countries ........................................................................... 63
  Annex J: Launch of the Network for Africa ............................................................................................ 69

Bibliography ..................................................................................................................... 75
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired immunodeficiency syndrome</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
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<tr>
<td>ARV</td>
<td>Antiretroviral drug</td>
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<tr>
<td>CME</td>
<td>Continuing Medical Education</td>
</tr>
<tr>
<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
</tr>
<tr>
<td>FBO</td>
<td>Faith-Based Organization</td>
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<tr>
<td>GSMF</td>
<td>Ghana Social Marketing Foundation</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
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<tr>
<td>HPN</td>
<td>Health Population and Nutrition</td>
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<tr>
<td>IFC</td>
<td>International Finance Corporation</td>
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<tr>
<td>KiW</td>
<td>Kreditanstalt für Wiederaufbau (Reconstruction Credit Institute)</td>
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<tr>
<td>MAPPP-E</td>
<td>Medical Association of Physicians in Private Practice-Ethiopia</td>
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<td>MDA</td>
<td>Market Development Approach</td>
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<td>MDCN</td>
<td>Medical and Dental Council of Nigeria</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MNH</td>
<td>Maternal–Neonatal Health</td>
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<td>MOF</td>
<td>Ministry of Finance</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>MOU</td>
<td>Memorandum of Understanding</td>
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<td>MSI</td>
<td>Marie Stopes International</td>
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<td>MSH</td>
<td>Management Science for Health</td>
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<td>MWRA</td>
<td>Married Women of Reproductive Age</td>
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<tr>
<td>NACA</td>
<td>National AIDS Control Agency</td>
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<td>NGO</td>
<td>Nongovernmental Organization</td>
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<td>NHIS</td>
<td>National Health Insurance Scheme</td>
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<td>NMC</td>
<td>Nurse and Midwifery Council</td>
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<td>NSP</td>
<td>Non-State Providers</td>
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<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<td>PPI</td>
<td>Public-Private Interactions</td>
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<td>PPM</td>
<td>Public-Private Mix</td>
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<td>PPP</td>
<td>Public-Private Partnership</td>
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<td>PPPDP</td>
<td>Public-Private Product Development Partnership</td>
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<td>PSP-One</td>
<td>Private Sector Partnerships-One</td>
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<td>QA</td>
<td>Quality Assurance</td>
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<td>QI</td>
<td>Quality Improvement</td>
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<tr>
<td>RH/FP</td>
<td>Reproductive Health/Family Planning</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
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<tr>
<td>VLDP</td>
<td>Virtual Learning Development Program</td>
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<td>WHO/RHR</td>
<td>World Health Organization/Reproductive Health and Research Department</td>
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1. INTRODUCTION

1.1 ANTECEDENTS TO NETWORK FOR AFRICA AND ADDIS ABABA REGIONAL WORKSHOP

The Private Sector Partnerships-One (PSP-One) project and the World Health Organization’s Department of Reproductive Health and Research (WHO/RHR) continue to work together in support of increasing access to reproductive health and family planning (RH/FP) through the private health sector in Africa. In December 2006, PSP-One and WHO/RHR co-sponsored a consultation meeting on Public Policy and Reproductive Health Franchising and produced a joint guidance note on the evidence and future direction of private provider networks and franchising of RH/FP services (http://www.who.int/reproductive-health/healthsystems/meeting06.htm). Building on the success of this first policy meeting, the organizations designed a regional workshop focusing on Africa.

With funding from the United States Agency for International Development’s (USAID’s) Repositioning Initiative, the PSP-One project is leading a two-year initiative – Network for Africa – that will build public-private linkages to advance universal access to RH in the region. WHO/RHR and PSP-One co-sponsored a regional workshop, held May 7-10, 2008, in Addis Ababa, Ethiopia, as one of the Network’s first activities.

1.2 OVERVIEW OF ADDIS ABABA REGIONAL WORKSHOP

The purpose of the workshop was to develop national capacity to design and manage partnerships with private sector stakeholders and provide an overview of the selected policy instruments commonly available to Ministries of Health (MOHs) and the public-private partnership (PPP) units. The workshop curriculum was based upon a World Bank Institute course on public policy for the private sector, which was revised for the African context and substantially updated with new information to reflect current trends in private sector provision of health services.

Workshop objectives included:

- Developing existing public sector capacity to engage the private sector in the provision of RH/FP and HIV/AIDS-related services in selected Anglophone African countries
- Creating a network for experiential learning across countries on challenges in strengthening PPPs for RH/FP and HIV/AIDS
- Strengthening existing relationships and linkages across priority programs within African MOHs to work effectively with the private sector in support of national health goals (in general) and RH/FP (in particular)
- Identifying key actions and important next steps for participant countries to design, develop, and manage PPPs following the workshop

1 Repositioning Family Planning is a multilateral initiative to mobilize commitment to address the serious problem of unintended pregnancies by strengthening FP services in sub-Saharan Africa. The goal of Repositioning is for FP to be recognized by clients, providers, governments, and donors as critical to the health and development of the nations of sub-Saharan Africa.
**Participating countries:** Teams of MOH officials from Ethiopia, Ghana, Kenya, Nigeria, United Republic of Tanzania, and Uganda attended the Addis workshop. The teams comprised: (i) the RH/FP director, (ii) the HIV/AIDS director, and (iii) the PPP unit director and/or PPP adviser. In addition, several USAID Health, Population and Nutrition (HPN) officers and President’s Emergency Plan for AIDS Relief (PEPFAR) PPP advisers from these countries attended. (See Annex A for a directory of the participants.)

**Overview of workshop agenda:** The workshop was designed around three thematic areas (See Annex B for a more in-depth discussion of the workshop agenda and methodology.):

1. Making the case for why it is important to work with the private health sector as a means to help address health challenges in RH/FP and HIV/AIDS
2. Offering a concise overview of the policy instruments the public sector can utilize to engage and encourage the private health sector to deliver RH/FP and HIV/AIDS services
3. Designing a partnering process while, at the same time, stressing the management and leadership skills required to implement and sustain a PPP
2. OVERVIEW OF TECHNICAL SESSIONS

2.1 WHY PARTNER WITH THE PRIVATE HEALTH SECTOR?

The first set of presentations set the stage by introducing the participants to the latest data presented in the recent International Finance Corporation (IFC) report, *Investing in the Business of Health in Africa* (IFC and Marek 2005). (See Annex C for a summary of the data used in these presentations. Link to narrated presentations on the web: http://www.psp-one.com/section/technicalareas/policy/network_for_africa) The data demystified some of the common misperceptions surrounding the private health sector in Africa:

Myth 1 - Health care is primarily financed by the public funds from the government

Myth 2 - The private health sector in Africa is insignificant

Myth 3 - Only the wealthy and urban populations seek health care in the private health sector

The private sector, in fact, constitutes an important, diverse component of Africa’s health care systems with the potential for complementary solutions. The private health sector has a positive role to play in the broader context of strengthening African health care systems by expanding access and improving quality and efficiency. Following are some of the reasons why it is important to partner with the private health sector:

- PPPs can help expand the pool of human resources
- The private health sector can extend the reach of the public sector
- Involving the private sector allows the public sector to focus on those most in need
- Private sector services and products require little support from donors and governments

2.2 WHY THE PRIVATE HEALTH SECTOR AND RH/FP?

The private sector plays an important role in the delivery of FP services. As the data from the most recent Demographic and Health Surveys (DHSs) demonstrate, the private sector is a major source of FP services and methods in many African countries (DHS Ghana, Kenya, and Nigeria 2003; Tanzania 2004; Ethiopia and Rwanda 2005; and Uganda 2006). The same data reveal that the private health sector is also an important source of maternity services; the majority of these services are provided by midwives in the private health sector.

Despite the positive role of the private health sector, much remains to be done to improve contraceptive RH/FP services in the region. None of the workshop countries – Ethiopia, Ghana, Kenya, Nigeria, United Republic of Tanzania, and Uganda – have experienced a significant decline in fertility since the last DHS. Consequently, it is imperative for all African countries to re-double their efforts to address the high unmet need of African families for FP services and products. Working with the private health sector is one strategy that can complement an MOH’s effort to satisfy African couples’ family planning needs.
2.3 DEFINITIONS OF KEY CONCEPTS USED IN THE WORKSHOP

During the introduction of the workshop, the participants discussed the meaning of several core concepts to be used throughout the workshop in order to create a common understanding and shared language. (See Annex D for definitions.) The key concept of stewardship had its own session to define what it means to be stewards of the private sector. There was discussion on the definitions of:

- Elements of a PPP in health
- Whole-market approach
- For-profit commercial sector
- Market segmentation

2.4 GOVERNMENT AS THE STEWARD OF THE PRIVATE HEALTH SECTOR

The concept of stewardship and the evolving model of public sector governance of the private sector was the focus of a third presentation. The presentation focused on why MOHs need to be proactive with the private health sector, provided a working definition of what is ministry stewardship, and finally presented a new model of stewardship. (See Annex E for the presentation on stewardship.) In addition, the presentation described three broad strategic directions for policy development for re-engaging the private health sector:

- **Conversion** from public to private: MOHs consider this option when the public sector is large and/or has excess capacity.

- **Growth** of the size or scope of the private health sector: The MOH can invest in well-functioning parts of the private sector such as nongovernmental organizations (NGOs) and faith-based organizations (FBOs).

- **Harnessing** of existing private sector services: Through policies and partnerships, the MOH can realign existing private sector activities to address public health goals, improve performance (quality and reporting), and address long-standing challenges such as improving access and coverage for underserved population groups.

2.5 RANGE OF POLICY INSTRUMENTS

To enhance the private sector’s role in health care, MOHs and donors will need to take action. When appropriately regulated, the private sector can increase services and products available in the marketplace and improve quality in ways that complement an MOH’s efforts. Effective and targeted regulations can have large and immediate benefits for the private health sector but they are not sufficient. In addition to regulations, the MOH has a range of different policy and program interventions at its disposal to grow and harness the private health sector. (See Annexes F and G for descriptions of the technical modules, including summary of learning objectives, key topics covered, and “take home” messages.)
2.6 WHY PARTNERSHIPS ARE IMPORTANT

In addition to the technical modules, there were three sessions on partnership and the challenges associated with working with the private health sector. They covered the challenges in developing and sustaining partnerships, elements of a successful partnership and the MOH staff’s role as leaders and managers in PPPs. (See Annex H for an overview of the key points in the three sessions on partnerships.)

2.7 LESSONS FROM THE FIELD IN WORKING WITH THE PRIVATE SECTOR

Throughout the course of the 3½ day workshop, the participants shared their insights, experiences, and frustrations in working with the private health sector. One can conclude from the workshop discussions that the MOH staff were very comfortable with the concept of working with the private health sector. There was overall agreement from all the participants about the benefits in working with the private health sector. As a result, the plenary session discussions and group work focused on the many challenges in “getting started,” “addressing concerns,” or “going to scale” with the private health sector.

CHALLENGES IN WORKING WITH THE PRIVATE SECTOR

How to motivate the private sector to deliver preventive health services, such as RH/FP, and how to improve quality of services were the areas most frequently cited by participants as the most difficult challenges confronting the MOH. Some workshop participants wanted to know what types of policies and/or programs have worked in other African countries to successfully motivate the private sector to deliver RH/FP and HIV/AIDS services while others wanted to know if there has been research (or “proof”) of effective incentives to mobilize the private health sector so they can apply them in their own country.

<table>
<thead>
<tr>
<th>Challenges - Motivating the Private Sector</th>
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<td>Incentives</td>
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Quality in the private sector continues to be a concern for the MOH but many at the workshop acknowledged that the public sector often has more stringent rules for the private sector, requiring higher standards for private sector providers than for those in the public sector. One of Ghana’s and Nigeria’s strategies to improve quality involved inviting private sector providers to help develop the RH/FP norms and standards. Ghana and Uganda shared their experience in working with private sector midwives’ associations and how the MOH helped strengthen the quality of care that midwives delivered.
through simple interventions such as training to update skills, linking the midwives to the public health system, and providing needed commodities and supplies. Others, like Ethiopia and Nigeria, discussed how they are using quality improvement tools and checklists with private providers as a means to improve quality among private providers. But all of these interventions, as one participant observed, are small in scale. The question remains how can MOHs scale up these mechanisms to reliably address quality issues in the private sector.

### Challenges - Quality of Care

| Quality of care | • Lack of quality and regulatory framework for either the public or private sector  
• Rules governing quality in the private sector are often more stringent than those for the public sector (Nigeria)  
• Lack of access to training for private sector staff  
• How to ensure quality of drugs that are outside the government procurement system |

There was also a lot of discussion around the use of financing mechanisms as a means to motivate the private health sector to get involved in RH/FP and HIV/AIDS. All the participants recognized that funding the private sector is the most powerful incentive to engage them to deliver preventive and other health services. But they were not familiar with the range of the financing mechanisms available and wanted more information on the mechanics of and steps to implement them (see next table). Moreover, many of the MOHs present have had experience in working with NGOs and FBOs, but wanted to know how to move from memoranda of understanding and other informal agreements to legal contracts. They also wanted to explore contracting out to the private sector.

### Challenges - Financial Sustainability

| Financing and sustainability | • How can we determine which health care finance option is most appropriate?  
• Does contracting out with the private sector differ from contracting out with the NGO sector?  
• How to set the “right price” for cost-recovery schemes and/or contracting without overpaying, yet permitting the private sector to earn a profit?  
• How can an MOH with limited resources pay for PPPs with private sector?  
• Who is going to pay for subsidies in voucher programs after the donors leave?  
• How can donor priorities be coordinated to reflect country priorities, including growing the private health sector? |

During the discussion on financial mechanisms, the participants’ biggest concern was how to pay the private sector for its work. Many of the countries are using donor funds (Ethiopia/USAID funds, Uganda and Kenya/KfW funds, Nigeria/PharmAccess funds) to finance private sector partnerships but are concerned about what to do when the donor funds dry up. Others were concerned about how to
convince donors to align their funding with MOH priorities, particularly when it includes financing the private sector to deliver priority services such as RH/FP and HIV/AIDS. Still others worried about how contracting is possible when public funds and financial flows can be slow and irregular.

Leadership was also considered a major challenge for the MOHs. The discussion on leadership centered on how to build support and obtain approval from senior MOH leadership to work with the private health sector. Uganda described its internal advocacy initiatives to overcome the MOH leadership’s resistance to working with the private sector. Other participants shared their struggles to convince the Department of Regulatory Affairs to modify its regulations to permit private providers wider scope. In Ethiopia, the MOH is trying to secure approval to permit private providers to prescribe and dispense antiretroviral therapy (ART).

### Challenges - Leadership and Management

<table>
<thead>
<tr>
<th>Leadership</th>
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<tbody>
<tr>
<td>• How to foster political will within the MOH to work with the private health sector?</td>
</tr>
<tr>
<td>• How to foster political will to change/reform regulations to permit greater private health sector participation?</td>
</tr>
<tr>
<td>• Negative attitude toward the private sector; lack of trust; lack of recognition of private sector value</td>
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<tr>
<td>• Short-term responses to gaps in systems; no “systems approach to problem solving”; many of these problems will require long-term vision and funding to build the system</td>
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</table>

Finally, many participants listed how to organize and structure the private sector as a major obstacle to greater participation with the private sector. The participants were keen to learn: (i) how other countries have collected information and assessed private sector potential; (ii) what strategies work to “collectivize” and “group” the private sector; and (iii) how to structure a dialogue process to engage providers.

### Challenges - Structuring the Private Sector

<table>
<thead>
<tr>
<th>Organization of private sector</th>
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<tr>
<td>• Where to start with the private health sector?</td>
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<tr>
<td>• Who represents the private sector? Do they really represent the private sector?</td>
</tr>
<tr>
<td>• How to network private providers and facilities?</td>
</tr>
<tr>
<td>• What are effective strategies to organize the private health sector?</td>
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<tr>
<td>• How to engage the private sector?</td>
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</table>
CHALLENGES OF THE PRIVATE SECTOR WORKING WITH THE PUBLIC SECTOR

The workshop organizers invited three private sector representatives to talk about the challenges they encounter in partnering with the public sector. The panel, which comprised a hospital director, the owner of a chain of laboratories, and the assistant director of a private physicians association, were frank in discussing the difficulties and roadblocks the public sector creates for them. Some of the key themes from the exchange between the panelists and participants included:

- The public sector has a negative, even adversarial attitude toward the private sector and focuses only on the private sector’s shortcomings. Lack of trust and a desire to control the private sector are common. Moreover, the public sector does not recognize or value the potential contribution of the private sector in addressing public health objectives.

- Although private sector providers/owners need to earn a profit to stay in business, some also have a social mission to help people in need. Finding these common areas of interest and acknowledging them would greatly help build trust with the private sector.

- Most private sector providers truly want to deliver quality services. But in many circumstances, the public sector: (i) has not established a quality and regulatory framework; (ii) does not widely disseminate information that the private sector providers need to improve their quality of services; and (iii) does not provide and/or invite private sector staff to donor-sponsored training.

- Undue regulations and procedures cost time and money for the private sector. The laboratory owner described his problems with customs, which may result in expiration of drugs and loss of money. In some cases, private sector representatives, as in the example of the Ethiopian laboratory owner, had to provide leadership to solve the problems with customs and supply bottlenecks because the public sector does not perceive them as problems and is not trying to address them.

- Government would play a positive role and help the private sector grow if it would: (i) provide relief from duties on the importation of supplies; (ii) liberalize the regulations allowing qualified private providers to expand their scope (e.g., private doctors prescribe and dispense ART); (iii) access key commodities (e.g., ART) so they do not have to compete with free public goods; (iv) provide tax incentives to motivate the private sector to locate outside of Addis (e.g., no tax on profit until after three years in which business breaks even); and (v) facilitate access to capital.

PRIVATE SECTOR EXPERIENCE AND INNOVATIONS

The participants confirmed a basic assumption going into the workshop that many African countries are indeed experimenting with a wide range of partnerships with the private sector. The variety of PPPs ranges from: contracting out with the private sector; using donor funds to support private sector initiatives managed by the public sector; private businesses sponsoring health projects through corporate social responsibility strategies; MOHs donating products such as FP and ART to private providers; social franchising of FP, tuberculosis, and HIV/AIDS services; insurance schemes as a mechanism to incentivize and organize private providers; and different individual initiatives to ensure quality in the private sector. (See Annex I for a comprehensive list of country examples of private sector innovations.) The challenge remains documenting these PPPs to create a body of evidence and sharing these experiences and successful practices with other countries.
3. COUNTRY ACTION PLANS

3.1 METHODOLOGY

To prepare for the Addis workshop, the country teams received “homework” assignments. All of the country teams successfully completed the assignments, which contributed to the high quality of the country action plans. The planning exercise was divided into three sessions and concluded with country teams sharing the highlights of their plans.

- First step: Scoping the problem to be the focus of the PPP. The country teams came prepared and had identified the priority reproductive health/family planning (RH/FP) or HIV/AIDS program objective(s) relevant to the private health care providers.

- Second step: Identifying and selecting potential private sector partners. Referring to their homework, the country teams mapped out potential partners, weighed the risks and rewards, and identified the resources each partner could bring to the partnership. The country teams also listed the steps they will take upon returning to their country to initiate the partnership.

- Third step: Identifying relevant private actors for implementation and policy instrument to incentivize them. Country participants conducted a preliminary assessment of potential private sector implementation partners as preparation for this workshop. During this session, country teams compiled and assessed this information. They also discussed which policy instrument to use with the implementation partners.

3.2 SUMMARY OF COUNTRY ACTION PLANS

GOALS AND OBJECTIVES

<table>
<thead>
<tr>
<th>Goal/objective</th>
<th>Country/Approach</th>
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| Scale up ART through private sector | **Ethiopia:** Policy reform, subsidized commodities, and contracting out with private sector clinics  
**Nigeria:** Exploration of appropriate PPPs with private providers  
**Kenya:** Policy reform and examine market-based incentives such as vouchers and contracting out to incentivize private providers  
**Tanzania:** Building/refurbishing 100 rural clinics |
| Increase FP coverage through private providers | **Ghana:** Integration of FP into HIV/AIDS services in private sector; scale up Marie Stopes franchise, and policy reform  
**Kenya:** Policy reform and examination of market-based incentives such as vouchers and contracting out to incentivize private providers  
**Nigeria, Ghana:** Inclusion of FP services and products in national health insurance schemes (NHIS) |
**COMMON AREAS IN COUNTRY ACTION PLANS**

Certain key themes and common areas emerged from the six country action plans. One of the major themes to surface at the workshop was a strong desire to integrate — both forward and backward — FP into HIV/AIDS services. All the countries are moving toward a comprehensive package of services for women that capitalizes on any health event to introduce another (e.g., offer women FP methods when they come in for prevention of mother-to-child transmission). Additionally, the country teams were seeking opportunities to use the great influx of HIV/AIDS funds to strengthen other service systems, particularly FP and maternity services. The strong focus on integration might have been due to the fact that both the FP and HIV/AIDS directors were present at the workshop and worked together on private sector issues with the private sector adviser.

Another common area among the plans was recognition of the need to engage and co-opt a wide range of stakeholders. All country plans included a formal debriefing with MOH colleagues to share workshop materials and to inform them of the proposal to involve the private health sector as partners. All recognized the importance of building support with internal constituencies that may be critical and resistant as the MOH moves to implement the private sector action plan. Key internal constituents identified included the Regulatory and Quality Assurance Departments and Policy and Planning Departments. Others also planned to reach out to the Ministries of Finance and of Trade and Development to build support for their private sector action plans. Also, all country action plans included some form of a dialogue process bringing together a wide range of private sector and public sector stakeholders.

Furthermore, all country action plans included conducting analyses to assess and better understand private sector capabilities. Many countries expressed frustration at not having a clear picture of who all the private sector actors are and the absence of mature organizations representing private sector interests. Also, many were concerned that their current private sector partners, such as professional associations, may not truly be representative of the private health sector and were looking for new strategies to identify “true” private sector leaders and representatives. Moreover, some of the plans included steps to prepare and get organized to work with private sector. Examples of types of analyses many of the countries plan to undertake include: (i) costing studies; (ii) feasibility studies; (iii) private provider and pharmacy mapping; and (iv) policy reviews.

**THEMES/PROBLEMS SPECIFIC TO CERTAIN COUNTRIES**

There were countries that identified similar problems and actions to address them:

- Redoubling advocacy efforts to ensure FP services and commodities are included as reimbursable expense in NHIS (Nigeria and Ghana)
- Examining the private sector's role in ensuring contraceptive security (Ghana and Uganda)
- Strengthening the PPP unit's role within the MOH at both national and district levels (Nigeria)

### 3.3 COUNTRY ACTION PLANS

#### SUMMARY OF COUNTRY ACTION PLANS

<table>
<thead>
<tr>
<th>ETHIOPIA</th>
<th>Objective</th>
<th>Actions</th>
</tr>
</thead>
</table>
| Scale up ART in 20 clinics covering 2,600 patients by 2008 | - Conduct cost study to understand cost of delivery of service in private sector setting  
- Identify providers and secure commitment  
- Identify public sector leaders and secure commitment  
- Provide training to clinic staff  
- Reform needed policies to permit clinics to deliver ART  
- Align and implement monitoring and evaluation  
- Secure funds for project | - Convene regional health bureaus to share plan  
- Conduct planning meeting with Medical Association for Physicians in Private Practice-Ethiopia (MAPPP-E) regarding project  
- Carry out consultative process with key stakeholders  
- Conduct variety of studies  
- Convene planning meeting with key stakeholders |

<table>
<thead>
<tr>
<th>NIGERIA</th>
<th>Objective</th>
<th>Actions</th>
</tr>
</thead>
</table>
| No goal stated | - Link private providers to subsidized FP products  
- Encourage PPPs between public and private facilities  
- Reimburse FP products and services through NHIS  
- Build trust between public and private health sectors  
- Secure universal access to ART | - Debrief and disseminate new ideas from workshop with MOH colleagues  
- Conduct stakeholder meetings  
- Develop operating guidelines for PPPs - roll out in phases and scale up |
### GHANA

<table>
<thead>
<tr>
<th>Goal</th>
<th>Objectives</th>
<th>Actions</th>
</tr>
</thead>
</table>
| Increase role of private sector in FP | • Increase coverage of integrated RH/FP/HIV/AIDS services  
  • Facilitate franchising strategy of Marie Stopes International (MSI) and Ghana Social Marketing Foundation (GSMF)  
  • Increase contraceptive security by exploring private sector contribution  
  • Strengthen advocacy to include FP products in NHIS  
  • Strengthen integration of FP into HIV/AIDS services | • Debrief colleagues at MOH on workshop lessons learned and action plan  
  • Increase dialogue with private sector on key topics  
  • Redouble advocacy efforts with NHIS  
  • Review policies to identify barriers to greater private sector participation |

### KENYA

<table>
<thead>
<tr>
<th>Goal</th>
<th>Objectives</th>
<th>Actions</th>
</tr>
</thead>
</table>
| No goal stated                | • Increase access to FP  
  • Increase access to skilled birth attendants  
  • Increase access to youth-friendly services  
  • Increase access to ART  
  • Increase access to prevention of mother-to-child transmission | • Increase dialogue with the private sector  
  • Examine market-based incentives to motivate private sector  
  • Reform policies to incentivize private sector  
  • Link and dialogue with other MOH departments that will have an impact on private sector  
  • Look for opportunities to contract out some services or part of health services |
### TANZANIA

<table>
<thead>
<tr>
<th>Goal</th>
<th>Objectives</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involve the private sector in the national health services and infrastructure</td>
<td>• Increase client services in hard-to-reach areas through building/refurbishing 100 facilities by 2011</td>
<td>• Lead a consultative process with key private and public sector actors to build support for project</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Identify and negotiate with private sector providers to deliver these services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Plan for project roll-out</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Conduct feasibility study</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Identify performance targets</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Develop guidelines</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Conduct costing study for services</td>
</tr>
</tbody>
</table>

### UGANDA

<table>
<thead>
<tr>
<th>Goal</th>
<th>Objectives</th>
<th>Actions</th>
</tr>
</thead>
</table>
| Improve contraceptive security through PPPs | • Establish efficient delivery mechanism for different segments of the market  
• Contract company to deliver FP products  
• Train private companies  
• Improve skills and capacity to make medium- and long-term projections of contraceptive needs | • Conduct market segmentation analysis  
• Map providers  
• Conduct feasibility study of contracting private distributor and/or company for any aspect of supply chain  
• Conduct consultative process of results of analysis  
• Provide training in commodity forecasting  
• Identify incentive mechanisms to motivate private distributors to work in rural areas |
4. LAUNCH OF THE NETWORK FOR AFRICA

The Addis workshop also served as the launch for the Network for Africa that PSP-One will manage. The participants provided input on network objectives and types of activities desired. (See Annex J for a more detailed discussion of the Network for Africa.)

PURPOSE OF NETWORK

All the participating countries agreed enthusiastically to create a network to keep the groups together. The purpose of the Network is to: (i) foster the exchange of experiences; (ii) share tools and materials; and (iii) build MOH capacity to work with the private health sector.

NETWORK MEMBERS

Initially, the Network will comprise the Addis meeting participants. Participants will invite others from their ministries to visit the Web site (www.network4africa.com) and to become active in future Network activities. Depending on participation, Network organizers may expand the membership to include other relevant ministries (Finance, Trade and Development, etc.) and private sector counterparts.

NETWORK FOR AFRICA ACTIVITIES

Participants put forth the following types of activities that could add value to their work with the private health sector: (i) share information, tools, and methodologies; (ii) build skills through workshops; (iii) build skills through study tours; (iv) build skills through long-distance learning (virtual learning development program); and (iv) network and mentor members working on private health sector initiatives. (See Annex J for in-depth description of activities.)
5. PRIVATE SECTOR OPPORTUNITIES IN AFRICA

The Addis workshop revealed a growing enthusiasm and interest among African MOHs to work with the private sector. This change in perspective presents an exciting opportunity for USAID and the donor community to further support the public sector’s efforts to harness and grow the private health sector. The country action plans show that the MOHs require continued technical assistance and financial support if they are going to realize their full potential as stewards of the private health sector. In addition, all the participating countries agreed enthusiastically that creating a Network for Africa would be an effective mechanism to strengthen their understanding of and capacity to work with the private health sector.

5.1 DEEPEN MOH SKILL BASE TO WORK WITH THE PRIVATE HEALTH SECTOR

The Addis workshop was primarily a survey course designed to provide an overview of the different policy/program options available to MOHs in their stewardship role. All of the country teams indicated a strong desire to develop their skills in four technical areas: (i) demand-side initiatives such as vouchers and cash transfers; (ii) performance-based contracting for health services; (iii) analytical strategies to identify and assess private sector capacity; and (iv) stakeholder engagement and structuring a formal dialogue process. There are numerous ways to support country’s capacity building in these technical areas.

- **Implement country-level workshops** similar to the Addis workshop. Many of the participants expressed a keen interest to replicate the Addis workshop in their countries for several reasons: (i) to increase knowledge of the private sector among a greater number of MOH staff; (ii) to bring private sector representatives to the workshop to discuss how the MOH and private sector can work together; and (iii) to build a joint action plan that includes private health sector input and buy-in.

- **Provide resources to attend workshops** offered on the four technical areas identified by the Addis participants. Several bi- and multi-lateral donors offer workshops on a range of technical topics targeted to MOHs. For example, the World Bank will offer two workshops in Africa, one in July and a second in September, on performance-based contracting.

- **Support targeted technical assistance to assist countries to implement their action plans.** In developing their country action plans to work with the private health sector, several countries also identified technical assistance needs to help them implement the proposed activities. A few examples of technical assistance needs are: (i) Uganda requested technical assistance on how to conduct a market segmentation analysis and develop a whole-market strategy to ensure contraceptive security; (ii) Ethiopia and Nigeria identified advocacy and partnership processes as their technical assistance need; and (iii) Ethiopia, Ghana, and Tanzania requested technical assistance to review and update current MOH regulations to permit greater private sector provision of health services.
• **Support Network countries’ ability to provide technical assistance to each other through study tours.** There is a nascent and growing experience in working with the private health sector among the Network countries. Donor funds could be used to support south-to-south transfer of knowledge, tools and methodologies, and “know how” by facilitating study tours between countries. The table below provides an overview of opportunities.

<table>
<thead>
<tr>
<th>Country</th>
<th>Leadership area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nigeria</td>
<td>• Quality assurance in the private sector</td>
</tr>
<tr>
<td></td>
<td>• Insurance to pool resources and organize private providers</td>
</tr>
<tr>
<td>Kenya</td>
<td>• Vouchers to stimulate demand for maternal-neonatal health (MNH)/FP and sexually transmitted infection services and pay private providers</td>
</tr>
<tr>
<td>Uganda</td>
<td></td>
</tr>
<tr>
<td>Ghana</td>
<td>• Different models of private health sector policy and legal framework and different organizational approaches to PPP units</td>
</tr>
<tr>
<td>South Africa</td>
<td></td>
</tr>
<tr>
<td>Uganda</td>
<td>• Donated ART drugs and other HIV/AIDS-related commodities to quality private providers</td>
</tr>
<tr>
<td>Kenya</td>
<td></td>
</tr>
<tr>
<td>Nigeria</td>
<td></td>
</tr>
</tbody>
</table>

• **Pairing of countries working on the same technical issue.** Another approach is to support exchange of strategies and approaches among two to three countries struggling with the same issues. Nigeria and Ghana have both identified the need to re-double their advocacy efforts with their NHIS to include FP services and products. Kenya and Nigeria want to expand the role of the PPP units within their ministries.

5.2 BUILD A KNOWLEDGE BASE OF PRIVATE HEALTH SECTOR APPROACHES IN AFRICA

A critical contribution to building the knowledge of MOHs as well as the international health community would be documentation of the more promising approaches currently underway. Examples would include: (i) voucher programs for MNH services in Kenya and Uganda; (ii) quality assurance program in the State of Lagos, Nigeria; and (iii) NHIS in Nigeria and Ghana. Another contribution would be a series on in-depth analysis on topic areas of interest for the MOHs.

• **Approaches to quality improvement** in the private health sector. Some of the most promising strategies include: (i) the creation of a third-party NGO in Lagos to monitor quality in both the public and private sectors; (ii) quality assurance systems in private provider networks (Kenya, Ghana); (iii) partnerships with professional associations; (iv) harmonization of regulations to expand private sector scope in RH/FP and HIV/AIDS (Ethiopia, Zambia); and (v) inclusion of private providers in public sector training and supervision systems (Ethiopia). Documentation of these
approaches would include a summary of how it was implemented, the strengths and limitations of each approach, and a discussion on when to use which approach.

- **PPP units.** All of the MOHs present at the Addis workshop have a PPP unit and/or a PPP adviser to guide MOH policy and programs with the private and NGO sectors. The objective of a policy brief on PPP units in Africa would be to share different models and to discuss the strengths and weaknesses of each to guide MOH development and design of PPP units. A policy brief would discuss and compare: (i) the process/conditions creating the change in MOH perspective and policy to include the for-profit health sector; (ii) the range of MOH private sector policy objectives; (iii) the PPP unit/adviser terms of reference; (iv) a description of the PPP unit/adviser organizational structure within the MOH; and (v) an overview of roles and responsibilities and linkages inside/outside the MOH.

- **Private sector policy frameworks.** Many of the countries at the workshop identified insufficient and/or outdated policy frameworks as a barrier to working with the private health sector. Pulling all these policies and regulations together and analyzing them would provide an invaluable resource to other African countries that are exploring how to develop the policy and regulatory framework supporting a greater private sector role.

### 5.3 INVEST IN PRIVATE SECTOR INNOVATIONS

The two most exciting initiatives were proposed by Kenya and Uganda in their country action plans. These initiatives warrant substantial investment to help the countries implement them because they could provide important information for other countries on how to design, implement and scale up these kinds of initiatives.

- **Evaluate the Kenya MNH voucher experience.** The Kenyan MOH has just completed an evaluation of the pilot voucher program. The preliminary results indicate that the voucher program has achieved its stated objectives, and therefore the MOH is planning to scale-up this initiative. A significant donor investment could help the Kenyan MOH in the following areas: (i) disseminate the results and lessons learned of the pilot project; (ii) assist in the design to scale up the pilot nationwide; (iii) document the scale-up process and the tools and instruments used; (iv) evaluate the scale-up process and nationwide voucher program; and (v) write a paper to be published in a peer-reviewed journal. Additional donor funds could help pay for the voucher subsidies for the private health sector.

- **Document the Uganda market development approach.** Uganda may be the first country to agree to apply the market development approach. The objective of the total-market initiative would be to facilitate market segmentation with a broad range of in-country stakeholders from the public and non-public sectors with a view to ensuring that all individuals within Uganda are able to obtain and use the RH commodities of their choice when they need them. Donor funds would help the Ugandan MOH to carry out: (i) the formative research to identify market segments; (ii) the consultative process and forums of all the stakeholders to reach agreement on roles and responsibilities; (iii) implementation of activities such as advocacy around segmented approaches and the continual renewal of consensus on matching providers to segments, demand creation for generic RH products, targeted subsidy schemes, and supportive advocacy and policy work; and (iv) definition of indicators against which to monitor progress and the capturing and dissemination of lessons learned from the market development approach.
6. CONCLUSIONS AND NEXT STEPS

As the workshop evaluations demonstrated, the participants found the themes of public sector stewardship and partnering with the private health sector to be timely and relevant to their day-to-day work. Many of the participants are currently working with the private health sector in the areas of RH/FP and HIV/AIDS in exciting and new ways. Countries are experimenting with strategies on how to ensure quality in the private sector, others are using innovative financing and risk-pooling mechanisms to organize and motivate the private health sector to deliver preventive services, while others are learning how to work with the private health sector through partnerships and dialogue to better understand each other and to build trust.

Many challenges remain, however, in harnessing and growing the private health sector in Africa. All of the participants indicated a need for further skills and capacity building in how to get started and maintain productive relationships with the private health sector. Additionally, many of the MOH representatives present requested training in specific technical skills areas as part of their stewardship role. There is insufficient documentation on, and evidence of, the private sector contributions to RH/FP and HIV/AIDS. Clearly, the six countries present are doing a lot of different and exciting work with the private health sector, but much of the information and experience does not go beyond their own country. Moreover, the tools and methodologies used with the private health sector are constantly being “reinvented” because of the absence of sharing and experiential learning. Finally, many of the examples of PPPs are still in exploratory or pilot stages and need considerable investment to go to scale in order to realize the full potential of private sector contribution. The Network for Africa provides an ideal platform to address many of these challenges.

The workshop participants presented a clear agenda on what is needed to support and advance greater partnerships with the private health sector:

1. Strengthen African MOHs’ capacity to harness and grow the private health sector
2. Build a knowledge base of African experience in working with the private health sector
3. Invest in promising private health sector approaches

Now the challenge is to mobilize the resources to support African MOHs’ agenda to move forward in their work with the private health sector as a strategy to increase access to RH/FP and HIV/AIDS services.
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ANNEX B: WORKSHOP DESCRIPTION AND METHODOLOGY

OVERVIEW OF ADDIS ABABA REGIONAL WORKSHOP

The Addis workshop endeavoured to advance universal access to RH/FP and HIV/AIDS services through more effective engagement with the private health sector in Africa. The purpose of the workshop was to develop national capacity to design and manage partnerships with private sector stakeholders and provide an overview of the selected policy instruments commonly available to MOHs and PPP units. The workshop curriculum was based upon a World Bank Institute course on public policy for the private sector, which was revised for the African context and substantially updated with new information to reflect current trends in private sector provision of RH/FP and HIV/AIDS services.

WORKSHOP OBJECTIVES INCLUDED:

• Developing existing public sector capacity to engage the private sector in the provision of RH/FP and HIV/AIDS-related services in selected Anglophone African countries

• Creating a network for experiential learning across countries on challenges in strengthening PPPs for RH/FP and HIV/AIDS

• Strengthening existing relationships and linkages across priority programs within African MOHs to work effectively with the private sector in support of national health goals (in general) and RH/FP (in particular)

• Identifying key actions and important next steps for participant countries to design, develop, and manage PPPs following the workshop

PARTICIPATING COUNTRIES

The criterion used to select countries was the existence of an active MOH official, PPP unit, or private sector policy and/or strategy. Teams of MOH officials from Ethiopia, Ghana, Kenya, Nigeria, Tanzania, and Uganda attended the Addis workshop. The teams comprised: (i) the RH/FP director; (ii) the HIV/AIDS director; and (iii) the PPP unit director and/or PPP adviser. In addition, several USAID HPN officers and PEPFAR PPP advisers from these countries attended.

OVERVIEW OF WORKSHOP AGENDA

The workshop was designed around three thematic areas:

1. Making the case for why it is important to work with the private health sector as a means to help address health challenges in RH/FP and HIV/AIDS. In recent years, there has been a growing body of evidence confirming the size and scope of the private sector contribution to health care services in Africa. A recent International Finance Corporation report (IFC 2007) states that, of the total health expenditures in Africa of $16.7 billion in 2005, roughly 50 percent was financed by private parties – predominantly out-of-pocket payments by individuals – and about 50 percent of that was captured
by private providers. Moreover, the PSP-One project and WHO have done analyses of DHSs and other data sources such as National Health Accounts to further highlight how many Africans are seeking RH/FP and HIV/AIDS services in the private sector. At the workshop, participants learned about the evidence demonstrating the private health sectors’ current and growing contribution to priority health services and discussed strategies for how to make this information more visible among African MOHs.

2. **Offering a concise overview of the policy instruments the public sector can utilize to engage and encourage the private health sector to deliver RH/FP and HIV/AIDS services.** The private sector, especially the commercial for-profit health sector, responds to market conditions, profit opportunities, and perceived risk and loss. The public sector can play an important policy and regulatory role by encouraging reforms that influence pricing and market size and demonstrate to the private sector that favorable market conditions exist. Moreover, the public sector needs to play a regulatory role, ensuring that quality services are provided by the private sector. The “toolkit” of policy instruments available to the public sector includes creative financing mechanisms, contracting for health services, regulation of health services, and quality assurance. The challenge therefore is to balance regulations and policies aimed at quality control while simultaneously creating market conditions conducive to private sector participation. The majority of the technical sessions focused on the range of policy instruments and discussion on how and when to use them to support RH/FP and HIV/AIDS programs.

3. **Designing a partnering process while, at the same time, stressing the management and leadership skills required to implement and sustain a PPP.** Experience from those who have been in the forefront of innovative partnerships has shown that partner initiatives that engage different stakeholders in health can be highly effective and sustainable when designed, developed, and managed in a systematic way. The partnership process is outlined in Figure B-1. The workshop dedicated three technical modules to partnerships and offered a concise overview of the essential elements that make for an effective partnership, highlighting the need for management and leadership skills to enable partners to work well together effectively.

**Figure B-1. Twelve Steps to Partnering Cycle**

![Figure B-1. Twelve Steps to Partnering Cycle](source: Partnering Toolbook, IBLF)
Table B-1 is an overview of the workshop schedule. The WHO country representative and USAID/HPN officer made statements to open the workshop. There were three technical tracks in the workshop: (i) policy track, (ii) partnership track, and (iii) planning track. To provide participants with the necessary technical information in the policy and partnership track, each technical module involved a presentation.

**TABLE B-1: BUILDING PUBLIC-PRIVATE LINKAGES TO ADVANCE PRIORITY HEALTH SERVICES IN AFRICA**

<table>
<thead>
<tr>
<th>Time</th>
<th>Wednesday - May 7</th>
<th>Thursday - May 8</th>
<th>Friday - May 9</th>
<th>Saturday - May 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 - 8:45 am</td>
<td>Welcome Official welcome to Workshop</td>
<td>Welcome Review of day's agenda</td>
<td>Welcome Review of day's agenda</td>
<td>Welcome Review of day's agenda</td>
</tr>
<tr>
<td>8:45 - 10:15 am</td>
<td>Module #1: Presentation and Q&amp;A in plenary “Trends in private provision of priority health services” <strong>Barry Kistnasamy</strong></td>
<td>Module #4: Presentation Working Group discussion “Introduction to financing mechanisms to mobilize the private health sector” <strong>Allison Gamble Kelley</strong></td>
<td>Module #7: Presentation and Q&amp;A session “Creating legal and regulatory environment supportive of the private health sector” <strong>Rich Feeley</strong></td>
<td>Progress report: Country teams reporting out, sharing plan</td>
</tr>
<tr>
<td>10:15 - 10:30 am</td>
<td>Coffee Break</td>
<td>Coffee Break</td>
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<tr>
<td>10:30 am - 12:00 pm</td>
<td>Module #2: Presentation “Government as a steward of private health sector” <strong>Dale Huntington</strong></td>
<td>Module #5: Presentation Working Group discussion “Introduction to contracting of health services provided by the private sector” <strong>Barry Kistnasamy</strong></td>
<td>Module #8: Presentation Working Group discussion “Assuring quality in the private health sector” <strong>Allison Gamble Kelley</strong></td>
<td>Plenary discussion Next steps: Launching Network for Africa: Public-Private Linkages for Health <strong>Barbara O’Hanlon</strong></td>
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<tr>
<td>12:00 - 1:00 pm</td>
<td>Lunch</td>
<td>Lunch</td>
<td>Lunch</td>
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<tr>
<td>1:00 - 2:30 pm</td>
<td>Module #3: Presentation Working Group discussion “Introduction to contracting of health services provided by the private sector” <strong>Sharon White</strong></td>
<td>Module #6: Presentation Working Group discussion “Management and leadership skills needed to manage partnerships” <strong>Karen Sherk</strong></td>
<td>Module #9: Panel discussion in plenary “Private health sector perspective on implementation challenges with the public sector” <strong>Barry Kistnasamy</strong></td>
<td>Concluding Remarks WHO - <strong>Dale Huntington</strong> USAID - <strong>Alex Todd</strong> Participants</td>
</tr>
<tr>
<td>2:30 - 2:45 pm</td>
<td>Coffee Break</td>
<td>Coffee Break</td>
<td>Coffee Break</td>
<td>Afternoon free</td>
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<tr>
<td>2:45 - 4:45 pm</td>
<td>Working Group Session #1: Country Teams: Identify and agree on FP and/or HIV/AIDS priority for private health sector</td>
<td>Working Group Session #2: Country Teams: Identify potential partners and steps to build the partnership</td>
<td>Working Group Session #3: Analysis of private health sector with stated objective and exploring possible policy mechanisms</td>
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<tr>
<td>4:45 - 5:00 pm</td>
<td>Wrap up day</td>
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<td></td>
<td>Welcome Reception at Fasika Restaurant</td>
<td>OPEN</td>
<td>Farewell Reception at Makush Restaurant</td>
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</table>
followed by group discussions led by a technical expert in the topic area. To help structure the group discussions, the technical experts prepared a case study based on mostly African examples in each of the topic areas. (See Annex G: session briefs that describe each of the technical modules.) The participants enjoyed the case study methodology; the case studies were instrumental in encouraging all participants to speak up in the small group discussions after each technical module.

Given the range of technical topics covered in the workshop, the workshop organizers assembled a team of technical experts to cover the policy and partnership tracks.

For the planning track, participants were organized by country teams. Over the course of the workshop, the country teams carried out a “hands-on” exercise to plan how they will engage the private health sector when they return to their respective countries. By the end of the workshop, each country group had a plan to start the engagement process with the private health sector. The plan: (i) articulated RH/FP or HIV/AIDS priority to be the scope of the partnership; (ii) identified which organizations will become partners and the resources they can bring to the partnership as well as the steps to confirm each partners’ participation; and (iii) mapped out the next steps for engaging these potential partners in which the teams will structure the partnership process and develop the “rules of the road” for the partnership.
ANNEX C: SESSION OVERVIEW ON THE CASE FOR WORKING WITH THE PRIVATE HEALTH SECTOR

WHY PARTNER WITH THE PRIVATE HEALTH SECTOR?

The first presentation set the stage by introducing the participants to the latest data presented in the recent IFC report, *Investing in the Business of Health in Africa* (IFC 2007 and Marek 2005). The data demystified some of the common misperceptions surrounding the private health sector in Africa.

1) Myth 1 - Health care is primarily financed by public funds from the government

FIGURE C-1. WHO PAYS FOR HEALTH CARE IN AFRICA?

As Figure C-1 illustrates, of the approximately $16.7 billion spent annually in health care in Africa, about 40 percent comes from the public sector while 50 percent comes from payments from individuals and families. Furthermore, of the $8.5 billion spent by individuals and families, approximately 50 percent of that amount, $4.3 billion, is spent in the private health sector, and the majority of that is spent on health care delivered by for-profit providers (IFC 2007).

2) Myth 2 - The private health sector in Africa is insignificant

FIGURE C-2. THE SIZE OF THE PRIVATE HEALTH SECTOR IN AFRICA

Consistent with international trends, the 5 percent growth in gross domestic product (GDP) in Africa will drive a greater demand for health care and an increase in per capita spending on health goods and services. As Figure C-2 illustrates, actual total health expenditures of $16.7 billion spent in 2005 are expected to more than double, to $35 billion, by 2016. Private health expenditures will also grow dramatically during this time period (IFC 2007).
3) Myth 3 - Only the wealthy and urban populations seek health care in the private health sector

**FIGURE C-3. USE OF PRIVATE SERVICES FOR DIFFERENT SYMPTOMS**

The private sector, therefore, constitutes an important, diverse component of Africa's health care systems, with the potential for complementary solutions. The private health sector has a positive role to play in the broader context of strengthening the African health care systems by expanding access and improving quality and efficiency. Following are some reasons why to partner with the private health sector.

**Public-private partnerships (PPPs) can help expand the pool of human resources:** The public and private sectors can work together to create a supportive environment that encourages medical professionals to stay in their home country instead of leaving for professional opportunities elsewhere. Also, the public sector can increase the number of trained professionals working in a country by simply including private providers in its training programs. Private providers could then apply their new knowledge and skills to the benefit of their clientele.

**The private health sector can extend the reach of the public sector:** With the HIV/AIDS crisis, there is growing recognition that all service providers must be mobilized and harmonized to cope with the epidemic. MOHs can play an important role in encouraging the private sector to address this public health emergency by setting standards and monitoring the quality of care so that public health goals can be reached. Many private clinics run by companies and non-profit organizations operate in isolated areas. The public sector can extend its reach into these areas at a lower cost by contracting out public sector services to these clinics. For distribution of health products, social marketing, and other services, private sector partnerships can ensure wider and more reliable access to urgently needed health services and products.

**PPPs allow the public sector to focus on those most in need:** Currently, public health service provision in sub-Saharan Africa is imperfectly targeted, more often benefiting the wealthier population groups than the poorer ones, raising issues of equity and efficiency. The public sector can create policies and incentives that would encourage those who could afford to pay to go to the private sector for their health needs, thereby freeing up much needed resources for the public sector to focus on priority services for segments of the population that cannot afford to pay.

Source: Marek 2005
Private sector services and products require little support from donors and government budgets: The advantage of the private sector is that it is self-sustaining because it leverages consumers’ willingness to pay and is able to offer products and services at affordable prices. Profit made by private sector providers sustains the provision of health services over time and encourages more people to invest in the health sector.

Why the private health sector and RH/FP?

FIGURE C-4. PRIVATE SECTOR PROVISION OF FP SERVICES IN AFRICAN COUNTRIES REPRESENTED AT THE WORKSHOP

![Graph showing contraceptive prevalence rates in African countries]

The private sector plays an important role in the delivery of FP services. Figure C-4 demonstrates the public and private contribution to modern methods. As the data from the most recent Demographic and Health Surveys (DHS) demonstrate, the private sector is a major source of FP services and methods in countries like Ghana, Kenya, Nigeria, and Uganda (DHS 2003, 2004, 2005, 2006).


FIGURE C-5. PRIVATE SECTOR PROVISION OF DELIVERIES IN AFRICAN COUNTRIES REPRESENTED AT THE WORKSHOP

![Bar chart showing location of deliveries]

Similar data from DHS reveal that the private sector is also an important source of maternity services (Figure C-5); although the majority of these services is provided by midwives in the public sector (DHS 2003, 2004, 2005, 2006).

Despite the positive role of the private sector, much remains to be done to improve RH/FP services. Contraceptive prevalence is very low in all the countries participating in the workshop (Figure C-6). Modern method use ranges from as low as 9 percent in Nigeria and Ethiopia to 23 percent in Kenya (DHS 2003, 2004, 2005, 2006).

Moreover, unmet need for FP methods remains very high in Africa. Looking at the countries represented at the workshop (Figure C-7), Nigeria has the lowest percentage of married women of reproductive age (MWRA), with unmet need (17 percent) compared with Uganda (40 percent). Unmet need is highest among women who want to space compared with women's desire to limit (DHS 2003, 2004, 2005, 2006).
All the workshop countries – Ethiopia, Ghana, Kenya, Nigeria, Tanzania, and Uganda – have not experienced a significant decline in fertility since the last DHS (Table C-1). Consequently, it is imperative for all African countries to re-double their efforts to address the high unmet need of African families for FP services and products. Working with the private health sector is one strategy that can complement MOHs’ efforts to satisfy African couples’ desire to plan their families.

**TABLE C-1. CHANGES IN FERTILITY SINCE MOST RECENT DHS IN SUB-SAHARAN AFRICA**

<table>
<thead>
<tr>
<th>No significant decline in fertility</th>
<th>Significant decline in fertility</th>
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<tbody>
<tr>
<td>Cameroon</td>
<td>Nigeria</td>
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<td>Cote d’Ivoire</td>
<td>Rwanda</td>
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<td>Ethiopia</td>
<td>Tanzania</td>
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<td>Ghana</td>
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<td>Kenya</td>
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<td>Namibia</td>
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<td>Niger</td>
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<td>Senegal</td>
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ANNEX D: DEFINITIONS OF KEY CONCEPTS FOR THE WORKSHOP

During the introduction of the workshop, the participants discussed the meaning of several core concepts to be used throughout the workshop in order to create a common understanding and shared language. The key concept of stewardship had its own session to define what it means to be stewards of the private sector. (See Annex E.)

ELEMENTS OF A PPP IN HEALTH

The first concept centered on PPPs. The development field uses a range of terms to describe partnerships in health, including public-private interactions (PPIs), public-private product development partnerships (PPPDPs), and public-private mix (PPM). All agreed that PPPs is the term most frequently used by the international health community. Below is a list of the common elements of a PPP in health:

1. Collaboration with private partner(s)
2. Work together to achieve common objective (public health good)
3. Share risks and rewards
4. Aim to leverage comparative advantage and use effectively each partner’s resources
5. Strengthen the entire health system - building blocks

WHOLE-MARKET APPROACH

Another important concept discussed was the “whole-market approach” or “integrated health systems.” Simply stated, a whole-market approach recognizes the presence and contribution of a wide range of actors in the health system. The health system is organized into three sectors: (i) public or government sector; (ii) not-for-profit sector comprised of NGOs, private voluntary organizations, and, most importantly in Africa, FBOs; and (iii) for-profit sector or commercial sector (Figure D-1). Since the United Nations-sponsored International Conference on Population and Development in 1994, MOHs have increasingly recognized and worked collaboratively with a wide range of NGOs to deliver both services and products. Today, the challenge for MOHs is to move beyond working with NGOs and to consider strategies on how to integrate the for-profit health sector.

FIGURE D-1. SECTORS OF THE HEALTH SYSTEM

- Public Sector
- For-Profit Sector
- Not-for-Profit Sector
FOR-PROFIT COMMERCIAL SECTOR

The third concept reviewed at the workshop was “private health sector.” Figure D-2 illustrates the range of entities that constitute the for-profit private health sector – including some whose core business is not health. To help organize the numerous players, there are three activities which private entities engage in related to health: (i) the direct provision of private health services; (ii) the provision of health products through private channels; and (iii) the financing of health services.

FIGURE D-2. OVERVIEW OF FOR-PROFIT PRIVATE HEALTH SECTOR

There is a variety of formally trained and licensed private health care providers, including private doctors, nurses, midwives, and paramedical staff (such as clinical officers and physician assistants), who deliver essential health services. Private pharmacists and drug sellers also are critical in developing countries, as they are often first-line providers in the formal health sector that serves poor and remote population groups. In addition, there is an active informal health sector that consists of traditional healers, midwives, traditional birth attendants, and market drug sellers. The informal sector is an important, if not well documented, source of health care, particularly among rural and poor populations in developing countries. For example, the aforementioned IFC report states that approximately 10 to 20 percent of private health expenditures are captured by the informal health sector in Africa.

These private providers, whether formal or informal, deliver their services in a variety of venues. An individual private practice can be offered in a simple facility as small as a single room in a provider’s home or in a state-of-the-art clinic. Other services are delivered in private clinics and hospitals owned...
by provider groups or businesses that offer an array of health services. Many businesses and industries offer health care services through company clinics.

The pharmaceutical industry, both internationally and locally, has a key role in the manufacture and distribution of health products. Wholesalers and distributors ensure that products reach retailers, often retailers in remote areas. Retail outlets—an important segment of the private health sector—include pharmacies, over-the-counter drug shops, medicine and chemist shops, supermarkets, corner groceries, market stalls, and kiosks. There is also an informal sector for health products, particularly drugs. The poor quality of some drug products in the private sector is creating other health problems, such as drug resistance in malaria and HIV/AIDS.

Who finances private health services and products is also important to understand. In most developing countries, private expenditure is the leading form of payment for health services. In Africa, for example, the majority of health care services are funded by individuals (either through taxes or out-of-pocket payments). In addition, some employers directly fund health care for their employees either through a company clinic or by purchasing health insurance for them.

MARKET SEGMENTATION

Market segmentation analysis and whole-market strategies recognize there is a multiplicity of health needs in a country and ensure that the entire market of providers and clients are covered and included. Planning and implementing a whole market approach first requires sound empirical analysis. A market segmentation study identifies:

- **Who** provides key health services – public, private, NGO - providers
- **What** health services and products – FP/RH, HIV/AIDS, others
- **What** populations groups – i) by socio-economic characteristics, income levels, education levels, geographic location, age/sex; ii) by consumer preferences, such as types of providers (male vs female, public vs private)
- **Who** pays for these services

Market segmentation permits the MOH, in partnership with the private sector, to determine appropriate roles and responsibilities.
ANNEX E. GOVERNMENT AS THE STEWARD FOR THE PRIVATE HEALTH SECTOR

The concept of stewardship and the evolving model of public sector governance of the private sector was the focus of a third presentation. Below are the key points presented on this essential topic germane to the MOH participants’ mandate.

WHY MINISTRIES OF HEALTH NEED TO BE PROACTIVE

There is a variety of reasons why the public sector in Africa needs to respond to the growing presence of a private health sector there. The most commonly cited reason is concern about quality of care (malpractice, failure to adhere to standards and norms, quality of drugs). The public sector is also suspect of the private sector’s profit motive, referring to the practice of over-charging, refusal to treat the poor, and other unethical practices that further fuel the mistrust between the two sectors.

It is interesting to note that the points driving the public sector response to the private health sector typically center upon the private health sector’s shortcomings, often involving policy responses focused on controlling the private sector through regulations. The desire to control the private sector stems from a lack of trust between the two sectors and the fact that there is little dialogue and/or communication between these sectors.

To develop effective PPPs in health, MOHs need to change the focus and how they engage the private sector to maximize its potential to support national health goals while limiting negative consequences. To build effective PPPs, MOHs need to create a paradigm shift from “controlling” to “partnering” with the private health sector. MOHs have many technical interventions and policy instruments to stimulate and encourage private sector behavior; equally important, however, is the relationship and quality of engagement between the MOH and the private sector. Therefore, stewardship requires both technical and partnership capacities.

DEFINITION OF STEWARDSHIP

So what is meant by stewardship exactly? Stewardship and its related concept of governance can be used to characterize what should be done as well as how things should get done. Stewardship is an element of governance, but the two terms are not synonymous: governance is broader in the sense that it reflects actions to affect the environment in which the health sector operates, including normative/cultural elements and systems of governance. Stewards of the health system have the responsibility to ensure the health system operates according to governance principles, i.e., its instrumental effectiveness. The six key functions of stewardship identified by the WHO are listed in Box E-1.

BOX E-1.WHO: SIX FUNCTIONS OF STEWARDSHIP

- Generating intelligence
- Formulating strategic policy framework
- Ensuring tools for implementation: powers, incentives, and sanctions
- Building coalitions and partnerships
- Ensuring a fit between policy and organizational structure, culture
- Ensuring accountability

Source: Travis et al. 2002
TOWARD A NEW MODEL OF STEWARDSHIP

International experience suggests a need for a continued and significant role of the state in the health sector. Indeed, the challenge is to find complementary roles. But there are numerous sources of doubt concerning the effectiveness of many governmental interventions aimed at producing health services. For reasons that are both ideological and also related to weak public sector capacity, many governments often try to do too much – especially in terms of in-house service production – with too few resources and little capability.

This argues for a more focused stewardship function of governments in securing outcomes related to equity, quality, access, and coverage through more effective policy-making (“steering”), regulating, contracting, and ensuring that adequate financing arrangements are available for the whole population. At the same time, it also argues for a strong case of greater private participation in providing health services (“rowing”). Figure E-1 illustrates the imbalance between the public and private sector roles under the current model (left-hand side) and the strengthened financing and stewardship role in the new model (right-hand side).

FIGURE E-1. STEWARDSHIP ROLE OF GOVERNMENT

There are three broad strategic directions in policy development for engaging the private health sector (Harding and Parker 2003):

- **Conversion** from public to private: MOHs consider this option when the public sector is large and/or has excess capacity.

- **Growth** of the size or scope of the private health sector: The MOH can invest in well-functioning parts of the private sector such as NGOs and FBOs.

- **Harnessing** existing private sector services: Through policies and partnerships, the MOH can realign existing private sector activities to address public health goals, improve performance (quality and reporting), and address long-standing challenges such as improving access and coverage for underserved population groups.
GOVERNMENT CAN BE MORE PROACTIVE

Although dialogue is essential, often there are missed opportunities. In fact, multiple types of forums and mechanisms for communication between public and private actors are required. Government must take the first step to create venues and invite the private sector to participate. However, there is often simply a lack of political will to include the private sector. For example, the private sector is not engaged in planning, revising, and updating norms and new programs (e.g., health insurance schemes). In part this lack of engagement stems from a sense of unhealthy competition between public and private sectors. The reality is that government and donors commonly hold the private sector accountable for higher standards than public facilities (e.g., quality of care, efficiency, and transparency). More needs to be done to “level the playing field” by applying equal standards to both the public and private sectors when considering actions such as improving quality of care or reducing out-of-pocket expenses.

PRIVATE SECTOR ALSO NEEDS TO BE MORE PROACTIVE

Once the public sector has indicated interest in working with the private health sector, the private sector also needs to demonstrate motivation and commitment to collaborating. A first step would be for the private sector to show how it could add value to the government’s efforts to deliver RH/FP and HIV/AIDS services by generating evidence on coverage, quality, and costs. Moreover, the private health sector can exhibit commitment to the public health sector by:

• Participating in government-sponsored schemes that serve needs of the poor and vulnerable
• Providing service statistics and coverage data
• Enacting self-regulation measures to ensure quality
• Adhering to cost-containment measures (ceasing unnecessary prescriptions and treatments)

DONORS NEED TO BE MORE OPEN TOWARD THE PRIVATE HEALTH SECTOR

Similarly, international donors also need to be receptive to a private sector role in addressing public health challenges. As MOHs increasingly move to establish partnerships with the private health sector, there are many actions donors can take to assist MOHs so they harness and grow existing private sector capacity in their respective countries. This is particularly important as foreign assistance moves toward more up-stream funding actions, such as sector-wide approaches and direct budget support. Actions include:

• Earmarking a higher proportion of aid to fund private sector providers, particularly those that target the poor or provide health care services of public goods nature
• "Blending" aid money with commercial financing in order to create and expand sustainable private sector entities
• Supporting documentation and dissemination of best private sector practices and government support to the private sector
• Investing in the development of public sector capacity to manage pluralistic health systems
POLICY ACTIONS OUTSIDE OF THE HEALTH SECTOR ARE REQUIRED

Many of the key policy issues that concern the private sector need to be taken by non-health sector branches of government. Senior leadership from the MOH must work across government for consistency and support. Strong partnerships outside of government can be helpful to achieve progressive policies favoring the private health sector. A few key areas were discussed during the workshop, including the following:

- Address cumbersome and bureaucratic regulatory procedures
  - Liberalize pharmacy chain ownership
  - Build regional credential recognition programs, allow local staff trained abroad to practice at home
  - Streamline application processes for establishment of non-profit and other private sector networks or individual practices
  - Develop common regional drug registration requirements
- Policies that impede access to health supplies or raise cost are a major concern for private businesses and private health sector patients
  - Take a nuanced view of import barriers favoring local pharmaceutical manufacturing
- Re-examine customs clearances and other cargo-handling procedures for health care products
ANNEX F. RANGE OF POLICY INSTRUMENTS

To enhance the private sector’s role in health care, MOHs and donors will need to take action. When appropriately regulated, the private sector can increase services and products available in the marketplace and improve quality in ways that complement MOH efforts. Effective and targeted regulations can have large and immediate benefits for the private health sector but they are not sufficient. In addition to regulations, the MOH has a range of different policy and program interventions at its disposal to grow and harness the private health sector.

Table F-1, drawn from the 2007 IFC report Investing in the Business of Health in Africa, provides an overview of the types of interventions used in public sector stewardship of the private sector.

TABLE F-1. POLICIES AND PROGRAMS TO INCREASE ACCESS AND EXPAND COVERAGE

<table>
<thead>
<tr>
<th>Type</th>
<th>Description and examples</th>
</tr>
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<tbody>
<tr>
<td>Procurement</td>
<td>• Purchase of supplies or equipment from external private sources (e.g., NGOs, private clinics, etc.).</td>
</tr>
<tr>
<td>Funds transfer</td>
<td>• Funds channeled to the private sector in exchange for provision of a single concrete episode of care, effectively subsidizing service provision (e.g., grants to NGOs for HIV/AIDS care, voucher schemes for maternal check-ups).</td>
</tr>
<tr>
<td>Service contracts</td>
<td><strong>“contracting in”</strong></td>
</tr>
<tr>
<td></td>
<td>• Private sector delivers a defined set of services for public facilities, e.g.,</td>
</tr>
<tr>
<td></td>
<td>- Non-clinical support services (e.g., housekeeping, maintenance, catering, transportation, security, laundry, etc.)</td>
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<td></td>
<td>- Ancillary clinical services (e.g., laboratory, radiology)</td>
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<td>- Core clinical services (e.g., surgery, reproductive health care)</td>
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<td></td>
<td>- Third-party administration</td>
</tr>
<tr>
<td>Service contracts</td>
<td><strong>“contracting out”</strong></td>
</tr>
<tr>
<td></td>
<td>• Private sector delivers a set of predefined services for the public sector within private settings (e.g., immunization programs, nutrition programs, consumer education campaigns).</td>
</tr>
<tr>
<td>Management contracts</td>
<td>• Private sector assumes management responsibilities (e.g., staffing and labor supplies, ongoing training) for public facilities.</td>
</tr>
<tr>
<td>Leasing</td>
<td>• Temporary operation and management of public facilities by private sector players; the private sector bears all risk and retains any profits, but does not enjoy ownership of facilities.</td>
</tr>
<tr>
<td>Concession</td>
<td>• Private sector provides capital investment for new or existing facilities and transfers ownership to the public sector after a specified period of time (e.g., build-operate-transfer).</td>
</tr>
<tr>
<td>Divestiture/privatization</td>
<td>• Sale of a public facility to the private sector (e.g., build-own-operate-transfer) for ongoing operations and ownership.</td>
</tr>
</tbody>
</table>

Session Brief Module 1 - Introduction to the Private Health Sector in Africa

Session title: Trends in the private provision of priority health services
Presenter: Barry Kitsnasamy

Objectives:
- Introduction of the private health sector in Africa
- Rationale for why the public sector should engage the private health sector
- Motivation for re-emphasis on family planning as a priority for both the public and private sectors
- Overview of what we know to do on the private sector’s role on HIV/AIDS

Outline of session:
- The presentation will present the latest data on the four thematic areas covered in this presentation.

Main messages:
- The private sector plays a major role in the provision of health services in Africa, requiring public sector engagement if MOHs want to successfully address the key health issues in the region
- FP remains a long-standing challenge in Africa and should become a top priority for the public sector. One possible strategy to make FP more accessible is to work with the private sector.
- Information is preliminary on the private sector role in HIV/AIDS. The private sector plays an important role in VCT, opportunistic infections and to a lesser degree, ART. An increased role for the private sector is threatened by the large influx of global funds “crowding” out the private sector.

Discussion questions:
1. What is the private health sector’s contribution to FP and HIV/AIDS in your country? Please describe some of the programs/initiatives.
2. What type of interactions and/or programs does your MOH have to work with the private health sector to address FP and HIV/AIDS challenges?
3. Does your country have a private health sector policy? If not, why not? If so, what are its goals and objectives?
4. Is FP a health priority for your MOH? What types of policies and/or programs is the MOH implementing to make FP available and affordable to couples? If FP is not a priority, why not? What actions are required to make FP a priority?

5. Does the data reflect your country experience? What roles does the private health sector play in the range of HIV/AIDS related services in your country? Is it sufficient? Where do you think the private sector can play a bigger role in helping the MOH achieve its HIV/AIDS goals?

Background/additional reading:


USAID Repositioning On-Line Resource Library

www.usaid.gov/our_work/global_health/pop/techareas/repositioning
Session Brief Module 2 - Stewardship

Session title: Government as a steward of the private health sector
Presenter: Dale Huntington

Objectives:
• To have a good understanding of major structural and technical challenges related to implementing policies to influence private health sector activities
• To familiarize the course participants with different analytic frameworks related to health systems, partnership cycles and stewardship functions

Outline of session:
• Why government should respond to the private sector, including discussion of a health systems framework to identify points of policy intervention, recent trends in private health sector participation, common concerns
• Logical framework for the course: 12 steps to Partnering Cycle and a condensed version of four phases to the Partnering Cycle
• Discussion of the second phase in depth: managing and maintaining engagement with the private sector
• Stewardship challenges: government, private sector and donors
• Stewardship role of the government: examples from within the health sector and other sectors of government

Main messages:
• Private sector engagement/growth is sought as a means to achieve national health goals and works through clearly identified government health policies
• There is a range of policy options and constraints to action that impede progress by government and private sector alike
• Important to work within the health sector as well as with other sectors of government for effective and comprehensive policy development
Background/additional reading:


Session Brief Module 3 - Building Successful Partnerships

Session title: Elements of a successful partnership

Presenter: Sharon White

Objectives:
- Introduce the five principles of a successful partnership
- Define a third-party or facilitator to broker partnerships in the private sector
- Familiarize participants with the Partnership Action Framework

Outline of session:
- Significant political and financial commitments are promoting universal access to an essential package of public health care for HIV (that includes antiretroviral treatment for all who need it) by the end of the decade. This presentation describes an applied strategy for strengthening the private sector’s contribution to scaling up access through promoting Public-Private Partnership Mix service models for HIV care (PPM-HIV).

Main messages:
- Success comes through people working together
- Taking responsible action based on principles of:
  - Participation
  - Alignment
  - Coordination
  - Harmonization
  - Accountability
- Implementing the model of PPM through very practical steps (hard work)
- Agency taking the role of: brokering, facilitating, implementing, transferring, scaling up and innovating
- Understanding partnership action framework – *coordination, cooperation and collaboration*

Discussion questions: Think about a PPP that you have either initiated or been actively a part of (does not have to be work-related!)

1. What made this PPP work?
2. In retrospect, what would have made the PPP even more successful?
Now that I have shared our experiences with you as firstly a broker for a PPP and secondly the way we went about implementing the PPP – think critically and creatively.

3. Have your ideas and thoughts about PPP changed somewhat? If so how?

4. When you begin implementing a new PPP, revising a PPP or continuing an established PPP, what one creative thing would you do differently?

5. Lastly, what advice would you give back to my team as we move forward with our PPM (take note I have used the term PPM for a reason)?

Background/additional reading:


Session Brief Module 4 - Financing

Session title: Financing mechanisms to mobilize the private sector

Presenter: Allison Gamble Kelley

Objectives:
• This session is designed to introduce decision-makers to a selection of health financing tools that might be relevant to mobilize the private sector to achieve FP/RH goals, as well as to provide context and examples to guide the choice of appropriate financing strategies.

Outline of session:
• This presentation begins by discussing the overall context of health financing in Africa, the importance of out-of-pocket expenditures across income groups, and the high utilization of the private sector. It then introduces selected financing mechanisms to engage the private sector: primarily insurance (various types) and subsidies/vouchers. We then look at how these mechanisms relate to meeting FP/RH goals specifically, as well as examples of where and when they have been used in Africa. Finally, we discuss the pros and cons of various financing mechanisms to help inform strategic decisions about their use for specific objectives.

Main messages: The main messages from this session are:
• Out-of-pocket expenditures are high across Africa and the private sector fragmented. Financing mechanisms can directly address both issues
• Financing mechanisms can be powerful
  o Provide incentives to encourage private sector participation in FP, RH, HIV/AIDS
  o Organize consumers, providers in more formal ways, facilitating targeting, collaboration
  o Leverage quality and efficiency improvements
• Government can play a strategic role by setting up market dynamics
  o Advocate for inclusion of FP or HIV/AIDS in financing strategies (benefits packages)
  o Provide incentives for target services/populations/providers
Discussion questions: In the discussion for this session, we will focus on the following questions:

1. Have any of the financing mechanisms discussed been experimented in your country? To target FP or HIV/AIDS? With what successes? What challenges?

Background/additional reading: Many good resources on financing and the private sector are available on the websites listed below. The readings suggested provide more in-depth information about the specific financing mechanisms discussed in this presentation.


Websites: www.psp-one.com/section/resource/

www.who.int/health_financing/mechanisms/en/

www.phrplus.org
Session Brief Module 5 - Contracting

Session title: Contracting for health services

Presenter: Barry Kistnasamy

Objectives: The objectives of the session are to:

- Provide participants with a broad understanding of contracting with non-state providers (NSPs) to deliver services
- Discuss practical issues in contracting to see how key issues could be addressed in the participants' context

Outline of session: The presentation will focus on practical issues in the design and implementation of contracts, organized by the contracting process:

- Consultation with stakeholders and other process issues
- Design of contracts
- NSP selection and setting prices
- Contract management
- Monitoring and evaluation of contracts

Main messages:

- There is now sufficient experience with contracting so that it is no longer something unusual or experimental. Evidence demonstrates that contracting can increase access, improve equity and ensure quality. Decisions about contracting should be based on evidence. The successes in contracting health services are attributed to focusing on the details in the design and management of contracts.

Discussion questions: 1. When and why would you decide that contracting should be the preferred mechanism of interaction with the private sector as opposed to grants and agreements?

2. Does your country have examples of contracting for health services? If so, what were the objectives of these contracts? Who did you contract with and for what services?

3. Do you think contracting can also be a mechanism for interaction with the ministries, their departments and other government agencies?
4. In your experience, how important was engaging all the stakeholders in the contracting process? Who were the stakeholders? At what point in the process did you engage the stakeholders?

5. What do you think is critical information needed to design and manage a contract with private providers for health services? Do you have the necessary information?

6. What other inputs do you think you would need to contract with the private sector? (Reviews of contracts in other sector; policy/legal frameworks in place; development of partner agreements; others?)

7. What resources and management systems would the MOH need to administer the contracts? What organizational unit will oversee the technical aspects of the programs? What organizational unit will manage and administer the contract? How are the roles and responsibilities, if in different units or ministries, coordinated? By whom?


Session Brief Module 6 - Leadership and Management

Session title: Management and leadership skills needed to manage partnership

Presenter: Karen Sherk

Objectives:
- Understand the importance of leadership and management to fulfill role as steward of the health sector and to manage successful public-private sector partnerships
- Define key leadership and management practices and competencies
- Understand approaches used to strengthen leadership and management in the health sector and partnerships with the private sector

Outline of session: The presentation will cover the following topics:
- Why focus on leadership and management in health?
- Defining leading and managing
- Examples of leadership and management practices necessary for stewardship & partnerships
- How leadership and management are developed and examples of results

Main messages:
- Partnerships will operate sub-optimally in the absence of strong leadership and management practices within partner organizations and among partners
- Leadership and management can be developed to ensure successful partnerships

Discussion questions: (to go with case study)
1. What management and leadership development and other planning and preparation do you think must occur in order to establish a sustainable PPP in this case?
2. In your experience with the public or private sector, have you encountered a similar situation in which management and/or leadership skills of either or both of the partners needed to be strengthened in order to have a successful partnership? What action did you take?
3. What do you think is the most important first step for this MOH team to take in order to start engaging successfully with the districts that offer FP services?
4. Thinking about your own skills, what management and leadership and systems-building capacity needs do you have in your MOH that, if addressed, would help you develop more successful public-private partnerships?

Background/additional reading:


Session Brief Module 7 - Legal and Regulatory

Session title: Creating legal and regulatory environment supportive of the private health sector

Presenter: Frank (Rich) Feeley

Objectives:

- Develop understanding of the limits to regulation, the requirements to make regulation more effective and the alternative mechanisms available to improve the performance of private sector health providers.

Outline of session:

- Review evidence on deficiencies in quality of care in the private sector, and the factors which contribute to quality problems. Review the goals for both quality and economic regulation, and the methods to be used. Identify common problems in regulation and the techniques that can be used to minimize these problems. Briefly review other techniques/incentives that can be used to improve private sector performance. Discuss the case of an African country that set out to revise its medical licensing law, the conflicting needs and interests to be reflected in the new law, and the lessons for regulatory reform.

Main messages:

- Given the large amount of care provided by the private sector, fulfillment of the stewardship role in health requires attention to both regulatory and non-regulatory approaches to improving the performance of private providers.

- The amount that can be accomplished in shaping the private sector through conventional regulation is limited, but countries must pay attention to modernizing both rules and enforcement procedures. Excessive regulation (requiring standards that cannot be met) may be counter-productive.

- Because of the limitations of regulation, countries should include in their private sector policies additional levers to improve the performance of the private sector.

Discussion questions:

1. What role does the MOH in your country play in regulating medical professionals?

2. Is the present system of regulation effective? If not, why not? Do you see a need to improve the quality or availability of private medical care?
3. Do current regulations permit non-physicians (nurses, clinical officers) to do “privately” what they do in public facilities? If so, is this a good thing? If not, why not?

4. If you could reform the current system for regulating medical practitioners, what are the three most important changes you would make?

5. Is the system of medical regulation in your country dominated by the medical providers (particularly doctors)? If so, have they used this dominance wisely, from a policy point of view?

6. Is your country using any non-regulatory approaches (subsidies, accreditation, voluntary Continuing Medical Education (CME), public education) to improve private sector performance? Are these effective?

7. How does your country exercise its “stewardship” role with respect to the private sector? How is the Ministry organized to deal with the private sector? What improvements would you make in this structure?

Background/additional reading:


Session Brief Module 8 - Quality

Session title: Engaging the private sector around quality assurance

Presenter: Allison Gamble Kelley

Objectives: This session is designed to introduce decision-makers to:

- Basic quality assurance (QA) concepts
- What we know about quality in the private sector
- Approaches to engage the private sector around QA

Outline of session:

- In many countries in Africa, the private sector delivers a majority of health care services in RH. This session will review core concepts in quality of health care, including a framework for engagement around QA. The session will review the evidence on quality in the private sector (versus public sector). Finally, it will present promising approaches for engaging with the private sector in QA activities in Africa, including one detailed example from Kenya.

Main messages: The main messages from this session are:

- Quality is a major concern and priority for both public and private sectors, and therefore is a strategic opportunity for collaboration and engagement, not directives.
- Quality problems exist throughout the health care market – public and private alike.
- Public sector approaches are not always applicable or appropriate to the private sector; need to dialogue, be creative.
- The key is finding the right strategy for the specific problem; engage at all levels; don’t hold out for a comprehensive QA approach.
- Quality initiatives can lay the foundation for broader engagement with private sector providers.
- There are examples of successful public-private collaborations to improve quality in the private sector, as well as a patchwork of promising approaches.
Discussion questions:

In the discussion for this session, we will focus on the following questions:

1. Do you agree with the definition of quality put forth in the presentation? What amendments would you make for work in your country?

2. What would you add to what we know about quality of RH and FP services in the private sector from your country’s experience?

3. Have any of the promising approaches discussed been experimented in your country? With what successes? What challenges?

4. What were the key factors to the success of the Kenya Quality Improvement (QI) initiative? What were its weaknesses? How would these factors be different in your own setting? Would this approach work? With what groups of private providers?

5. What approaches are you currently using to assess quality in the public sector? How could these be applicable to the private sector?

6. Which organizations existing in your country could be engaged to start a QI initiative with the private sector?

Background/additional reading:

There is a range of good resources on quality of care that would be useful as background education and tools available from the websites listed below. The readings suggested below provide more in-depth information about two successful examples of QI in the private sector:


Websites:  
www.qaproject.org/methods/resources.html  
www.ahrq.gov/qual/  
www.jhpiego.org/scripts/pubs (performance improvement)
ANNEX H. WHY PARTNERSHIPS ARE IMPORTANT

THE PARTNERING CHALLENGE

The underlying reason for a PPP approach is that only a comprehensive and multi-stakeholder collaboration can ensure health initiatives are creative, coherent, and integrated enough to address some of the most pressing health challenges such as RH/FP and HIV/AIDS. Single-sector approaches, such as top-down health sector reforms led by the public sector, have been tried, with disappointing results. PPPs offer new opportunities for providing better health care by recognizing the qualities and competencies of the different actors in the health sector and finding ways to harness and leverage these actors for the common good.

But there are many reasons why PPPs are difficult. Table H-1 details some of the challenges the workshop participants have encountered in their work with the private health sector. As the participant discussions revealed, there are many setting/context conditions specific to each country that affect the development of partnerships and it is therefore difficult to generalize too broadly about how to move forward with the private sector. However, there are some commonalities that seem to be universal, even among the African countries present at the workshop. For example, creating multiple and diverse types of forums where private and public sector providers, managers, and other types of agents from both sectors can meet and discuss appears to be very important. Table H-1 provides an overview of some of the more common partnership challenges from both the public sector and private sector perspectives.

TABLE H-1. CHALLENGES TO PUBLIC-PRIVATE PARTNERSHIPS

<table>
<thead>
<tr>
<th>Public sector perspective</th>
<th>Private sector perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Concerns about quality and how to control the private sector</td>
<td>• Lack of political will to include private sector</td>
</tr>
<tr>
<td>• Concerns about competing with the private sector</td>
<td>• Limited information-sharing and restricted access to key information</td>
</tr>
<tr>
<td>• Little dialogue and communication between the two sectors</td>
<td>• Little dialogue and communication between the two sectors</td>
</tr>
<tr>
<td>• Lack of trust between the public and private health sectors</td>
<td>• Lack of or no access to supportive quality system</td>
</tr>
<tr>
<td>• Suspicion of profit motive</td>
<td>• Government and donors commonly hold the private sector accountable to higher standards</td>
</tr>
<tr>
<td>• The private health sector is highly fragmented and disorganized, creating a series of</td>
<td>than public facilities (e.g., quality of care, efficiency, and transparency)</td>
</tr>
<tr>
<td>implementation challenges</td>
<td></td>
</tr>
<tr>
<td>• Entry point to work with private sector is difficult</td>
<td>• Not invited to participate in strategic planning or policy reforms that affect the private sector</td>
</tr>
<tr>
<td>• Activities with the private health sector are ad hoc, often not focused on priority</td>
<td>• Private sector not engaged in planning, revising, and updating norms</td>
</tr>
<tr>
<td>issues</td>
<td></td>
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<tr>
<td>• Little knowledge and information available on private sector (who, what, where)</td>
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</tbody>
</table>
BUILDING PARTNERSHIPS

Building partnerships is critical to the success of any interaction between the public and private sectors. However, working collaboratively with other partners is a new function for MOHs, requiring a paradigm shift in how the MOH engages and interacts with the private health sector to maximize its potential to support national health goals.

The first presentation in the partnership track focused on what are the elements of a good partnership and how to structure a process whereby the MOH can foster a collaborative relationship with its private sector partners. Box H-1 highlights the key elements of a successful partnership. In the breakout groups, participants identified “what has worked” in partnering based on their own experience with the private health sector (Box H-2).

BOX H-1. ELEMENTS OF A GOOD PARTNERSHIP

- Creating a shared vision
- Agreement on respective roles and responsibilities
- Working through governance issues on compliance, coordination, and collaboration
- Dealing with ‘issues’ transparently and proactively
- Learning how to build and celebrate each other’s successes

BOX H-2. COUNTRY EXPERIENCE OF “WHAT WORKS” IN A GOOD PARTNERSHIP

Uganda:
- Trust is critical
- Dialogue is crucial for holding the PPP together
- Acknowledgement of the need for private sector to earn a profit
- High-level MOH support to work with private sector

Kenya:
- Shared vision and common goals
- Recognizing each partner’s mission
- Involving stakeholders in planning stage
- Openness and flexibility
- Formal institutional arrangement/structure for the partnership
Table H-2 outlines the five principles serving as the foundation for PPPs and the actions needed to develop and sustain a partnership.

**TABLE H-2. FIVE PRINCIPLES FOR PUBLIC-PRIVATE PARTNERSHIPS**

<table>
<thead>
<tr>
<th>Principles</th>
<th>Steps to implement them</th>
</tr>
</thead>
</table>
| Participation| • Identify and scope-out possible partners  
• Establish a partnership mission  
• Build working relationship through agreement on goals, objectives, core principles  
• Define partnership activities  
• Get agreement (memorandum of understanding)  
• Put in place participation mechanisms *(agency, institutional arrangements)* to manage partnership  
• Work through modes of participation *(cooperation, coordination, collaboration)* |
| Alignment    | • Understand government policies and plans  
• Understand private sector partner’s business, perspective, and needs  
• Build a common vision  
• Broker memorandum of understanding |
| Coordination | • Identify and define roles and responsibilities  
• Share information  
• Jointly plan and implement activities  
• Strengthen and build different partners’ capacity to partner |
| Harmonization| • Identify where we can improve efficiencies  
• Work through existing systems where possible  
• Take an open collaborative approach  
• Jointly create solutions to identified challenges  
• Share ownership of results |
| Accountability| • Identify the stakeholders and what they expect  
• Demonstrate integrity and mutual respect for boundaries  
• Acknowledge mistakes and work together to fix  
• Monitor and evaluate partnership and its activities  
• Report on results and communicate well/share lessons |
There are three modes of partnerships: coordination, cooperation, and collaboration. The modes are related and build on each other. Coordination is necessary but not sufficient to attain cooperation. Similarly, coordination and cooperation are required but not enough to result in full collaboration. As Figure H-I illustrates, coordination produces synergies and cooperation produces strategies and activities aligned with a common goal and purpose. Collaboration is the partnership mode that produces sustainable results and therefore the model MOHs should strive for in developing partnerships with the private health sector.

FIGURE H-I. PARTNERSHIP ACTION FRAMEWORK

PARTNERS AS LEADERS AND MANAGERS

Partnerships raise interesting issues about leadership. What is the role of leadership in a paradigm that is essentially collaborative and based on equity between players? The second presentation put forward that MOHs need to cultivate and demonstrate leadership and management skills during the partnering process with the private health sector. For any partnership to be effective and to deal successfully with challenges, it needs to be built on a strong foundation of individual commitment to partnering and on the conviction that a partnership approach is necessary to achieve the desired goal. This requires leadership within MOHs to gain acceptance and support for the idea of partnering with the private health sector and leadership to bring the private sector to the table.

DIFFERENCE BETWEEN LEADERSHIP AND MANAGEMENT

There is often confusion between leadership and management. Leading entails “enabling others to face challenges and achieve results under complex conditions.” Managing, on the other hand, is “organizing the internal parts of the organization to implement systems and coordinate resources to produce
reliable performance.” It is important to note that both management and leadership are indispensable in partnering (Sherk 2008).

**SKILLS NEEDED FOR MANAGEMENT AND LEADERSHIP**

Each discipline has its own set of tools and skills. In the area of leadership, core competencies include the ability to: see the big picture, create a shared vision, clarify purpose and priorities, communicate effectively, motivate teams, negotiate conflict, and lead change. Examples of management practices needed to be an effective steward of and partner with the private health sector include:

- **Planning** to conduct a strategic planning exercise before engaging in partnerships and to determine the usefulness of a specific partnership.

- **Organizing** your own institution to prepare internally (administratively, programmatically, and financially) to partner with the private sector. In addition, it is important to conduct an action planning exercise together to agree on the goal, identify target population and geographic focus, determine roles and responsibilities, duration, and governance of partnership.

- **Implementing** the activities identified in the workplan and managing the partnership to maintain full involvement of all partners, following established and agreed-upon rules and guidelines.

- **Monitoring and evaluating** the partnership and its activities to help deal with “issues” transparently and proactively and to learn how to build and celebrate each other’s successes.

Investing in building organizational capacity in leadership and management practices in both the MOH and partner organizations will increase the likelihood of successful partnerships with the private health sector. Fortunately, both leadership and management skills can be developed through training, application, and lots of practice.
**ANNEX I. PRIVATE SECTOR EXPERIENCES IN WORKSHOP COUNTRIES**

<table>
<thead>
<tr>
<th><strong>Private sector experiences</strong></th>
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<tbody>
<tr>
<td><strong>Contracting/Partnerships</strong></td>
<td>• PPP model in which private provider contracted to offer free VCT to high-risk groups; health bureau selects site and monitors quality; women’s group mobilize community (Ethiopia)</td>
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<tr>
<td></td>
<td>• PPP model in which private providers deliver HIV/VCT at a subsidized rate, receive training and subsidized commodities (Kenya - GoldStar Network)</td>
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<td>• MOH contracts with Broad Reach and Right to Care using public money and public/donor ARVs for private sector provision of antiretroviral therapy. Broad Reach and Right to Care both have private sector networks treating “public” AIDS patients under this contract arrangement (South Africa)</td>
</tr>
<tr>
<td><strong>Donor Funds to Support Private Sector Initiatives</strong></td>
<td>• Provision of ART services in private hospitals using global funds through Hygiea (Nigeria)</td>
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<tr>
<td></td>
<td>• Creation of investment funds to build 100 private sector facilities to deliver HIV/AIDS care and treatment using PEPFAR funds (Tanzania)</td>
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<tr>
<td></td>
<td>• Use of vertical funds for HIV to support horizontal health insurance program for informal sector (Tanzania)</td>
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<tr>
<td></td>
<td>• Donor-funded ARVs made available to certified private sector clinics. The Business PART project uses donor-funded ARVs to expand treatment to populations of company clinics, along with regular private sector clinics, such as African Air Rescue and Microcare. Government condition for access to donated ARVs is that the clinics meet MOH certification standards and the clinics do not charge for the ARVs and do not “gouge” on other charges (Uganda)</td>
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<td></td>
<td>• Donor-funded ARVs provided to a network of private clinics organized by the Malawi Business Coalition on AIDS. Clinics can charge service fees, but not for the drugs (Malawi). Same program but on a limited basis in Kenya.</td>
</tr>
<tr>
<td><strong>Corporate Social Responsibility (CSR)</strong></td>
<td>• ELOBank builds youth-friendly centers in some universities (Nigeria)</td>
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<td>• Pfizer donated funds to build two state-of-the-art facilities: one for training in HIV/AIDS in the public sector, the other a facility run by an HIV/AIDS NGO, The AIDS Support Organization (TASO) (Uganda)</td>
</tr>
<tr>
<td></td>
<td>• Pfizer Fellows Program offers quality professional staff to help grow MAPPP-E (Ethiopia)</td>
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<td>• Shell, through the Nidar Project, provides comprehensive TB and HIV/AIDS care and support services in five cottage hospitals (Nigeria)</td>
</tr>
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<td>• A large mine gets government ARVs and treats its worker population, and also warehouses the ARVs for nearby public AIDS clinics (Guinea)</td>
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<tr>
<td>Private sector experiences (continued)</td>
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<tr>
<td><strong>Donated Products and Commodities</strong></td>
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<tr>
<td>• Government donates vaccines to private providers in exchange for reporting information to health management information system (HMIS) (Tanzania)</td>
<td></td>
</tr>
<tr>
<td>• Government donates FP commodities to private providers in exchange for reporting information to HMIS (Tanzania)</td>
<td></td>
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<tr>
<td>• Government donates HIV/AIDS and TB drugs to 11 private hospitals (Ethiopia)</td>
<td></td>
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<tr>
<td><strong>Franchising</strong></td>
<td></td>
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<tr>
<td>• Social franchise (Biruh Tesfa) to deliver RH/FP (Ethiopia)</td>
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<tr>
<td>• Care shops (GSMF) to deliver drugs through pharmacies and chemical shops (Ghana)</td>
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<tr>
<td>• Network of midwives managed by MSI (Ghana)</td>
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<tr>
<td><strong>High Tech</strong></td>
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<tr>
<td>• CELTEL works with National AIDS Control Agency (NACA) to spread messages using mobile networks (Nigeria)</td>
<td></td>
</tr>
<tr>
<td>• Mobile phone-based system used to distribute vouchers for bednets and to transfer funds</td>
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<tr>
<td><strong>Infrastructure</strong></td>
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<tr>
<td>• Mission hospital serves as district-level hospital; symbiotic relationship between MOH and mission hospital (Ghana)</td>
<td></td>
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<tr>
<td>• Co-location of private services in public facilities (South Africa, Kenya) permitting public sector staff to serve their private sector patients</td>
<td></td>
</tr>
<tr>
<td>• Conversion of hospital wing for private services offered by public sector staff (Ethiopia)</td>
<td></td>
</tr>
<tr>
<td><strong>Insurance</strong></td>
<td></td>
</tr>
<tr>
<td>• Use of national health insurance schemes (NHIS) to “organize” the private sector and to motivate them to provide key preventive services (Ghana, Nigeria)</td>
<td></td>
</tr>
<tr>
<td>• Innovative low-cost health insurance program that includes full cost of an AIDS treatment program. Also, the public sector employees health insurance program pays private providers for all costs of AIDS care (Namibia)</td>
<td></td>
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<tr>
<td><strong>Quality</strong></td>
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<tr>
<td>• Nigerian MOH developed tools and methodology for quality improvement. Includes assessment tool for accreditation, on-site mentoring and supervision to ensure that guidelines are followed – team is led by MOH. The Medical and Dental Council of Nigeria (MDCN), Nurse and Midwifery Council (NMC), and NHIS all monitor quality in the public and private sectors. MDCN governs licensing and reads complaints.</td>
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<tr>
<td>• Kenya has similar model to Nigeria with district health teams that conduct annual district visits to both public and private sector providers.</td>
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<tr>
<td>• Ugandan MOH Department of QI works across sectors and includes supervision of both private and public sectors. Medical Doctor accredits private practice and ensures compliance with standard. There is also annual process to renew one’s license.</td>
<td></td>
</tr>
<tr>
<td>• Several countries (Ghana, Kenya, and Uganda) work with professional associations to monitor and improve quality of private sector providers. In Ghana, the professional councils accredit facilities based on MOH guidelines.</td>
<td></td>
</tr>
</tbody>
</table>
### Private sector experiences (continued)

| Quality (continued) | • Professional associations are using quality improvement tools/checklists to improve quality (Uganda and Nigeria)  
• Banking on Health project is working in Ethiopia, Nigeria, and Zambia to link banks with private providers to lend them capital to improve and equip facilities |
| Vouchers | • Voucher schemes to increase sexually transmitted infection treatment. Voucher scheme managed by MSI. KfW provides funds for subsidies. Patient purchases voucher at minimum cost and voucher can be redeemed with participating private providers (Uganda)  
• Also has voucher scheme to increase access to and use of maternal health services (Uganda)  
• KfW-funded pilot voucher scheme for integrated maternal and child health package including FP; patient purchases voucher at minimum cost and voucher is redeemed at participating providers. Recently evaluated and in process of scaling-up nationally (Kenya) |
ANNEX J. LAUNCH OF THE NETWORK FOR AFRICA

At the workshop, the participants discussed what would be the objectives of the Network, the technical priorities, and topics that the Network would address. The participants also provided input on the types of activities desired as well as frequency of interaction.

PURPOSE OF NETWORK

All the participating countries agreed enthusiastically on creating a network to keep the national groups together. The purposes of the Network are to: (i) foster the exchange of experiences; (ii) share tools and materials; and (iii) build MOH capacity to work with the private health sector.

The PSP-One project will use the Network as a platform to continue raising awareness of the positive contribution and potential role of the private sector in addressing RH/FP challenges in the region and provide technical assistance in support of promoting PPPs in the network countries.

NETWORK MEMBERS

Initially, the Network will comprise the Addis meeting participants. The Network organizers are encouraging the meeting participants to invite others from their ministries to visit the web site (www.network4africa.com) and to become active in future Network activities. Depending on participation, Network organizers may expand the membership to include other relevant ministries (Finance [MOF], Trade and Development, etc.) and private sector counterparts. Funding permitting, a set of Francophone African countries will be identified to join the Network at a later time during this initiative.

NETWORK ACTIVITIES

Many of the participants indicated that networks are time-consuming and for this Network to be useful for its members, its activities should focus on issues and real-life challenges confronted by its members. Participants put forth the following types of activities that could add value to their work with the private health sector; the proposed activities are organized into clusters of similar activities:

Information

- Create a reference library of relevant articles
- Gather materials and tools from different MOHs on their private sector strategies/programs (e.g., policies, laws, regulations; contract templates; evaluations of private sector activities; program design for private sector programs; etc.)
- Document and disseminate “good” practices and lessons learned to support PPPs
- Post announcements of upcoming trainings on leadership and management and other key technical areas that would be of interest to Network members and would help them implement action plans
Skill building through workshops

- Replicate the Addis workshop at the country level to help expand and deepen the knowledge base of MOH and MOF staff and to include private sector representatives. Workshops would focus on technical elements related to country action plans and encourage private sector participation in designing the policy/program intervention.

- Conduct additional workshops that permit the Network counterparts to deepen their knowledge and skills in a select number of the policy instruments presented at the Addis workshop.

Skill building through study tours

- Facilitate study tours to provide Network counterparts the opportunity to observe and experience different national private sector policies and programs.

- The Network could “pair” countries, like Ghana and Nigeria, that are working on similar projects to learn from each other and share experiences.

Skill building through long-distance learning

- A representative from the Management Sciences for Health (MSH) project presented and offered the Virtual Learning Development Program (VLDP) as an opportunity to build Network member skills in leadership and management around partnering with the private health sector. Both the Ethiopia and Nigeria country teams expressed keen interest in participating in a VLDP.

Networking and mentoring

- Use web-based technology to facilitate regular events, such as a regular “on-line” chat on a specific technical issue for learning and sharing among counterparts.

- Coach, mentor, and provide targeted technical assistance to the Network country teams as they implement their action plans.

Leveraging resources to work with the private health sector

- Assist Network country teams to identify resources and funding for private sector activities.

- Bring in other groups, such as the World Bank, other private sector companies (i.e., mining, other multinational corporations), and other donors to support Network activities.

IDEAS FROM ONE UGANDAN PARTICIPANT

The Network would be helpful to share ideas and experiences. It would provide us with confidence to experiment with new strategies. Technical assistance to help us implement our actions plans would be most welcomed. Also, the Network can help us identify the technical experts we need to assist us with implementation.
BIBLIOGRAPHY


