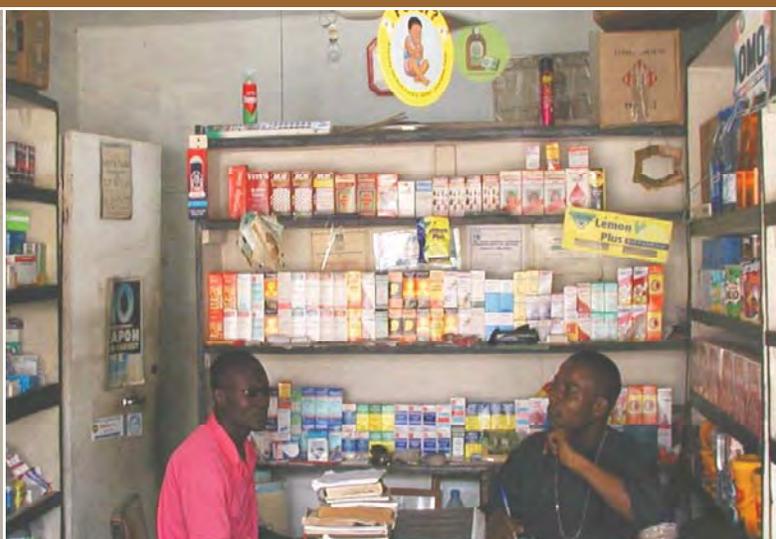


FORUM ON ENGAGING THE PRIVATE SECTOR IN CHILD HEALTH

FINAL REPORT
April 2007



Cover Photo Credits:

Photo on left: ©2003 Amelie Sow/CCP, Courtesy of Photoshare. A private health service provider sits behind the desk at his small practice in the Kaolack region of Sénégal.

Top right: George Greer/Africa's Health in 2010 project. A patent medicine vendor shop in Abia State, Nigeria. PMV shops sell a wide range of pharmaceutical products.

Bottom right: George Greer/Africa's Health in 2010 project. A general store in Mahajanga Province, Madagascar. These stores sell insecticide-treated nets (ITNs) and prepackaged anti-malarials (chloroquine) for children under 5 years.

FORUM ON ENGAGING THE PRIVATE SECTOR IN CHILD HEALTH

30th November - 2nd December 2005

Munyonyo, Uganda

FINAL REPORT
APRIL 2007



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FORUM ON ENGAGING THE PRIVATE SECTOR IN CHILD HEALTH

30 November - 2 December 2005 - Munyonyo, Uganda

EXECUTIVE SUMMARY

There has been a growing recognition that private providers, and the private sector more broadly, constitute a huge resource for improving community health outcomes. In Africa, it has been estimated that nearly 80% of treatments for uncomplicated illness, such as fever, are provided through the private sector. However, these services are frequently unregulated and too often involve inappropriate or substandard care. The potential of the private sector for providing quality services and commodities is great, though it remains largely untapped. Over recent years, a growing body of experience demonstrates the important role of the private provider in community health, and information is now available on strategies and approaches that have been employed in a wide range of settings to improve the quality of these services.

With the aim of learning from these experiences, a forum was convened to review the different approaches and strategies that have been used and to identify strategic approaches to engaging the private sector more effectively at international, regional and country levels.

Seventy-three participants from eight sub-Saharan African countries¹ and representatives from multilateral, funding and technical agencies participated in the forum with the following objectives:

1. Stimulate debate among key stakeholders to reach a shared vision for moving forward in engaging the private sector to improve child health services,
2. Determine priorities in making public-private partnerships effective to improve child health in poor and underserved populations,
3. Identify and discuss how to manage policy, technical and regulatory constraints to involving the private sector in health initiatives,
4. Share lessons learned and best practices that countries can adopt when planning their own approaches,
5. Identify country priorities for action and corresponding regional and international actions that will help support them.

The forum was sponsored by the World Health Organization (WHO), the World Bank (WB), and the U.S. Agency for International Development (USAID) and received additional financial support from the Bill & Melinda Gates Foundation. It was made possible thanks to the kind hospitality of the Government of Uganda and the Ugandan Ministry of Health.

The forum was developed by a steering committee, representing various agencies², and organized by USAID's Bureau for Africa, under the SARA II Project/AED with the Malaria Consortium.

The Forum included plenary presentations on: Public-Private Partnerships; Lessons Learned; Working with the Informal Private Sector; Trends in Public-Private Partnerships; Public-Private Partnerships for TB Control and Uganda's approach to public-private partnerships. A panel discussion covered the common interests of the public and private sectors and examined the challenges of, and opportunities for, working together. Group work topics included: Policy context; Public/private roles and capacity; Quality of drugs and commodities; Quality of services, access, coverage and equity [drugs, commodities and services]; and Consumer demand. On the final day participants worked in country teams on country priorities and draft action plans. An international team focused on regional and donor responses to public-private partnerships.

1. Ghana, Kenya, Mali, Nigeria, Rwanda, South Africa, Tanzania, and Uganda

2. The World Bank, WHO, USAID, UNICEF, AED, SARA II Project, BASICS, Malaria Consortium, Project HOPE, MSH, HCP, LSHTM, the Uganda MOH, SIDA

MUNYONYO DECLARATION ON THE IMPORTANCE OF PUBLIC-PRIVATE PARTNERSHIPS FOR CHILD HEALTH

2nd December 2005

WHEREAS:

- if “business as usual continues” it is unlikely that the African region will meet the MDG target of reducing child mortality by half; and
- many African governments and development partners continue to concentrate on the traditional public health sector, even though Africa has a vibrant private health sector, which has not been fully recognized and utilized; and
- the poorest quintile in many African countries relies on private sector outlets for drugs and services more than public sector outlets; and
- the first source of treatment for childhood illnesses in Africa is generally the private sector; and
- the majority of consumers in Africa are incurring high out-of-pocket expenses for services of varying quality in the private sector, with the lowest quintile often receiving the poorest quality; and
- investment in the private health sector can be cost-beneficial in the long run; and
- evidence shows that effective public-private partnerships can increase access, improve equity and raise quality of health services

THEREFORE BE IT RESOLVED THAT:

1. African governments urgently engage with private stakeholders to formulate appropriate policies that will facilitate increased private sector participation in the delivery of interventions to reduce child mortality.
2. African governments, development partners and other stakeholders focus on building capacity in both the public and private sectors for effective management of public-private partnerships.
3. African governments encourage and support the organization and mobilization of effective regulatory bodies and professional associations to ensure quality of services and drugs for both private and public sectors.
4. African governments, development partners and private stakeholders mobilize and allocate resources to facilitate the scaling up of public-private partnerships.
5. Consumers, who are critical to the success of public-private partnerships, must be fully informed and actively engaged in all its facets, including quality monitoring and assurance.

FORUM RECOMMENDATIONS

OVERARCHING GOAL:

Take urgent action to engage the private sector in reaching MDGs 4 and 5

The Forum recommends urgent pursuit of ways to engage the private sector in order to reach more children with high-quality health interventions needed to achieve the Millennium Development Goal on child health by 2015.

1. Identify a suitable global-level host to act as a catalyst for developing public-private partnerships

A global focal point or working group is needed in order to increase the momentum for better engagement of the private sector. The potential of the newly developing Partnership for Maternal, Newborn and Child Health should be explored as a vehicle for rapid introduction of public-private strategies.

2. Carry out evidence-based advocacy at all levels to stimulate public-private partnerships for child health

Advocacy for greater engagement of the private sector in child health should be supported where evidence has shown its positive effects. At global and regional levels, advocacy should focus on mobilizing support and resources to move the agenda forward. At the national level, situation analyses and pilot interventions can provide material for advocacy.

3. Develop a policy environment to support implementation at scale

A wide group of public, private and NGO stakeholders should be involved in creating an enabling policy environment, including laws, for the effective implementation of public-private partnership interventions to increase equitable access to quality child health care.

4. Include public-private partnerships in all health sector and multi-sectoral development plans

Opportunities to develop effective public-private partnerships should be considered and incorporated in all health sector plans and in plans of other sectors where child health could benefit. Situation analyses and stakeholder dialogue should be carried out systematically in each country to provide a basis for realistic planning.

5. Support implementation at scale by strengthening capacities of both public and private sectors

Where policies have been developed, the emphasis should be on removing bottlenecks to implement at scale with approaches tailored to build on local strengths. Increased capacity is essential in the public sector to engage the private sector effectively; for example, for contracting and quality assurance. Capacities in the private sector also require strengthening to offer quality child health care services. Technical support is needed to select, implement, monitor and evaluate public-private partnership interventions. Common guidance documents are needed to support policy development and implementation.

6. Support improved organization of professional associations and coalitions

Professional associations, as well as coalitions of not-for-profit organizations, should be stimulated to work more effectively with their members to improve and maintain the quality of child health services; for example, by playing a greater role in accreditation.

7. Increase funding available to develop public-private partnerships for child health

Funding is needed to go to scale with public-private partnership interventions. This should include seed funds to develop country-level interventions that can feed into a global strategy and stimulate greater dialogue.

8. Monitor the effect of private sector partnerships on reaching the hard to reach and underserved

There is evidence that the private sector can be effective in reaching populations underserved by the public sector. The potential of the private sector for providing child health services to the poor should be fully developed and monitored, and coverage data disaggregated to track equity issues. The role of the private sector in targeted subsidy schemes should be developed.

9. Pay particular attention to incentives / motivating factors

Motivating factors and incentives are key if the public and private sectors are to work effectively together. These must be seriously studied and taken into account, involving all the stakeholders in identifying common interests and win-win opportunities for collaboration.

10. Conduct interventions to influence consumer demand for quality services

Opportunities for greater consumer influence on service delivery by private providers should be pursued. These may include linking with other sectors to empower communities through cooperative schemes, as well as developing rural risk pooling mechanisms for medical coverage.

11. Invest in better testing, monitoring, evaluation and operational research

There is a need for more information on the efficiency and effectiveness of private sector interventions, so it is important to test strategies, build strong monitoring and evaluation into intervention plans and undertake focused operational research, recognizing the difficulties of monitoring the private sector. Support national level, low-cost, action-oriented situation analysis and pilot interventions to test various models for public-private partnership for child health. Results of these interventions should guide national policy dialogue and large-scale planning. Better information on cost is needed from both the public and private sectors.

ACRONYMS

ACT	-	Artemisin-based Combination Therapy
ADR	-	Adverse Drug Reaction
ARI	-	Acute Respiratory Infection
ADDO	-	Accredited Drug Dispensing Outlet
AED	-	Academy for Educational Development
CBD	-	Community-Based Distribution
CQ	-	Chloroquine
ECSA-HC		East, Central and Southern African Health Community Secretariat
EPI	-	Expanded Program on Immunization
FDB	-	Food and Drugs Board
GSMF	-	Ghana Social Marketing Foundation
HSSP	-	Health Sector Strategic Plan
HSR	-	Health Sector Reform
IMCI	-	Integrated Management of Childhood Illness
ITN	-	Insecticide-treated Net
LCS	-	Licensed Chemical Seller
LSA	-	Local Service Area
LSHTM	-	London School of Hygiene & Tropical Medicine
MCE	-	Multi-Country Evaluation (for IMCI)
MDGs	-	Millennium Development Goals
MoH	-	Ministry of Health
MSH	-	Management Sciences for Health
NGO	-	Nongovernmental Organization
NHP	-	National Health Policy
NTP	-	National Tuberculosis Program
OOPS	-	Out-of-Pocket Spending
ORS	-	Oral Rehydration Salts
ORT	-	Oral Rehydration Therapy
PAHO	-	Pan American Health Organization
PC	-	Pharmacy Council
PDA	-	Personal Digital Assistant
PEAP	-	Poverty Eradication Action Plan

PP	-	Private Practitioner
PHP	-	Private Health Practitioner
PNFP	-	Private Not For Profit
PPM	-	Public-Private Mix
PPP	-	Public-Private Partnership
PPPH	-	Public-Private Partnership in Health
PSP	-	Private Sector Provider
RMPs	-	Rural Medical Practitioners
SARA	-	Support for Analysis and Research in Africa
TCMP	-	Traditional and Complementary Medicine Practitioners
TB	-	Tuberculosis
TFDA	-	Tanzania Food and Drugs Authority
UNICEF	-	United Nations Children’s Fund
USAID	-	U.S. Agency for International Development
WB	-	World Bank
WHO	-	World Health Organization
WHO/AFRO	-	World Health Organization Regional Office for Africa

1. Introduction

1.1 RATIONALE

There has been a growing recognition that private providers, and the private sector more broadly, constitute a huge resource for improving community health outcomes. In Africa it has been estimated that nearly 80% of treatments for uncomplicated illness, such as fever, are provided through the private sector. However, these services are frequently unregulated and too often involve inappropriate or substandard care. The potential of the private sector for providing quality services and commodities is great, though it largely remains untapped. Over the last years there has been a growing body of experience that documents not only the important role of the private provider in community health, but also strategies and approaches that have been employed in a wide range of settings to improve the quality of these services.

With the aim of learning from these experiences, the present forum was conducted to review the different approaches and strategies that have been used and to identify strategies to move the agenda forward at international, regional and country levels. Groups of public and private sector representatives from eight African countries with experiences to share (Ghana, Kenya, Mali, Nigeria, Rwanda, South Africa, Tanzania and Uganda) were joined by representatives of several technical and development agencies for the forum.

1.2 FORUM OBJECTIVES

1. Stimulate debate among key stakeholders to reach a shared vision for moving forward in engaging the private sector to improve child health services,
2. Determine priorities in making public-private partnerships effective to improve child health in poor and underserved populations,
3. Identify and discuss how to manage policy, technical and regulatory constraints to involving the private sector in health initiatives,
4. Share lessons learned and best practices that countries can adopt when planning their own approaches,
5. Identify country priorities for action and corresponding regional and international actions that will help support them.

1.3 EXPECTED OUTCOMES

1. A shared vision of the way forward
2. A policy framework with key areas and roles of government and private sector actors
3. Suggestions for strategies and investments, based on current evidence on interventions
4. Initiation of country plans to take forward policies and interventions to improve public-private partnerships for child health
5. Recommendations for international and regional actions
6. An advocacy statement with four to five key messages, including the rationale for working with private sector providers to reach the Millennium Development Goals (MDGs), lessons learned and guidance for investments

2. Common Interests of the Public and Private Sectors – Challenges of and Opportunities for Working Together

Common interests of the public and private sectors and the challenges of and opportunities for working together were introduced during plenary sessions (see annex 7). A summary is provided in the introduction section below, based on information from the presentations and on Paul (2006) and Sundaram & Holm (2005).

2.1 INTRODUCTION

The poor in low-income countries continue to be disproportionately affected by diseases. The health of newborns and young children is one of the specific concerns, as 99% of the four million global neonatal deaths per year take place in developing countries. Sub-Saharan Africa and South Asia account for two-thirds of this burden. Existing interventions, delivered through a mix of outreach, family, community and clinical services, could reduce neonatal deaths by more than 70% and could make a similar contribution to child health after the first month of life.

The MDG of reducing the mortality of children under the age of five by two thirds from the 1990 baseline by the year 2015 (<http://www.un.org/millenniumgoals/>) will not be achieved unless there is a major change in the delivery of child health interventions. Low- and middle-income countries must urgently review their existing programs and investigate new approaches. To increase the likelihood of achieving the health-related MDGs, it will be necessary to: i) devise and implement strategies that ensure accessibility of existing and new products and services to poor populations, and ii) establish environments conducive to product quality, appropriate use, sustainability and commercial viability, and iii) develop new drugs, vaccines and other health products.

Neither the public nor the private sector alone will be able to adequately address these issues in order to eliminate the existing health inequities. However, over the last decade it has become increasingly recognized that, when appropriately organized and motivated, players from the public and private sectors can combine their different skills in partnerships to solve problems that have so far not been adequately addressed by independent action. In the last decade an unprecedented number of public-private partnerships (PPPs) have therefore been established. These are of great diversity, due to the wide range of institutions in both the public and private sectors. The public sector comprises intergovernmental organizations, governmental agencies, ministries, institutions and programs in which governments own the assets. The private sector included everything that is not government owned, including civil society entities and commercial companies.

The resources and public opinion that have been mobilized by PPPs to date are impressive. Given their importance as an ongoing tool to help achieve the MDGs, it is imperative to study their operation and impact in more detail, to learn from their experiences and to use the findings to improve ongoing and future implementation. The present forum opened its investigation into the potential of PPPs to improve child health through a panel discussion. Common interests, challenges and opportunities were explored by drawing on the experiences of six participants from both the private and public sectors. This was followed by a plenary discussion, allowing for clarifications, questions and comments. The sections below summarize the overall outcome of these interactions.

2.2 COMMON INTERESTS

The public sector cannot provide services and commodities to an entire country. Private providers therefore have a role to play in improving the availability and quality of services and commodities. Unfortunately, it is often not realized that the two sectors can complement each other and that they share the common goal of reducing child mortality.

In their desire to achieve this goal, both sectors share the interest of high-quality service delivery, as they aim to make a positive impression on the consumer. To ensure quality services and commodities, appropri-

ate policy needs to be formulated and implemented. Early involvement of the private sector is important to ensure a sense of ownership and that its activities complement those of the public sector.

2.3 CHALLENGES

Given that both sectors are often unaware of their common interests, there is a need to highlight the potential benefits of intersectoral collaboration and to support activities to establish and improve it. The current mistrust on both sides needs to be overcome through more involvement of the private sector in activities such as training, policy discussions, standardization of interventions, etc. In many cases this will require a 'revolution' in public sector thinking regarding the role of the private sector and the fact that private providers have other motives as well as financial profit.

Involvement of private providers will have to take account of their time constraints (e.g., by designing short and flexible training sessions). Human resources in both sectors are often in short supply. Financial support is required to develop human resources (e.g., through training), to compensate partners for their time and to fund and oversee implementation. Raising the required funds to establish and maintain PPPs requires a change of the current perception that something that is implemented by the private sector does not require funding.

Further challenges include how to address the issue of practitioners that work in both the public and private sectors, and how to ensure that the private sector is involved in policy discussions while maintaining control over its implementation.

2.4 OPPORTUNITIES FOR WORKING TOGETHER

Increasingly it is realized that the private sector provides a great resource to improve the availability and quality of services and commodities. Private sector associations / organizations are often already present and can be used as a mechanism to support this process. Associations provide a mechanism for a dialogue between the public sector and private providers, if the private providers can be encouraged to work through them. Establishment of further associations where these are not present should be encouraged.

3. Intervention models for improving the role of the private sector

Strategies for working with private sector providers (PSPs) were presented during plenary sessions (e.g., see annex 7, presentations 2 & 3 and annex 8, presentation 2). A summary of these is provided below, based on information from the presentations and on Smith et al. (2001) and other resources listed in annex 3. Governments are encouraged to use a range of these approaches rather than relying on a single one.

TRAINING AND SUPERVISION

Improving the knowledge and skills of PSPs is an important starting point. Most providers receive no guidance on diagnosis and treatment from the public sector and thus rely on more biased information from pharmaceutical companies or other sources. Disseminating evidence-based information to PSPs can improve this, but it does not change practice unless accompanied by training.

The advantages of training are that it is a relatively easy and quick way to improve practices of a large number of providers and that it tends to be less costly than other approaches, such as franchising or accreditation. However, it can be hard to engage the interest of providers, and improvements attributable to one-off training may be short-lived. It is therefore necessary to provide follow-up and supervision, which can be difficult for an under-resourced public sector. Furthermore, training usually focuses only on one or a few topics, and will thus need to be expanded over time to address other child health issues.

REGULATION

While private providers deliver a large proportion of curative and preventive services, concerns have been raised regarding the quality of those services and how they affect health outcomes. Governments can improve on this by setting rules, such as basic legislation that governs the licensing and registration of health professionals and facilities, and by enforcing these rules. There is a wide range of issues that can be regulated, for example the quantity, price, quality and distribution of health services, and the production and distribution of drugs.

However, despite the existence of basic legislation, the degree to which regulations are effective and enforced is generally low. Many regulations affecting the health sector are cumbersome and not relevant to today's concerns. Regulation is also an inherently political process involving individuals and groups with vested self-interests, who attempt to influence the relative success or failure of a regulatory intervention.

To draw up successful regulation it is essential to understand the political process, the importance of developing alliances, and the limitations of the public sector. Enforcing strict regulations is generally beyond the means of most governments. The design of policies therefore needs to reflect the capacity for their enforcement and the realities of the population's/community's needs. For example, shop attendants can be trained to treat key childhood illnesses, which should be reflected in policies.

MOTIVATION

Ensuring that PSPs are and remain motivated is crucial to the success of PPPs. Motivation should thus be considered a key component of all interventions. Health worker motivation, in general, is a complex challenge to address, as it is multifaceted and context-bound. Factors that directly affect motivation are the presence/absence of infrastructure, supplies and skills. Other factors affecting health worker motivation include feedback, branding, and posters or other materials that show the client that a provider has received training.

CONTRACTING

As governments review their role in ensuring the provision of health care, there is a shift from provision to purchasing services from private providers. These may include doctors, other health professionals, health centers or hospitals. Purchasing can be done through a competitive process or through choosing a reputable and/or established provider as a contractor. The client (usually the government) and the contractor enter into an agreement, which specifies the type of service to be provided, its coverage, quality and cost.

This strategy requires that institutional capacity is in place or is developed to draw up, manage, monitor and evaluate contracts. It also relies on the availability of suitable providers.

ACCREDITATION / FRANCHISING

These approaches recruit PSPs into a network and provide training in the delivery of a product or a service to a minimum standard, to make it more widely available. They are distinguishable from social marketing by the complexity of the product or service provided and because the provider, rather than the product, is accredited. Providers' skills and/or premises are assessed and accredited and their services are promoted to potential users. Accreditation is awarded for a time-limited period and compliance with minimum standards is externally assessed.

Some examples of accreditation are referred to as 'franchising,' with a for-profit or not-for-profit organization acting as the franchisor and PSPs as franchisees. In this case the PSPs deliver services in accordance with the franchisor's specifications and are promoted to users through the franchisor's branding. Franchisees typically receive training and subsidized supplies in return for conforming to the franchisor's standards.

The advantage of accreditation and franchising is that they provide greater quality control of PSPs. However, their limiting factors are that they are labor intensive, costly, and slow to roll out, and that accredited services

are unlikely to reach the very poor.

CLIENT EDUCATION

The client education strategy is based on the premise that consumer and community expectations of a type and quality of service can influence the behavior of PSPs. It requires that clients are aware of their rights, able to identify when they are not receiving adequate quality care and, ideally, are socially and legally empowered to take action. The media and consumer advocacy groups have an important role to play. Client education, particularly caregiver education, should be a part of all interventions.

NEGOTIATION

Negotiation techniques aim to improve the quality of service provision, such as childhood case management, and of formal and informal private practitioners, particularly of shopkeepers and private clinics. Negotiation sessions are conducted by facilitators/moderators trained in the relevant techniques. In the case of child health, the objectives of negotiation are to:

i) improve the practices of PSPs related to case management of diarrhea, malaria and acute respiratory infection, ii) improve PSPs' skills in identifying and referring severely ill children, iii) support PSPs in providing suitable child health prevention services, and iv) increase the proportion of private practitioners who are registered with the government regulatory authorities.

4. Key Issues in the Implementation of Public-Private Partnerships

A large proportion of the population in low-income countries relies partially or fully on PSPs to meet their health care needs. Close collaboration between the public and the private sector therefore holds great potential to improve child health. However, evidence is limited as to what the key issues in establishing and maintaining successful public-private partnerships are and how they are best addressed.

In preparation for the forum, five broad categories of potential key issues were settled on:

i) policy context, ii) public/private sector roles and capacity, iii) quality of drugs and commodities, and of services, iv) access, coverage and equity, and v) consumer demand. During the forum, the participants' experience was used to identify the priority issues under each of these categories, as well as potential ways to address these issues and needs for further research.

Participants were invited to choose a group that best reflected their interests and experience. Scene-setting presentations (summarized in annex 8) were given to pairs of groups to stimulate debate. Group work was later presented to the forum participants, followed by time for questions and discussion. Summaries of these group presentations are provided below, as well as comments and questions from a final plenary discussion and a general summary.

4.1 POLICY CONTEXT

Issues and Constraints:

The private sector consists of a wide range of qualified (e.g., private practitioners, nurses, midwives) and non-qualified providers (e.g., herbalists, bone setters, spiritualists), many of whom are not organized in associations and are thus hard to reach. Data on them and their practices (e.g., quality, payment mode) are often unavailable.

Among the private providers, traditional healers are generally the least recognized by the government, with the MoH often being particularly biased against their inclusion as part of the health system. Though certain areas

of the private sector are commonly mentioned in official policy statements, their involvement is generally not reflected in implementation of interventions on the ground. In the future, the private sector needs to become more engaged in all aspects of health care delivery, such as training, research, transport and pharmaceuticals.

Lessons Learned from Interventions and Ideas for Improvements:

In some countries, such as South Africa, traditional healers now form part of the health system. This linkage and other involvement of the private sector, particularly in policy development, has improved ownership by and efficiency and confidence of private providers.

Evidence on PPPs is still limited. Many interventions are not being evaluated and documented in terms of impact and cost. This makes it hard to compare different approaches and to assess their sustainability.

Future activities should focus on the development of leadership capacity in the public sector to manage collaborations with the private sector. Interest of the MoH in such undertakings should be stimulated by presenting officials with data on health care-seeking behavior (showing proportion of patients served by private providers).

Implementation Priorities [Roles and Responsibilities]

- Build capacity of the public sector to effectively engage the private sector [MoH with donor support]
- Conduct situation analyses to learn about private sector types, distribution, and types and quality of services offered [MoH with research institutions]
- Initiate field programs/interventions (pilot studies); properly evaluate and document these. Utilize results in advocacy at national and global levels [MoH, research institutions, private sector]
- Create an enabling policy environment to encourage working with the private sector [Government with private sector/civil society's participation]
- Share experiences (south-south) related to PPP interventions [Donors]
- Consider integrating certain interventions rather than using vertical one-intervention programs (e.g., community-based distribution (CBD) of anti-malarial and pneumonia drugs) [Donors, MoH, PS]
- Improve streamlining of donors' efforts and collaboration in PPP activities [Donors]

Research Gaps

More field programs and pilot studies are needed to provide evidence for advocacy at national and global levels. It is essential that these are well documented and evaluated, particularly with regard to their impact and sustainability. More operational research is needed to establish the effectiveness of integrated delivery systems.

Further work is also needed on the effect of PPPs on equity of child health services and on health systems in general. The use of non-health-sector resources should be explored with regard to improving communication, transport and services (e.g., mobile phones, food industry, agricultural sector).

Questions & Comments

Questions and comments that were raised during the discussion were as follows:

- Implementation could use an **integrated or vertical approach**. *What would be the preferred one and shouldn't there be a framework to allow for an integrated approach?*
- To improve child health outcomes, we need to also **look at other sectors** and private providers that work within these (e.g., communication, food, transport). For example, in Mali a mobile phone network has agreed to send out messages on ORS and other health-related issues.
- In case of operational constraints, **operational research** may provide an answer to guide decisions. For example, it might show that a certain type of private provider can safely dispense a specific medicine.

- Far too many people at the country level are doing different things – **these activities need to be harmonized.**
- Public policy for child survival needs to **involve all the stakeholders.**
- A potential recommendation from the forum might be to use the partnership for maternal, newborn and child health (<http://www.pmnch.org>) as a **vehicle for promoting** some of this dialogue.

4.2 PUBLIC / PRIVATE SECTOR ROLES AND CAPACITIES

Issues and Constraints:

One of the current issues related to public and private sector roles and capacities is the question of how to develop policy while ensuring sector-wide ownership. The sequence of events that needs to take place is frequently unclear (bottom-up versus top-down), as is the issue of how to get everybody involved. Similarly, in implementing the policy the relative responsibilities of the two sectors (monitoring, support, supervision, regulation, and evaluation) are often not defined. This is at least partially due to the wide diversity of private sector providers, the different levels of involvement within both sectors, and a general lack of awareness of PPPs and recognition of their potential to improve child health. Many of the potential partners also do not trust each other, making them reluctant to collaborate.

What seems to be needed is the political will to engage in PPPs and to facilitate the process, as well as resources to support partnerships. Once this commitment has been given, priorities need to be set. This process should take into account the variation in objectives between the public and private sectors and within the wide range of private sector providers.

Lessons Learned from Interventions and Ideas for Improvements:

Involvement in the establishment and maintenance of PPPs requires the commitment and time of public and private sector representatives. Private sector providers, in particular, need to be compensated for their opportunity costs (the time not spent on their wage-earning activities). To stimulate private sector initiatives, support should be offered in the form of training, services, or by waiving taxes and tariffs. A mechanism is needed to build and sustain capacity for PPP, as is a forum for information-sharing among partners and for advocacy. All of the above are dependent on high-level political commitment that is sustained over time and on the motivation of individuals involved in the process.

Implementation Priorities

- Develop policy and implementation guidelines
- Provide resources
- Build capacity
- Provide advocacy/networking
- Strengthen existing private sector coalitions / associations
- Employ an iterative process (evaluate, try new approaches, share information)

Research Gaps

To start the process of creating PPPs, the local context needs to be analyzed. Guidelines on how to conduct such situation analysis do not exist and should be developed. These could form part of a 'Global Guidance Tool' for PPPs, which should provide a general overview of how to establish and maintain PPPs.

Pilot studies and better documentation of existing interventions should be employed to provide the evidence to decide which components and implementation mechanisms are suitable for PPPs. Equally important is further work on issues related to scaling-up of interventions that seem effective at small-to-moderate scale (e.g., cost, cost-effectiveness, operational constraints/opportunities).

	Roles	
Responsibilities	Private Sector	Public Sector
Situation Analysis	Participates	Takes lead
Policy Development	“	“
Resources	Contributes	Identifies, mobilizes
Advocacy	Leader depends	
Capacity Building	Delivers or progressively contributes	Initiates
Iterative Process	To be defined during policy development	
Research*	Participates	Takes lead
<i>*Other partners will get involved (e.g., research institutes, universities)</i>		

Questions & Comments

Questions and comments that were raised during the discussion were as follows:

- **Roles and responsibilities** depend on and change according to country context. The matrix presented above will **change depending on the country**.
- Guidelines can be developed at the national level, but it would be good if an international agency could take on the role of developing more **general guidelines** that could be applied to a number of countries/ regions.

4.3 QUALITY OF DRUGS AND COMMODITIES AND OF SERVICES

Issues and Constraints Regarding Drugs and Commodities

To contribute to ensuring drug quality, traditional and herbal products will need to be standardized, which is costly, and regular quality control measures need to be implemented. These activities are often constrained by the need to maintain a low price of drugs to the consumer and the lack of sufficient laboratory technology. Limited or no quality control results in the influx of ‘counterfeit’ or substandard drugs at the lower levels. Effective post-marketing surveillance might help to reduce this.

Other constraints are the lack of human and logistic resources, which affects both the distribution of drugs to the customer (resulting in lack of availability and high prices) and the coverage by quality control systems of ports of entry for drug products (being unable to prevent the entry of sub-standard products). The latter is further complicated by the frequent corruption of regulatory systems and the lack of regional harmonization.

Issues and Constraints Regarding Quality of Services

Trained staff is in short supply and tend to be clustered in urban areas. Poor remuneration often leads to low motivation and morale and, in turn, to insufficient time being spent on patient consultation. This is exacerbated by a lack of provider knowledge on customer care and communication skills, particularly regarding adolescent-friendly care. Information for providers (guidelines and standards) and consumers (product information) is often absent, and service delivery is not adequately supervised and monitored. Further constraints to both the public and private sectors are the absence of sufficient logistics, infrastructure and equipment, which directly affects the availability and quality of services, and the lack of consumerism, which could exert pressure on quality.

Lessons Learned from Interventions and Ideas for Improvements (Drugs)

Experience to date has shown that franchising is an effective approach to reach rural areas with quality drugs, and indicates that monitoring of quality, using recent technologies such as Personal Digital Assistants (PDAs),

is promising. However, buy-in of all franchising stakeholders is needed and governments ought to reduce taxes and tariffs in order to reduce drug prices to consumers. To improve quality, governments could contract services to private sources.

Implementation Priorities for Quality of Drugs and Commodities

- Enforce existing drug regulations through:
 - Training of inspectors
 - Obtaining more financial resources
 - Public education/consumer empowerment
- Train drug sellers on new drugs and their use
- Improve drug availability via:
 - Changing policy to allow multi-source products
 - Reducing tariffs on drugs
- Disseminate information to the private sector on:
 - Essential drugs list
 - Standard treatment guidelines
- Liberalize the central medical stores to allow private sector providers to access generic drugs
- Strengthen and sustain post-market surveillance through:
 - Improving systems
 - Allocation of sufficient financial resources
- Use effective contracting mechanisms to achieve quality assurance

Implementation Priorities for Quality of Services

- Disseminate relevant guidelines and standard operating procedures to:
 - Private providers
 - Drug sellers
- To encourage private sector participation in preventive health care, the government should provide private providers with resources
- Enforce licensing of facilities in the private sector
- The government needs to set up a good incentive system to reward licensed/high- performing private providers
- Governments in the region should develop a joint database/website on health provider position vacancies to deal with gaps
- Develop/update a training curriculum for pharmacy assistants (both new entrants and existing) and implement it
- The government should assist traditional healers in forming associations and developing curriculum for their practices
- The government should support the training of traditional healers (excluding those not registered) in order for them to become licensed

Questions & Comments

Questions and comments that were raised during the discussion were as follows:

- **Franchising** and **accreditation** are mechanisms to improve access to child health services.
- Membership in **professional associations** should be encouraged.
- **Professional associations** can assist in setting incentive levels. For example in Senegal it is planned to anonymously assess the quality of providers (pharmacies) followed by publication of the results to allow providers to see how they compare to others.
- The private sector should be involved in **prevention activities** such as immunization (free provision of medication to the private sector, but allowing practitioners to charge consultation fees or for materials, e.g., needles).
- The **policy context** needs to be taken into account. For example, training of traditional healers to treat certain diseases might mean that they need to be allowed to use drugs such as cotrimoxazole, to which, according to regulations, they should not have access.
- The use of **incentive systems** needs further thought and study. Too much subsidy targeted at the private provider will create dependency. Subsidies should be targeted at the consumers and at the promotion of consumerism.
- The **self-regulation** of associations plays an important role in the quality of services and commodities. Currently, not everyone participates in these associations. How to increase participation needs further study.

4.4 ACCESS / COVERAGE / EQUITY

Issues and Constraints

A major question is how best to reach the poorest of the poor. Medicine shops (including accreditation/franchising) do not necessarily reach the hard to reach, and PPPs, like other strategies, face the challenge of how to target subsidies.

Expansion of services is limited by governments' lack of capacity for contracting and by the cost of establishing and sustaining accreditation schemes (e.g., yellow star). Reclassification of drugs for use by lower-level providers has potential to improve access.

Lessons Learned from Interventions and Ideas for Improvements

Improvements have been achieved through risk pooling (by means of community health financing), through involvement of private practitioners in immunization and by waiving taxes on products such as ITNs and artemisin-based combination therapies (ACTs). Particularly, ITNs have benefited from social marketing and the use of voucher systems (e.g., Nigeria).

It has also been shown that PPP policies need to be comprehensive (in Mali, policy was developed with full involvement of the private sector), and that stewardship and regulation roles need to be separated.

Implementation Priorities

- Develop policy and strengthen professional organizations in the private sector to facilitate collaboration with the public sector.
- Build capacity (training should include contracting at central and decentralized levels).
- Set up procedures and disseminate guidelines.
- Contract out services provision, public sector functions (e.g., distribution of drugs) and training.
- Government can manage contracts itself, or it can hire contracting agencies to manage the contracts on its

behalf.

- Increase collaboration and coordination between the public and private sectors at implementation level.
- Use voucher system and modern technology (e.g., telephone system linking central office).
- Use community volunteer health workers for distribution of drugs. There is a need for training and monitoring the use of drugs according to guidelines (e.g., WHO/UNICEF recommendations for community management of ARI).
- Franchising and accreditation of drug shops and clinics. Provide incentives to open shops in the rural areas or outreach/re-supply of drugs for community volunteers.
- Enter into dialogue with manufacturers to lower prices, e.g., Nigeria.

Research Gaps

The cost-effectiveness of different approaches to involving the private sector needs further investigation, with the aim of understanding the real costs of providing services in the public and private facilities. It will also be necessary to study whether approaches designed to provide equity have the desired impact and how effective different incentives for providers are (e.g., mode of payment).

Questions & Comments

Questions and comments that were raised during the discussion were as follows:

- **Training** needs to be considered in the context of other aspects of capacity building. Training on its own is not sufficient.
- *Is health insurance considered as a mechanism for equity enhancement?*
Data from Mali shows that community risk sharing mechanisms increase service utilization.
- *Has there been discussion in regard to a timeframe for **scaling-up**? Do we have a sense which of the interventions is likely to reach the population most quickly?*
Now that there are major changes taking place in health policy formulation in various countries, this provides opportunities to include scaling-up in government policy. Countries' representatives present at the forum should investigate critically which opportunities they see for scaling-up PPPs in their context within the next year(s).
- One needs to be aware that interventions used in pilot studies may not be suitable for **scaling-up**.

4.5 CONSUMER DEMAND

Consumer Demand and Quality of Care

Consumers, public health practitioners and other providers may all have different perceptions/standards of quality/guidelines. Apart from quality, consumers pay attention to client-provider interaction, sympathy, empathy, respect and the provision of 'tangible' services.

Consumer Demand and Service Utilization

Consumer demand is a complex interaction of a range of factors. These include the influence of global developments and mass media campaigns, the actual availability of a particular product and its effectiveness (perceived and actual), and the perceived quality of the service delivered (qualified by cost).

Lessons learned from interventions and ideas for improvements

Consumer demand can be stimulated by helping providers to facilitate the dissemination of 'tangible' information, by pre-packaging of drugs/products and through training (e.g., shopkeepers, non-formal training, provider networks). Further improvements at the provider level can be achieved through experiential marketing (see glossary). The concepts of marketing need to be explained to providers on the ground.

Clients can be involved in the development of quality services, for example by raising awareness of what product to expect, and decision-makers in care-seeking can be targeted specifically.

Implementation priorities [Roles and Responsibilities]

- Target subsidies
 - Vouchers
 - ITN vouchers
 - Fever vouchers (EPI 1&3, for 1st line anti-malarial or ORS, etc.)
[Private Sector – procurement / distribution / delivery;
Public Sector – manage voucher scheme, ensure noncompetitive environment]
- Increase access to quality goods and services
 - Franchising
[Public Sector – regulatory framework, provide guidelines, licensing;
Private Sector – investment, training, logistics, quality control, price controls, demand creation]
 - Contracting
[Public Sector – enter / manage contracts, e.g., for provision of care;
Private Sector – facilities, providers, treatment]
 - Accreditation
[Public Sector – policy-making and regulation;
Private Sector – provide independent professional regulatory body]
 - Pre-packaged products
[Private Sector – procurement / distribution / delivery;
Public Sector – regulation, identification of need]
- Increase awareness of products and services
 - Information / Communication
 - Generic Demand Creation, e.g., ITNs
 - Experiential Marketing (skits, road shows, etc.)
 - Mass Media
 - Improved provider/patient communication (explanations)
[Public Sector – provide technical content, develop message, engage professional marketers in the private sector;
Private Sector – package messages to increase demand, drug manufacturers financing, provide some free services (some constraints)]

Research gaps

Two key questions related to consumer demand are whether vouchers for fever work and if this strategy can be expanded to other child health interventions. On the provider side it is often not known what influences motivation and practices, and how different types of providers interact with the public sector (at all levels). Consumer research itself has a number of methodology gaps, meaning that methods to understand consumer desires and needs are limited. To identify gaps in the current understanding of consumer demand it would be useful to conduct a review of the literature on household production of child health.

Questions & Comments

Questions and comments that were raised during the discussion were as follows:

- **Targeted subsidies:** *Would competition be good?*
Reply from group: It needs to be ensured that targeting is effective. This should be done by using one scheme and focusing on this it (e.g., voucher scheme for nets).
Reply from audience: You should avoid competing subsidy systems in the same region, but use the advantage of the private sector, i.e., competition between providers.
- **Integration of approaches:** *How to do this for vouchers?* After all, it won't be possible to give a voucher for each of a variety of diseases.
Reply from audience: In Latin America you have a national insurance number instead of vouchers. This allows you to access health services. However, prevention has been left out of this scheme, which has had a negative effect on all preventative efforts.
- **Health insurance** in Rwanda has led to an increase in the consumption of health services; by 2009 it will hopefully have gone beyond 70%. However, one of the constraints is the poverty of the population.
- Ghana and Nigeria have recently launched **health insurance** schemes (health maintenance organizations, which have a list of hospitals/clinics that people can go to). In Nigeria the first two years are free, after which a premium will need to be paid. Also, people outside the country can pay a premium for their relatives in the country to be able to access health care.
- **Franchising** is about building a brand and, related to this, the quality promise, but no one tells each franchise how much to charge for the product. Other sectors should not try to control the price of the franchise.

4.6 PLENARY DISCUSSION

Questions and comments that had not been addressed during the discussions on each of the above issues were brought forward in the plenary discussion. The following issues were raised:

- *What happens if global **financial support** to PPP/PPM is withdrawn?*
Bringing the two sectors together does not require much money and should be feasible with limited financial resources.
- *The best examples for successful PPP are where a single issue has been addressed and where there is good program funding, e.g., TB. With child health there are a number of products. How should this be approached?*
A reasonably strong private sector is a prerequisite. Key conditions that are of public health importance **need to be identified** (e.g., the top three, such as diarrhea, malaria, respiratory distress). Otherwise, if one tried to address all childhood conditions, this would be too complicated.
- The TB initiative is driven by field interventions. Results have been used to stimulate more action in other countries and action at the global level. In child health this seems to happen the other way around (top-down). This needs to change. **Activities in the field need to be stimulated.**
- Experience in child survival from India: through PPPs there has been an increase in the number of pneumonia cases detected by the private sector. Other diseases are also being addressed this way.
- A fitting PPM model is only going to come from a **good situation analysis**. It is planned to develop a tool for carrying out TB situation analyses, which can then be applied in different countries.
- The **evidence for PPPs is still limited**. In some countries there may be evidence related to malaria, in another country for a different disease. There is a need to **be opportunistic** and **explore potentials** in different countries.
- Embezzlement is of concern for PPPs, as for other interventions. It is thus best to **set up some small projects** and to **learn from them**. If corruption and/or fraud are detected, this will need to be addressed.
- **Incentives** are not a big issue in TB because most doctors don't see more than five to six patients at a

time. A major incentive is the increasing number of patients. Doctors can still charge basic consultation fees, but are not meant to charge for drugs.

- *How does Uganda deal with the public-private mix (i.e., practitioners that are working in both sectors)?*
This has not been resolved and discussion on this aspect of PPP continues.
- *What is the best way to approach the challenge of a district-driven process for PPPs?*
Districts are encouraged to **go through the process systematically**, addressing one issue at a time.

4.7 COUNTRY CASE STUDY

The presentations from Uganda (see pp. 36-37, Annex 7 for abstract and CD-ROM for full presentations) on the development and implementation of a national strategy for utilizing the potential of private practitioners in child survival provided an overview of many of the issues discussed in the previous sections. It showed that it is necessary to:

- Address PPPs within the national health strategy
- Establish a coordinating mechanism
- Establish a process of participatory policy formulation
- Develop a holistic vision that is not just focused on small pilot projects or a small area
- Recognize the importance of decentralizing the process and giving more responsibility to the districts
- Realize the appropriate use of research data to inform policy formulation
- Recognize the need to build capacity at all levels to manage the process
- Realize that expectations can be high on both sides and need to be managed
- Make critical decisions on scaling-up, with evidence being needed to decide which aspects of PPPs to include

Uganda's example has also shown that we need to be cautious. The process should not be allowed to be driven by money, without regard to a clear vision. Vertical approaches focused on a specific disease may do this to the detriment of the larger vision.

4.8 SUMMARY OF KEY ISSUES

On the basis of points raised in the discussions here and from the country presentations, the framework below has been developed. It is based on an earlier version by Smith et al. (2001). Key PPP implementation strategies for better health care delivery are outlined, and the respective roles of public and private stakeholders are shown. The framework is meant to help planners to remind themselves of options to make better use of the private sector and of the potential outcomes of these strategic options.

Enabling Policy Environment		
OBJECTIVE	Public Sector	PSP
Increase COVERAGE	<p>Lower policy, regulatory and fiscal barriers to the work of PSPs by:</p> <ul style="list-style-type: none"> • Relaxing regulatory requirements • Simplifying bureaucracy • Removing taxes (e.g., on drugs, ITNs) • Providing incentives such as preferential loans and tax breaks <p>Facilitate market entry, e.g., by providing tax exemption to practitioners setting up in rural areas</p> <p>Contract PSP to deliver health services (e.g., package of essential health care)</p> <p>Support generic marketing to support products of many firms (e.g., Tanzanian ITN program)</p>	<p>Marketing through different strategies, e.g., social marketing using mass media and interpersonal techniques</p> <p>Establish/join accredited network</p> <p>Expand services through franchising</p> <p>Package products well (e.g., blister packs for drugs)</p> <p>Use branding</p>
Improve QUALITY	<p>Enact and enforce legal restrictions and regulatory controls</p> <p>Provide training, support and incentives to PSP to conform to good practice</p> <p>Raise awareness of services to be expected among the community</p> <p>Support the recruitment of PSP to accredited networks</p>	<p>Self-regulation through accredited network</p> <p>Professional associations for continuing education and self-regulation</p>
Reduce and Control COSTS	<p>Set and monitor PSP price levels</p> <p>Reduce or remove taxes and tariffs from public health products (e.g., ITNs)</p>	<p>Competition</p> <p>Participate in community financing</p>
Improve EQUITY	<p>Identify vulnerable groups</p> <p>Establish targeting mechanism for subsidies</p>	<p>Extend reach of services and commodities more widely</p>
Increase ACCESS	<p>Reclassify some essential drugs for use by lower-level health workers / over-the-counter sale</p> <p>Build capacity for contracting</p>	
Informed Consumer Demand		

5. Country Activities for 2006

To apply the outcomes from discussions and group work (sections 2 & 4), participants were invited to form groups according to the country they work in. Using their own experience and information and ideas gained during the workshop, each country team was meant to formulate activities for 2006, either to establish PPPs in their setting or to expand activities if such partnership is already in existence. A template was provided to facilitate discussion and subsequent reporting to the audience.

The section below contains key points from the presentations by individual country teams. A full version of these presentations is provided in Annex 9.

NIGERIA

Note: Nigeria already has a policy

- Start advocacy process (Federal Minister of Health will lead it)
- Develop a national strategy and operational plans
- Mobilize resources
- Build capacity and strengthen institutions of key stakeholders
- Deregulate some prescription drugs to over-the-counter use. This process is already ongoing (e.g., ACTs)

UGANDA

- Initiate PPP policy approval by parliament (not yet approved, but has not hindered implementation to date)
- Strengthen and build capacity of public and private sectors for service delivery
- Strengthen the structural framework (councils, coalitions and professional associations) for effective regulation and control for both public and private sectors
- PPPH is now mainstreamed within the health sector (i.e., has budget line, is mentioned in health framework and has some resources allocated to it). There is continued need to facilitate and scale up PPPH activities.
- Inform consumers and involve them in quality assurance

KENYA

Note: Kenyan government does not have a PPP policy yet

- Present the results of present forum to key stakeholders at MoH
- Advocate for stakeholder meeting (public, private, developmental partners)
- Set up a secretariat with a representative board with assistance from development partners
- Through the secretariat undertake a situation analysis, identify gaps and research needs
- Secretariat and partners to ensure implementation of policy and scale-up

SOUTH AFRICA (EASTERN CAPE)

Note: A provincial plan was prepared by one representative from South Africa

- Complete installation of provincial-level information system from central depot to all hospitals and local service areas (LSA)/districts

- Strengthen stock management information systems at the hospital and LSA levels
- Operationalize dispensing information system for hospitals and clinics
- Create electronic link between clinics, LSAs and depot, and between hospitals and depot

GHANA

Note: Already has policy document on the involvement of the private sector. This was recently released and many people still don't know about it.

- Improve quality of services through building institutional capacity, expanding licensure and branding
- Improve drug quality through surveillance of imports, publicizing manufacturers of drugs and consumer involvement
- Build consumerism through consumer education and creation of new consumer associations for health

RWANDA

Note: Has health insurance system (public and private)

- Identify the private sector
- Draw up a policy between public and private sector
- Revise the standards and objectives to reflect the new policy
- Organize the private sector
- Develop and implement a strategic plan for promoting partnership between the public and private sectors

TANZANIA

Note: Tanzania has a policy in place and discussion is ongoing on how to engage the private sector

- Conduct country situation analysis in order to understand the situation on the ground, especially to become familiar with the role played by other local stakeholders in child health care
- Develop and introduce PPP policy (review existing health policy) and guidelines in line with NHP with a particular focus on child health
- Introduce child health concepts in the private health sector
- Develop monitoring and evaluation mechanisms
- Scale-up child health initiative

MALI

Note: Mali currently has no PPP

- Provide a mission report on the present forum to the government
- Organize a big meeting for all professionals in the health sector. Part of this meeting needs to clearly define the private sector.
- Conduct an inventory of all people/organizations working in the area of child health
- Put in place a partnership framework for child health between the public and private sectors
- Establish social franchise for child health, based on existing structures

Annex 1: International Partners' Support of Forum Recommendations

During the time allocated to country teams (Section 5), representatives from partner institutions focused on five of the draft recommendations (pp. vii-viii) and established what action from international partners is required to move these forward and who should take responsibility. Individuals were identified within the group to provide follow-up on certain activities. These are shown in brackets.

Recommendation on global host to act as catalyst for PPP (1):

- Long-term host is needed. Transitional hosts to follow up on recommendation are proposed as: WB – Tonia Marek, WHO – Venkatraman Chandramouli, WHO – Phyllida Travis, USAID – Youssef Tawfik
- To host the PPP initiative, there is a recommendation that suggests hosting it within the Partnership for Maternal, Newborn and Child Health (<http://www.pmnch.org/>). [Khama Rogo, Venkatraman Chandramouli]
- One PPP person, high-level, 50% time in the partnership secretariat as a focal point/advocate. Talk to Joy Phumaphi, Assistant Director General, Family and Community Health, WHO Geneva. [Khama Rogo, Venkatraman Chandramouli]

Recommendation on advocacy for including private sector in child health (2):

- Each member of the forum will brief his/her organization about the forum's results and seek support. [All forum participants]
- There is a need to brief and involve WHO/AFRO. [Venkatraman Chandramouli]
- Participants of the forum will take advantage of suitable international events to advocate the importance of PPP for child health at the global level. World Bank [Khama Rogo], East, Central and Southern African Health Community (ECSA) [Steven Shongwe], Counterpart International [Darshana Vyas], USAID/Washington [Youssef Tawfik], e.g., the African Parliamentarian Meeting on Health to include PPP in the agenda [Khama Rogo, Steven Shongwe]
- Reach and advocate to new international partners and initiatives. e.g., Gates Foundation [MSH, Jane Briggs], Presidential Malaria Initiative [Netmark, USAID/Washington]
- There is a need to develop an effective tool(s) for advocacy and identify an organization/project to develop the needed advocacy tool. Possible candidates: Africa's Health in 2010, PSP-one, MSH, PATH, USAID, WB, WHO
- Share relevant documents on PPP such as situation analysis, field reports. e.g., Boston Consulting Group [Juan Manuel Urrutia, Netmark], SARA Toolkit updates
- Share communication strategy conducted by WB. Organize a meeting to share results with different partners. Seek financing to utilize results. [WB – Tonia Marek, PATH – Michelle Folsom]

Recommendation on including PPP in all health sector development plans (4):

- All participating players will advocate for including PPP in all health sector development plans within their own organizations
[WHO, PAHO, WHO/AFRO, USAID, WB, ECSA]

Recommendation on the need for technical support (5):

- To maintain momentum, there is a need to stimulate interventions quickly at the country level. The donor community will need to identify a pool of experts from projects/programs to provide technical support to country initiatives.

Recommendation on the need for monitoring, evaluation and operations research (11):

- There is a need to continue to evaluate interventions' impact and use them for advocacy.
[Country teams, pool of TA experts, see above]
- Ensure adequate objective evaluation and documentation of country-level interventions.
[Country teams, pool of TA experts]

Annex 2: Glossary

Accreditation

A third-party endorsement and assurance of the quality of service and care provided by a health provider. For this to be effective, the third party must have some credibility in the eyes of potential users.

Consumerism

Consumerism is a term used to describe the effects of equating personal happiness with purchasing material possessions and consumption. In the current context consumerism is used to name the belief that the free choice of consumers should dictate the economic structure of a society. Health care consumerism is about putting more of the decisions in the hands of the consumer, and providing consumers with useful tools and information that allow them to make decisions more comfortably.

Experiential Marketing

A type of marketing that attempts to evoke a strong emotional response, often by the use of sensory techniques, in order to create an affinity between a product and a potential buyer. It is used by companies such as Apple Computer to create an aesthetically driven consumer purchase. In contrast, traditional product-centric marketing generally seeks to persuade consumers by invoking rational factors that position the advertised brand as better than competing brands.

Franchising

An arrangement whereby a marketer of a product or service (the franchisor) grants exclusive rights to local independent entrepreneurs (franchisees) to conduct business, marketing the product or service in a prescribed manner in a certain place over a certain period.

Halo Effect

Cases where promotion of a branded product results in an overall increase in demand for that product category, not just the branded product.

Social Marketing

Social marketing involves the stimulation of demand for a product or service among potential users (the “crowding in” or “halo effect”) in order to increase sales of both the socially marketed and non-socially marketed products. It has a strong component of working with the product manufacturer, distributor and/or the potential retailers to support and ensure the supply of the product or service.

Annex 3: Useful Resources and Literature

A new face for private providers in developing countries: what implications for public health? Palmer N, Mills A, Wadee H, Gilson L, Schneider H. *Bulletin of the World Health Organization* 2002; 80: 292-297.

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The current state of newborn health in low income countries and the way forward. Paul VK. *Seminars in Fetal and Neonatal Medicine* 2006, 11: 7-14.

Toolkit to improve private provider contributions to child health: Introduction and development of national and district strategies. USAID, November 2005.

This toolkit included a CD-ROM with:

- Tools/examples for national strategy development
- Tools for interventions of different types
- General papers related to private providers
- Intervention-related documents

The toolkit is available from:

Africa's Health in 2010 Project
Academy for Educational Development
1875 Connecticut Ave, NW Suite 900
Washington, DC 20009
Email: ah2010@aed.org
Website: <http://ah2010.aed.org>

Utilizing the potential of formal and informal private practitioners in child survival in Uganda: Situation analysis and outline for developing a national strategy. Ministry of Health, Integrated Management of Childhood Illness (IMCI) Unit. August 2001.

Utilizing the potential of formal and informal private practitioners in child survival: Situation analysis and summary of promising interventions. USAID, Bureau for Africa, Office of Sustainable Development. Available from URL: <http://www.aed.org/ToolsandPublications/upload/UtilizingthePotential.pdf> [Accessed 10 December 2005]

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Working with private sector providers for better health care: An introductory guide. Smith E, Brugha R and Zwi A. London, Options and London School of Hygiene and Tropical Medicine, 2001. Available from URL: <http://www.options.co.uk/images/Private-Sector-Guide-full-version.pdf> [Accessed 10 December 2005]

Annex 4: Useful Websites

Publications

www.msh.org

Best Practices

www.advanceafrica.org

Case Studies

www.idd.bham.ac.uk/service-providers/stage2.htm

Purchasing

www.ihsd.org

Health Systems

www.worldbank.org/hsd

Contracting

www.nigi.org

Provider Network

www.cmsproject.com

Training

www.hsph.harvard.edu/ihsq/ihsq.html

www.worldbank.org/wbi/healthflagship

www.ncppp.org/training/ncppp.html

Annex 5: Final Forum Agenda

Day 1: Wednesday, 30th November

08:30 – 09:00 Opening of the Forum

Chairperson for Day 1: Dr. Runumi, Commissioner for Planning, Ministry of Health, Uganda

09:00 – 09:15 Welcome: objectives of Forum, outcomes and scope of the meeting
(Dr. V. Chandramouli, WHO, on behalf of the Forum Steering Committee)

09:15 – 09:45 Overview: Public-private partnerships: their role and importance in helping to meet MDGs
(Dr. Khama Rogo, World Bank)

09:45 – 10:15 Engaging the private sector in child survival: Overview of approaches, issues and lessons
(Dr. Youssef Tawfik, USAID)

10:15 – 10:45 Working with the informal private sector: Overview of approaches, issues and lessons
(Drs. Abiodun Akinpelumi, George Greer)

10:45 – 11:15 Tea & coffee break

11:15 – 12:30 Panel Discussion: Common interests of the public and private sectors –
challenges and opportunities for working together

12:30 – 13:00 Plenary discussion

13:00 – 14:15 Lunch

Day 1: Wednesday Afternoon, 30th November

14:15 – 14:30 Introduction to group work – Dr. Sylvia Meek (Malaria Consortium):

Identification of:

- a) Issues and constraints
- b) Lessons learned and ideas for improvement
- c) Implementation priorities and roles and responsibilities
- d) Research gaps and priorities

In topic areas:

1. Policy context
2. Public/private roles and capacity
3. Quality of drugs and commodities
4. Quality of services
5. Access, coverage and equity [drugs, commodities and services]
6. Consumer demand

14:30 – 15.00 Topic 1 and 2, Introductory presentations by Dr. Youssef Tawfik (for Michelle Kouletio, Concern International), Dr. Suzanne Prysor-Jones, AED. (outside Meera)

Topic 3 and 4, Introductory presentations by Drs. Margaret Ndomondo Sigonda, and Ben Botwe, and Drs. Danny Mensah, and Emmanuel Alphonse (Meera)

Topics 5 and 6, Introductory presentations by Drs. Catherine Goodman and Caroline Jones, London School (outside Royal)

15.00 – 17.30 Breakout Groups by Topic: Session 1 (with tea break at 16:00)

Group 1: Policy context (outside Meera)

Group 2: Public/private roles and capacity (outside Regal))

Group 3: Quality of drugs and commodities (Meera)

Group 4: Quality of services (Meera)

Group 5: Access/coverage/equity [drugs, commodities and services]

Group 6: Consumer demand (outside Majestic)

17:30 Plenary Wrap-up

18.00 Welcome reception

Day 2: Thursday, 1st December

- 08:30 – 08:45 Review of Day 1, Dr. V. Chandramouli
- 08:45 – 9:15 Overview of trends and opportunities in public-private partnerships, Dr. Tonia Marek, World Bank
- 09:15 – 09:45 Private-public partnerships for TB Control, Dr. Uplekar, WHO
- 09:45 – 10:15 Plenary discussion
- 10:15 – 10:45 Tea & coffee break
- 10:45 – 12:30 Breakout Groups by Topic (continued) – Session 2
- 12:30 – 14:00 Lunch
- Group presentations and discussion on
- a) Issues and constraints
 - b) Lessons learned and ideas for improvement
 - c) Implementation priorities for working at scale and roles and responsibilities
 - d) Research gaps and priorities
- 14:00 – 14:30 Policy context (Group 1)
- 14:30 – 15:00 Public/private roles and capacity (Group 2)
- 15:00 – 15:30 Quality of drugs and commodities (Group 3)
- 15:30 – 16:00 Quality of services (Group 4)
- 16:00 – 16:30 Tea break
- 16:30 – 17:00 Access, coverage and equity [drugs, commodities and services] (Group 5)
- 17:00 – 17:30 Consumer demand (Group 6)
- 17:30 – 18:00 Wrap-up of Day 2
- 18:30 – 19:30 Marketplace of resources and tools to assist implementation

Day 3: Friday, 2nd December

Definition of shared vision and country priorities

- 08:30 – 09:00 Synthesis of Day 2 outcomes
- 09:00 – 09:30 Uganda approach to private-public partnerships and the strategy development process, Dr. Bagambisa, Dr. Jesca Sabiti
- 09:30 – 09:45 Introduction to country group work
- 09:45 – 11:00 Breakout groups by country, and international/regional action
- 11:00 – 11:30 Tea & coffee break
- 11:30 – 13:00 Group Work continued
- 13:00 – 14:00 Lunch
- 14:00 – 15:30 Group reporting (priority actions by country and international/regional actions)
- 15:30 – 16:00 Tea break
- 16:00 – 17:00 Recommendations and next steps and advocacy statement
- 17:00 – 17:30 Reflections from international partners
- 17:30 Closing remarks

Annex 6: Participant List

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Annex 7: Presentations

To provide background information on PPPs, a considerable number of overviews and presentations were given during the forum. Abstracts of the overviews and titles of presentations are provided below.

HEALTH SECTOR REFORM IN AFRICA: Will Stronger PPPs Enhance Child Survival? Dr. Khama Rogo, World Bank

Dr. Rogo described Africa's current burden of maternal and child morbidity and mortality. He highlighted the fact that progress towards the Millennium Development Goals (MDGs) in Africa is not on track and asked the question of whether public-private partnerships (PPPs) can contribute towards improving child health in Africa. He then provided a review of health sector reforms (HSR) in Africa and the achievements, constraints, lessons and challenges that these reforms have brought with them. He concluded that PPPs have not been a dominant subject of HSR to date, but have a role in improving accountability by increasing choice, strengthening self-regulation and by increasing participation of the consumer. Countries embarking on PPPs will need to do so by considering this approach in the context of the health sector, by paying attention to achieving broad consensus and by taking a long-term approach.

ENGAGING THE PRIVATE SECTOR IN CHILD SURVIVAL:

Overview of Approaches, Issues and Lessons Learned

Dr. Youssef Tawfik, Child Health Advisor, USAID

To date most health care investment goes to the public sector, though most parents take their children to private practitioners (informal, formal), who often provide poor quality services. There is a need for improvement. To engage the private sector, its motives (profit, reputation/image, quality, customers' loyalty) and incentives (guaranteed markets, cost sharing of production or advertising, and prospects to expand markets) need to be understood.

Private providers can complement public services by increasing accessibility, collaborating in quality control, investing in research and development, etc. To facilitate this process, governments can use a range of methods, such as regulation, motivation, training and supervision, negotiation, franchising/contracting, accreditation, client education. However, PPPs have been hindered by mistrust between the sectors and by the fact that many private providers are not organized in associations, which make them hard to reach. Obstacles encountered by private providers include complicated and expensive procedures, and lengthy trainings that are hard to attend while running a business.

Observations to date show that the private sector is often mentioned in national health policies, but that this rarely translates into strategies and interventions. Policy dialogue and situation analyses to find entry points for PPP are rare, and where PPP interventions are implemented these are usually small scale. There is over-emphasis on the role of regulations as the solution for improving the quality of care, despite the lack of resources in the public sector to enforce regulations, and on increasing knowledge, while changing practice is not sufficiently supported.

To make PPP work it will be necessary to: i) understand private providers' motives and constraints, ii) create/strengthen mechanisms for mutual trust, iii) focus on fewer essential practices that will have an impact on child health, iv) involve private providers in intervention design, v) use techniques that focus on changing practices, not just knowledge, and vi) evaluate intervention's impact and cost, and make modifications accordingly.

WORKING WITH THE INFORMAL PRIVATE SECTOR

Dr. George Greer, Academy for Educational Development (AED),
on behalf of Abiodun Akinpelumi and Uzo Gilpin

This presentation focused on the role of drug shops and general stores among the wide range of informal private providers. Both are important because a large proportion of caregivers use them as the initial source for medical treatment of their children. With regard to PPPs their advantages are that they are accessible, have drugs, are affordable, already exist (sustainable resource) and tend to be willing to change practice if the results are positive for clients (and improve their business). To date these advantages have been made use of in the delivery of interventions for family planning, diarrheal diseases, malaria and acute respiratory infection/pneumonia.

Interventions to improve shop attendants' practices can be categorized as: training, negotiating, franchising, accreditation, regulation, motivation and client education. The advantages of training and negotiation are that it is easy to improve practices of large numbers of shop attendants relatively quickly, and that these approaches are less costly than franchising. However, they can be hard to sustain, and initial interventions often address only one health issue (though expansion to other child health issues may be feasible over time). Accreditation and franchising provide greater quality control of shops and potentially higher sustainability, due to their strong monitoring component. However, they are labor intensive, costly and slow to roll out. For regulatory measures there is a need to reflect realities on the ground, such as the possibility of training shopkeepers in the treatment of key childhood diseases, and the realization that strict regulations can often not be enforced. Motivation and client education should form part of all interventions. Motivation may include branding and posters to show that medicine sellers have received training. Client education tends to be most successful when focused on the caregiver.

Challenges that have been encountered when working with the informal private sector are:

i) gaining support of government agencies and professional health associations, ii) the diversity of backgrounds of medicine shop attendants, iii) maintaining the quality of drugs and services provided, iv) difficulties of expanding the range of commodities to address some child health issues, v) sustainability, vi) that drugs used for treatment of some key childhood illnesses cannot be legally sold by medicine shops, and vii) that training may lead to some shop attendants gaining a false sense of confidence in areas beyond those covered by the training.

PUBLIC-PRIVATE PARTNERSHIPS FOR HEALTH SERVICE DELIVERY IN AFRICA

Dr. Tonia Marek, World Bank

This presentation aimed at putting an end to the three myths listed below and at providing guidance on ways in which PPPs can be established. The myths are as follows:

- Health is mainly financed by the public sector. In fact, the public sector finances less than half of total expenditures on health; the rest is financed mainly by OOPS.
- The private sector is not very developed in Africa. In fact, there is a large private sector.
- The private sector is for the rich and the public sector is for the poor. In fact, people do use the private sector, especially the poor.

People choose not to go to the public sector, because quality of care is perceived to be poor, staff and drugs are not always available, patients are often not well received and parallel payment systems often make treatment as expensive as in the private sector. However, the private sector faces many of the same problems as the public sector, which frequently results in low-quality care. Given the extent to which people use the private sector for health care provision, there exists a need to improve the current situation. Potential solutions are contracting, franchising, giving concessions (e.g., to hospitals, mainly applied in South Africa), leasing of facilities (mainly

applied in South Africa) and the use of vouchers. Experience has shown that for contracting, it is particularly important to clearly outline the services that are meant to be provided, the incentives/disincentives for delivery and other terms to ensure adequate health care provision.

What is now needed from the perspective of the World Bank are systematic assessments of the private sector in countries where this has not been done. The Bank itself needs to seek support from private sector expertise and make a higher commitment to PPPs. It also needs to make PPPs a dominant subject of health dialogue (need for advocacy to achieve this), establish direct channels with the private sector, set up a PPP fund to complement operations, and support donor coordination to limit the number of procedures. Furthermore, to establish functioning PPPs, the public sector needs to be strengthened to allow it to fulfill roles such as setting policy, generating resources, providing regulations, monitoring and quality control. The private sector, in turn, needs to get organized to ease dialogue and needs to gain a place at the policy table.

Six points to keep in mind to promote PPPs:

- The whole health system needs to be considered, not just the public sector.
- Ensure that the organizations adapt (e.g., public sector to have a PPP focal person).
- Be opportunistic, look for win-win situations.
- Expand contracting. Based on experience so far, contracting may make a real difference in achieving the MDGs.
- Improve evidence-based evaluation.
- Apply lessons learned.

PRIVATE-PUBLIC MIX FOR TB CONTROL

Dr. Mukund Uplekar, WHO

Since 1999, TB control has focused on engaging private care providers (referred to as public-private mix, PPM). The aim is to improve the quality of TB care, increase case detection, improve treatment outcomes, enhance access and equity, and reduce the financial burden on patients. Practical tools have been developed, and guiding principles for PPM have been developed. This approach has improved treatment outcomes from about 50% to about 80-90% (results from projects, not national scale). Economic analyses for scaling-up of PPMs for TB control are ongoing.

Lessons learned to date are that National TB Programs (NTP) need to provide training adapted to the needs and conditions of the providers and need to provide drugs, equipment and stationary free of charge. The role of the NTP should be to coordinate, supervise and provide quality control. The use of intermediaries, such as NGOs or medical associations, often facilitates the process of bringing the public and private sector together.

Every provider has a potential role and can be drawn in through a variety of 'contractual' mechanisms. To do so, non-financial incentives are as important (if not more) as financial ones (most TB initiatives have no direct financial incentives to providers). The provision of free TB drugs to the provider generally provides sufficient incentive and is linked to provider performance.

Essential steps for the establishment of a PPM are: i) to conduct a national situation assessment, ii) to create a national resource (e.g., a focal point), iii) to develop and disseminate operational guidelines, and iv) to provide guidance on local implementation. This should be followed by scaling-up of the partnership.

Lessons learned to date are that 'learning projects' need to be set up and that motivation should be high, but expectations low (start with a few willing private providers; if it works more will join). 'Champions' need to be identified and groomed on both the public and private sides. More investment into the public sector is

needed, as are local autonomy and solutions. Implementation is helped by the use of interfaces, incentives and enablers, and malpractice can be reduced by informing consumers of what to expect from providers.

UGANDA'S APPROACH TO PUBLIC-PRIVATE PARTNERSHIP AND THE STRATEGY DEVELOPMENT PROCESS

Dr Bagambisa, MoH Uganda

In Uganda, the private sector has more infrastructure than the government and is acknowledged as a contributor to national health. The public and private sector complement each other and share a common goal, the good of the people. The goal of Uganda's PPPH is to contribute to strengthening the National Health System with the capabilities and full participation of the Private Health Sector to maximize attainment of the national health goals. This partnership goes much beyond financial support to the private sector and involves interaction between the partners and flexibility on both sides (with the private sector including private not-for-profit, private health practitioners and traditional complementary medical practitioners). The objectives are:

- Increasing equitable access to health care by the population, particularly the vulnerable groups.
- Optimizing use of available resources through the functional integration of partners in the National Health System at different levels.
- Improving quality of services through a participatory, joint quality assurance process and Human Resource Development Plan.

By now, the PPP policy has been finalized and distributed, and a bill to operationalize the policy is awaiting approval from the cabinet. Once implemented it is expected to increase utilization and decrease fees. Challenges encountered were related to: i) advocacy (not all understand and/or agree with partnership arrangements), ii) macroeconomic constraints, iii) stability and balance of systems (human resources, equipment, infrastructure) to allow choice from users, iv) the unstructured nature of the private sector, and v) a gap in human resources.

[For further information on PPP in Uganda go to http://www.health.go.ug/part_health.htm]

UTILIZING THE POTENTIAL FOR FORMAL AND INFORMAL PRIVATE PRACTITIONERS IN CHILD SURVIVAL

J. Nsungwa-Sabiiti, MoH Uganda

The Multi-Country Evaluation (MCE) for IMCI in Uganda found that the formal sector was not seeing sufficient patients to demonstrate an impact on mortality. In fact, almost two thirds of children were seen by the private sector. To address this, it was decided to introduce disease-specific intervention at the community level (home-based management of fever). Nevertheless, the challenge remained that many patients access the private sector for most other illnesses. It was thus decided to conduct a situation analysis (desk-based review) to determine what types of Private Practitioners (PPs) operate in Uganda, their distribution, the quality of care provided and what laws regulate them. It was found that three categories of PPs could be differentiated:

- Doctors, midwives, nurses, clinical officers, pharmacists and other allied practitioners
- Nursing assistants/aides, drug sellers and retail shopkeepers
- Traditional healers and midwives

Less than 30% of these practitioners were registered. A number of existing channels were identified to engage the PPs, but development of a PPP strategy was challenging, because it was hard to reach the majority of private practitioners (most were not registered; great resistance from districts to pull in PPs), and there was

limited or no evidence as to which interventions were going to bring about effective behavior change.

It was agreed that the PPP strategy should be implemented within the health sector strategic plan (HSSP) and be led by MoH, but with full engagement of the PS and the regulatory body. Though the overall intervention was going to be large scale, it was realized that not all potential interventions were suitable for scale-up at national scale, and certain ones were thus left to individual districts. Also, because of the broad range of PPs, it was decided that interventions had to be tailored to each category and whether to implement in a rural or urban environment. To fill knowledge gaps, specific research projects were going to be implemented.

Some of the present challenges are:

- How best to provide continuous advocacy and to sustain the momentum of the process
- How to meet private sector expectations, such as a change in regulations
- How to reach consensus on what interventions can be scaled-up

A number of lessons have been learned by the Ugandan partners. For example, funding is needed to initiate the process, and public sector capacity needs to be built to engage the PPs and to apply regulations. Factors that influence PP practice need to be considered, and the dialogue between the sectors needs to be carried out in a non-threatening manner through credible channels, such as the professional councils. Monitoring and support of PPs needs to be emphasized and the resulting data used for advocacy among decision-makers. To facilitate the process it is advisable to work closely with some private sector catalyst or support group.

Annex 8: Introductory Presentations for Group Work

Prior to the initiation of group work (results of which are presented in section 3), introductory presentations were given to pairs of groups (1 & 2, 3 & 4, 5 & 6).

GROUPS 1 & 2

Presentation 1: Influencing National Policy: Case Study on Private Practitioners in Bangladesh's IMCI guidelines (Michelle Kouletio, Concern Worldwide)

The private sector in Bangladesh is mostly used by the poor for the treatment of young infants; 36% of sick children receive care from informal private providers. Private practitioners consist of rural medical practitioners (RMPs), homeopaths, drug sellers and medical doctors, most of whom are registered with their associations. Given that there is a wide range of providers, it is important to select the right categories when aiming at improving disease-specific practices. For example, a common problem with treatment of diarrhea is that practitioners rarely recommend oral rehydration therapy (ORT) or give advice on feeding. They also rarely ask caretakers about the duration or presence of blood in stools, assess dehydration or provide advice on danger signs that require urgent medical care.

The negotiated practices approach, as applied in Bangladesh, took an inventory of the practitioners and prioritized them. Practices were locally assessed, moderators oriented and negotiation sessions conducted. Practitioners were then requested to sign a form on their commitments and subjected to enforcement of these commitments by their peers. Regular monitoring was conducted and used to provide feedback. To bring about the policy change it was necessary to: i) review the existing policy positions, ii) identify precedent examples (e.g., vertical programs that had worked with PPs to influence safer practices), iii) identify a practical national forum (IMCI working group), and iv) pilot the intervention, evaluate its impact and share the results.

Presentation 2: Roles and Capacities: Public and Private Sectors (Suzanne Prysor-Jones, AED)

Most episodes of childhood illnesses are treated outside the public sector. The current challenges are to harness the potential of the private sector for the public health agenda (access and quality) and to promote high-quality products and services in the non-state sector. Strategies to expand coverage consists of: i) social marketing, ii) vouchers and other methods to target subsidies, iii) contracting out, iv) public/private co-investment, v) franchising, and vi) accreditation. Interventions to improve quality consist of: i) provision of information to non-state providers or consumers, ii) provision of resources to private providers, iii) franchising, iv) accreditation/certification, v) regulation, and vi) negotiation, training and education.

Implementation of above strategies requires a partnership between the public and the private sectors, where both recognize their respective roles and are willing to work towards a common goal. The public sector needs to provide the vision, leadership, policies and strategic directions; has to manage the regulation, oversight and quality control; and has to put mechanisms for coordination and information sharing into place. In turn, the private sector needs to be willing to provide quality goods and services, and be/become organized into associations that provide an interface with the public sector. To arrive at this scenario, the private and public sector knowledge of PPPs needs to be improved and attitudes towards such partnerships need to change on both sides. Capacity building also needs to focus on improving: i) the organization of private associations, ii) the skills of public sector managers to engage the private sector, and iii) the quality of care/products provided by private providers.

GROUPS 3 & 4

Presentation 1: Standardization, Regulation and Quality of Drugs and Services in Ghana

(Benjamin K Botwe, Food and Drugs Board, Ghana and Harrison Abutiate, Pharmacy Council, Ghana)

In Ghana, the standardization, regulation and quality of drugs and services is the responsibility of the Food and Drugs Board (FDB) and of the Pharmacy Council (PC). The FDB advises the MoH on the administration and implementation of the legal framework, and on measures for consumer health protection. It prepares regulations, cooperates with other agencies to ensure standards and uses existing local government structures to ensure compliance. The PC regulates training, possession and distribution of drugs, classifies drugs and advises on the structure of training courses. It prescribes the standards for professional practice, holds the disciplinary powers and oversees the inspection and licensing of distribution channels.

Quality of drugs and services is ensured through inspections of manufacturing outlets and through monitoring of distribution channels by means of audits, pre- and post-licensing surveillance, announced and unannounced inspections, and by following-up on complaints. Manufacturers, importers and distributors are licensed annually and the registration of drugs is valid for three years, subject to meeting the appropriate requirements. Drug imports and exports are restricted to two ports. At these, only registered drugs can be imported, which also applies to drug donations. All of the locally manufactured and imported drugs are subjected to random quality-control analysis. An import permit system and the WHO certification scheme are in use. Safety monitoring is conducted by encouraging reports on orthodox drugs, traditional medicines, quality defects, etc. from medical practitioners and consumers. A multidisciplinary advisory team is in place to deal with these reports. Furthermore, post-market sampling and analysis is regularly carried out, as is education of the public, manufacturers and distributors.

Challenges for ensuring the quality of drugs and services are issues such as the turnover of staff, the lack of financial support and difficulties of monitoring land borders and service providers.

Presentation 2: Regulatory Requirements, Tanzania Food and Drugs Authority

(M. Ndomondo-Sigonda, TFDA)

The Tanzanian Food and Drugs Authority (TFDA) holds key drug regulatory functions, such as drug registration, pre- and post-marketing surveillance, and the registration and licensing of pharmaceutical manufacturers, importers and distributors. All drugs need to be registered, and guidelines to facilitate this process are available. Inspections by TFDA staff are carried out at major ports of entry and medical stores to ensure compliance with these licensing requirements. Their work is supported by a quality-control laboratory, which was established in 2000. The TFDA also monitors adverse drug reactions (ADRs), reported by means of prepaid reporting forms provided to health care workers. Reported cases are assessed by the expert committee. All of the cases documented over the last two years were normal side effects (i.e., did not call for regulatory action) but, as elsewhere, there is serious underreporting of ADRs. Through its multi-pronged approach, the work of the TFDA has led to a substantial reduction in substandard products.

Presentation 3: Accredited Drug Dispensing Outlets (ADDO) Program in Tanzania

(Emmanuel Alphonse, TFDA)

The goal of the Tanzanian ADDO program is to improve access to affordable, quality medicines and services in retail outlets in rural or peri-urban areas where there are few or no registered pharmacies. The program aims to improve product and service quality, to change behavior of shop owners and dispensing staff, to improve local regulatory capacity, and to make customers more aware of quality and treatment compliance. A number of program components have been implemented, ranging from pharmaceutical and regulatory training to legal empowerment of local authorities. This has resulted in: i) almost doubling the average availability of prescription medicines, ii) noticeably improving the quality of dispensing services, iii) decentralizing the regulatory

authority, and iv) reducing the consumption of unapproved medicines. Evidence from the Tanzanian program indicates that ADDOs are sustainable. Challenges to this approach are the need for considerable financial and human resources, the time required to roll this strategy out though the whole country, and the requirement of systems and materials for monitoring, supervision, training, etc.

Presentation 4: Franchising of Licensed Chemical Shops (CAREshops) (D. E. Mensah, GSMF)

CAREshop stands for Customer-focused Affordable Reliable Efficient shop. The goal of this system is to improve access to essential medicines using a franchise approach. Specific objectives are to lower the sales price and to guarantee availability and quality of services and commodities. The franchise approach was chosen to ensure uniformity and consistency. Standardization was provided through the establishment of control systems and procedures such as a service delivery protocol and a combined patient/cash collection register. The physical appearance and cleanliness of the CAREshops was improved and their visibility was increased through the use of brand colors. Branded items included carrier bags, tablet envelopes and medicines.

Licensed chemical sellers (LCS)/CAREshop managers were carefully selected and trained in management and entrepreneurial skills, drug management/rational drug use and management of simple ailments in the community. Training was also provided on referral of clients that present with needs beyond the managers' capacity. To facilitate this, shops are provided with referral sheets that are reviewed during supervisory visits.

The CAREshop franchise is considered a success for all parties, as it has led to a large presence of the franchiser, a more profitable business for the LCS (the franchisee) and the availability of affordable, quality products to the client. However, this system faces a number of challenges. For example, it requires considerable financial input due to high capital and training costs, and it was found to be hard to manage, supervise and logistically sustain the rapidly growing network of outlets.

GROUPS 5 & 6

Presentation 1: Access / Coverage / Equity (Catherine Goodman, LSHTM)

Coverage of child health interventions is inadequate. The potential role of the private sector in addressing this issue needs to be investigated, as this sector is already a common source of primary care. This applies not only to facilities, but also to retailers such as pharmacies and shops. Unfortunately, coverage provided by private providers is patchy. Private-for-profit facilities and pharmacies are concentrated in urban areas, and not even drug shops or NGOs reach the most remote areas. Technical and drug quality problems are widespread, which is likely to result in poor health outcomes and potentially contributes to the selection of drug resistance. In addition, there is a lack of equity in utilization. Poor people tend to use less formal outlets that are of inferior quality, and they are more likely to use traditional healers.

Strategies of using the private sector to expand coverage include: i) lowering of policy, regulatory and fiscal barriers to widen availability, ii) subsidized marketing of products through retail networks, iii) recruitment of private providers to accredited networks, iv) contracting private providers to deliver packages of essential health care, v) expanding demand among priority target groups, and vi) introducing exemption schemes for priority target groups.

The key challenges of expanding health care delivery through private providers are to find ways to harmonize incentives, prevent 'crowding-out' and to minimize leakage from target group(s), while at the same time ensuring equity and avoiding undermining the public sector. Furthermore, there is a lack of capacity and expertise in the government for its new stewardship role and insufficient funding to meet the costs of increasing coverage, management and administration.

Presentation 2: Consumer Demand (Caroline Jones, LSHTM)

The primary concern of a sick person (the consumer) is to find relief for the symptoms that they (or their child) are suffering. From the public health perspective it is important that a sick person is fully cured, eliminating the source of infection for others. The consumer concern of relieving symptoms may not be the same as curing the disease. To try to improve on health care use from a public health perspective, what drives the treatment-seeking process needs to be understood. Provider choice is primarily driven by the availability of appropriate treatment, as perceived by the consumer. Modern pharmaceuticals are perceived to be highly effective and fast acting, and the search for these drugs drives treatment-seeking for all acute diseases. Generally, biomedical providers are thought to provide the best source for advice and the most appropriate modern pharmaceutical drug. However, consumers are constrained by the actual availability of services (What is in the vicinity? What is available from the providers?), their accessibility (physically and socio-culturally) and cost (direct and indirect). The drugs that patients end up taking are thus often not their first choice of treatment, as that may not be available and/or may be too expensive. Better treatment choice may be achieved by providing appropriate treatment at reduced cost or free of charge, by improving on provider prescribing practices/advisory practices and by making treatment more accessible.

Adherence is also of concern. As a result of a lack of communication between providers and consumers, the latter are often not being informed about the required length of the regime or the consequences of non-completion of the dose. Many patients thus don't complete the treatment course and retain remaining drugs for their next illness episode. This problem could be overcome through increased provider training on how to counsel patients in drug taking, pre-packaging drugs so that it is obvious what a whole dose entails, and information/advertising campaigns in locally appropriate terms/language on what constitutes a full dose and why patients need to complete it.

Annex 9: Complete Country Presentations, Key Steps for 2006

NIGERIA

Key Steps (in order of time)	Activities <ul style="list-style-type: none"> by the country by individuals in group 	Responsible Parties	Funding – for what and where will it be raised?	Technical Support – for what?
1. Advocacy on the implementation of the PPP policy with focus on child health in 37 states and 774 LGAs levels	Meetings with Governors, Legislators, Chairmen of LGAs, Opinion, Religious and Community Leaders National & Zonal Stakeholders for a (Government, Partners, Private sector).	Government, Development Partners and other Stakeholders	Government and Development Partners	Government and Development Partners
2. Development of national strategic and operational plans	A National Strategic Plan Framework (includes implementation approaches & M&E) Identification of FPs Consolidation of LGAs' Plans into State Plan and States' Plans into a National Plan	Government, Development Partners and other Stakeholders	Government and Development Partners	Government and Development Partners
3. Resource mobilization	Meetings with Stakeholders including Development Partners Request for Supplementary budget for PPP Strategy and activities	Government, Development Partners and other Stakeholders	Government	Government
4. Capacity building and institutional strengthening of key stakeholders (Professional and PMV associations, the public sector)	ToT Trainings Improve organization/ management skills Expand membership	Government, Development Partners and other Stakeholders	Government and Development Partners	Government and Development Partners
5. Deregulation of some prescription drugs to over-the-counter (OTC) drugs (ACTs)	Meetings already held between the Minister of Health, NAFDAC & PCN Process of deregulation on-going	NAFDAC	Government	Government

UGANDA

Key Steps (in order of time)	Activities <ul style="list-style-type: none"> by the country by individuals in group 	Responsible Parties	Funding – for what and where will it be raised?	Technical Support – for what?
1. To initiate PPP policy approval process by parliament	<ul style="list-style-type: none"> 1.1 Prepare Cabinet memo 1.2 Draft the bill 1.3 Advocacy 1.4 Disseminate policy 	<ul style="list-style-type: none"> 1.1 MOH 1.2 MOH 1.3 PPPH/MOH 1.4 Private sector 	<ul style="list-style-type: none"> 1.3 MOH 1.4 WB, USAID 	
2. Strengthen capacity building between public & private sectors for service delivery	<ul style="list-style-type: none"> 2.1 Training <ul style="list-style-type: none"> Drafting contracts/leases/franchises Implementing contracts/leases/franchises Monitoring contracts/leases/franchises 2.2 Expand PPPH secretariat 	<ul style="list-style-type: none"> 2.1 Public & private stakeholders, DPs 2.2 MOH/Private sector 	<ul style="list-style-type: none"> 2.1 WB, USAID, WHO, MOH, UNICEF 2.2 WB, USAID, WHO, MOH, UNICEF 	<ul style="list-style-type: none"> 2.1 Technical assistance Training process Drafting Implementing Monitoring 2.2 ICT
3. Strengthen the structural frameworks (councils, coalitions, & professional associations) for effective regulation and control for both public & private sectors	<ul style="list-style-type: none"> 3.1 To have professional associations, coalitions/networks strengthened at national and others levels 3.2 Create a forum of engagement interaction for informal practitioners (including referral) 3.3 Engage in a comprehensive data-management process <ul style="list-style-type: none"> Data collection Data management 	<ul style="list-style-type: none"> 3.1 Councils 3.2 Professional associations 3.3 LGs 	<ul style="list-style-type: none"> WB, USAID, WHO, MOH, UNICEF 	<ul style="list-style-type: none"> In all listed activities
4. PPPH is now mainstreamed within the health sector. There is continued need to mobilize more resources to facilitate and scale-up PPPH activities.	<ul style="list-style-type: none"> 4.1 Build capacity for proposal writing, implementation and monitoring by the private sector 			
5. Inform consumers and involve them in quality assurance				

KENYA

Key Steps (in order of time)	Activities • by the country • by individuals in group	Responsible Parties	Funding – for what and where will it be raised?	Technical Support – for what?
Present to key stakeholders at MoH	(2) Draft document of conference and call meeting, agree on need of stakeholders' meeting	Prof. Bwibo	None	None
Advocate for stakeholders' meeting (public, private stakeholders, developmental partners)	(1,2) Select participants Venue, resource people, agenda Obtain funding	The Kenya team, Prof. Bwibo, Dr. Ogaro, Mr. Odundo, Dr. Goodman, Ms. Kimbo	World Bank, USAID, GoK, UNICEF	Facilitation, funds, documentation
Set up a Secretariat with assistance from development partners, with a representative board	(1) Allocation of financial resources Selection of Board	MoH	Partners to mobilize for 3 years	Legal resources
Through Secretariat, undertake necessary situational analysis, gaps and research	Commissioning of studies	Secretariat	Budget	Consultants
Secretariat and partners ensure implementation of policy and scale-up	Secretariat Board activities	Secretariat	Budget	

SOUTH AFRICA (Eastern Cape)

Overall objective: To improve access and availability of drugs to all public sector facilities and patients in the Eastern Cape Province of South Africa.

Key Steps (in order of time)	Activities • by the country • by individuals in group	Responsible Parties	Funding – for what and where will it be raised?	Technical Support – for what?
Complete installation of provincial-level information system from central depot to all hospitals and local service areas/districts (LSAs)	Negotiations ongoing to define functionality and key deliverables, which will be used to measure and monitor performance	Eastern Cape Department of Health + private partner	Provincial over 10 years with private partner paying upfront development costs	Private partner for development and installation
Strengthen stock management information systems at the hospital and LSA levels	<ul style="list-style-type: none"> Complete situation analysis Install updated version of software 	EC DOH + private partner	Hardware funding from EC DOH; installation costs from donor	Private partner for system support
Operationalize dispensing information system for hospitals and clinics	<ul style="list-style-type: none"> Finalize software Pilot use in limited number of hospitals and clinics Adapt, if necessary Roll out to all provincial hospitals and clinics 	EC DOH + private partner	Hardware funding from EC DOH; installation, piloting, adaptation, and roll out costs from donor	Private partner
Create electronic link between clinics, LSAs, and depot, and between hospitals and depot	<ul style="list-style-type: none"> Explore IT options (e.g., handheld computers, telephone) Select option, develop, and pilot in limited number of sites 	EC DOH + private partner	Hardware funding from EC DOH; installation, piloting, adaptation, and roll out costs from donor	Private partner

GHANA

Strategic Objectives	Key Steps (in order of time)	Activities • by the country • by individuals in group	Responsible Parties	Funding – for what and where will it be raised?	Technical Support – for what?
Improve Quality of Service	<ol style="list-style-type: none"> Building Institutional Capacity Expanding licensure and Branding 	<ol style="list-style-type: none"> Organize PPP Stakeholder Meeting. Establish Working Group to develop TOR for: <ol style="list-style-type: none"> Situation analysis to be done in 3 districts of Ghana. Benefits packages for Associations to attract membership. Contract out and review as necessary. 	Private Sector Unit of the MOH	GOG Donors	MoH WHO World Bank
Improve Drug Quality	<ol style="list-style-type: none"> Surveillance Imports Publicize Manufactured Drugs Consumer Involvement 	<ol style="list-style-type: none"> Expansion of Network to collaborate with customs PDAs Training Incentives Develop website and Publicize QA Reports Establish Hotlines, Media for Consumer Feedback and Report 			
Build Consumerism	<ol style="list-style-type: none"> Consumer Education Creating New Consumer Associations for Health 	<ol style="list-style-type: none"> Educate Consumers through Mass Media Community-level Education and Empowerment 			

RWANDA

Strategic Objectives	Key Steps (in order of time)	Activities by the country by individuals in group	Responsible Parties	Funding – for what and where will it be raised?	Technical Support – for what?
Identification of Private Sector		<ul style="list-style-type: none"> • Conduct an exhaustive study about public and private sectors • Categorize public and private actors 		USAID, WB...	N/A
Elaboration of PPP Policy		<ul style="list-style-type: none"> • Organization forum Public/Private • Elaboration of PPP policy • Dissemination of PPP policy • Sensitize stakeholders 	Public (leader)/ Private	MOH/Donors	Yes
Revision of norms and directives		<ul style="list-style-type: none"> • Analysis of norms and existing directives • Identification of gaps • Update norms and directives • Dissemination of norms and directives 	Public (leader)/ Private	MOH/Donors	Yes
Organization of private sector		<ul style="list-style-type: none"> • Identification of available expertise • Exchange of experiences • Reactivate existing associations • Set up office of coordination (Interface) 	Public/Private (leader)	MOH/Donors/Private	Yes
Set up PPP		<ul style="list-style-type: none"> • Resource mobilization • Training • Setting up coordination of Win-Win approach. • Advocacy • Monitoring and evaluation 	Private/Public	Donors	Yes

TANZANIA

Key Steps (in order of time)	Activities • by the country • by individuals in group	Responsible Parties	Funding – for what and where will it be raised?	Technical Support – for what?
1. Conduct country situation analysis in order to understand the situation on the ground, especially to familiarize with the role played by other local stakeholders in child health care	<ul style="list-style-type: none"> Identify available health care providers in the private sector and evaluate their practices Determine gaps and available opportunities Identify available local initiative on child health, e.g., IMCI and Malaria initiative 	Development partners/ MoH	MSH/RPM Plus and explore with other funding agencies	<ul style="list-style-type: none"> Conduct situation analysis
2. Develop and introduce PPP Policy & Guidelines in line with NHP with a particular focus on child health	<ul style="list-style-type: none"> Review of the existing NHP to ensure PPP with a particular focus on child health Define roles and responsibilities of all the key players, e.g., RCH, Professional Councils, NRA, TPHA, private health care providers, TBAs Establish a PPP coordination structure Conduct stakeholders meeting to discuss reviewed NHP 	MoH/Development partners	MoH/Development partners	<ul style="list-style-type: none"> Develop PPP policy and guidelines Consultative meetings with stakeholders
3. Introduction of Child Health Concept in private health sector	<ul style="list-style-type: none"> Advocacy on child health concept to various key players including the community Design Child Health Interventions in private sector Piloting where there is PPP initiative, e.g., ADDO in Ruvuma Conduct operational research Implementation of child health concept by private health care providers 	Development partners/ MoH	MoH/Development partners	<ul style="list-style-type: none"> Advocacy Designing child health interventions Operational research Implementation
4. Develop Monitoring and Evaluation mechanisms	<ul style="list-style-type: none"> Develop indicators Develop M&E tools Conduct supervision and monitoring Conduct meetings with stakeholders to discuss evaluation findings 	Development partners/ MoH	MoH/Development partners	<ul style="list-style-type: none"> Developing indicators Develop M&E tools
5. Scale up Child Health Initiative	<ul style="list-style-type: none"> Identify operational gaps based evaluation results Develop scaling-up strategy 	MoH/ Development partners/others	MoH/Development partners	<ul style="list-style-type: none"> Scale-up strategies

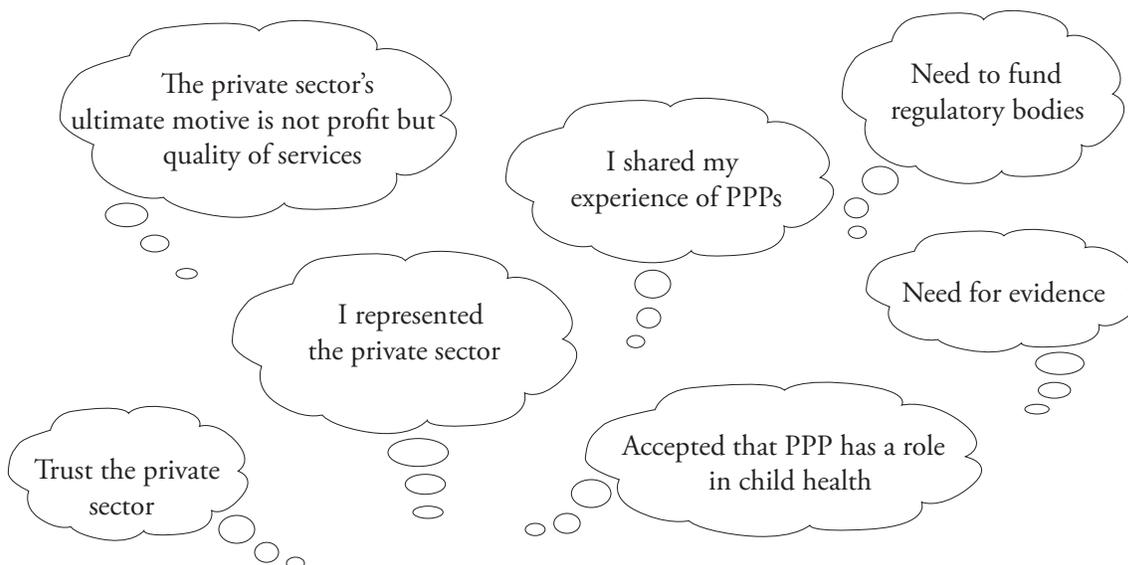
MALI

Key Steps (in order of time)	Activities by the country by individuals in group	Responsible Parties	Funding – for what and where will it be raised?	Technical Support – for what?
1. Mission report to Ministry of Health	<ul style="list-style-type: none"> Report write-up 	Dr Douga CAMARA		
2. Presentation of results and recommendations from forum	<ul style="list-style-type: none"> Invite technical services of MOH, professional associations, foundations, and partners. <p>NB: definition of private sector by consensus</p>	Dr Marguerite DEMBELE		
3. Institutional inventory of interventions in child health in Mali	<ul style="list-style-type: none"> Initiate dialogue with organizations and NGOs Advocacy with technical partners Create a strategic committee 	DNS	USAID, BM UNICEF, OMS, Save the Children	Tools, approaches
4. Set up a group of public-private partners	<ul style="list-style-type: none"> Create a strategic committee Set up rules and regulations Select strategies 	Ministry of Health Organization NB: Honorary presidency		DNS
5. Social franchising for child health services within existing structures.	<ul style="list-style-type: none"> Reinforce the capacity of public and private providers Brand services according to « Quality label » standard criteria 	DNS Committee	USAID, BM UNICEF, OMS, Save the Children	DNS

Annex 10: Comments from Forum Participants

As part of the closing ceremony participants were invited to note down two points: 1) what they felt they had contributed, and 2) what they felt they had gotten from the workshop. Excerpts are shown below.

Contributions



Personal Achievements

