INITIATIVES

PRIVATE INITIATIVES FOR PRIMARY HEALTHCARE

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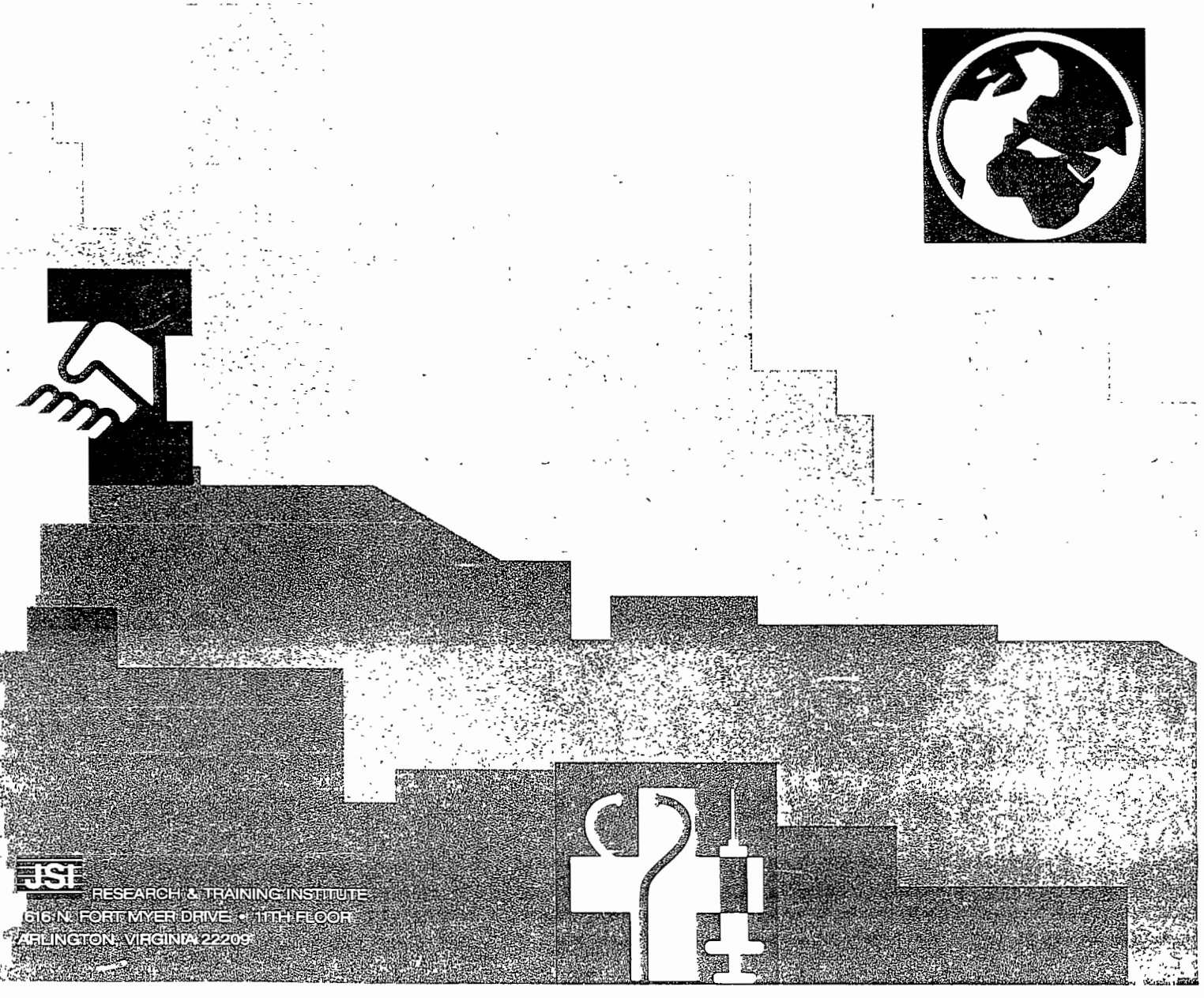
Final Report



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Final Report

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Executive Summary

Private Initiatives for Primary Healthcare (*Initiatives*), a component of the U.S. Agency for International Development (USAID) Health Financing and Sustainability (HFS) Project, was managed under a cooperative agreement by the JSI Research & Training Institute. The project began on September 18, 1992, and was completed on September 18, 1997.

Initiatives was designed by USAID as a flexible mechanism to test the extent to which private providers can make quality basic health services accessible to low-income urban residents in developing countries. Its overall goal was "to improve the health status of target population groups in LDCs through improvements in the allocation and use of resources within the health sector."

The project's initial design provided for three groups of implementation activities: targeted field assistance, comprehensive field assistance, and information dissemination.

Initiatives worked in six countries: Ghana, Nigeria, Ecuador, Guatemala, El Salvador, and Egypt. However, its comprehensive technical assistance was primarily focused on work with 15 provider groups in four countries: Ghana, Nigeria, Ecuador, and Guatemala. Referred to by the project as its "local initiative groups" or "LIGs," they encompassed a range of service types, from independent physicians and nurses, to networks of providers, to insurance schemes.

Initiatives gained substantial knowledge of how the private and public sectors work together to provide basic health services to low income urban populations in Africa and Latin America. Outcomes include a number of programmatic findings, of which the most significant have concerned: health seeking behaviors, private providers' characteristics and capabilities, and effectiveness and efficiency of private health care providers. In addition to programmatic findings, *Initiatives* captured a number of lessons learned about the technical assistance requirements of private sector providers, the role of marketing, and project design.

Findings include the perceived quality of service as a dominant consideration for clients selecting health care providers without regard to gender, socioeconomic status or location. Basic and reproductive health care were the services most in demand by respondents of surveys. Physicians were regarded as the best providers of health services, whether they are in the public or private sectors.

The results of various studies in the *Initiatives* countries reveal three important conclusions about private health sector providers:

- The private health sector is not homogenous.
- Many of the private health facilities studied operate as social enterprises -- that is they pursue a social mission while utilizing many traditional business practices.
- The private sector potentially provides a vehicle to reach vulnerable populations.

Lessons learned in implementing the project are grouped into three categories: technical assistance, marketing, and project design.

1. Technical Assistance

- The process of supporting the development of private sector health care organizations has important implications for any program that includes sustainability as an objective.
- The strategic vision of a private organization's leader(s) is a key element in the development and implementation of a service expansion program.
- Non-governmental organizations providing basic health and family planning services are genuinely interested in increasing their financial independence from donor grants and subsidies (i.e. financial sustainability), but require sustained, intensive technical assistance to move in this direction.
- Experience with donor-supported "development" projects can hamper efforts to develop or enhance the sustainability of service operations.
- The orientation of health and family planning providers to a client-based model of service sustainability can be done effectively within a workshop format.
- The ability to utilize technical assistance depends on key organizational and infrastructural prerequisites.
- Expanding service coverage through the development of private provider networks can be significantly constrained by a lack of adequate managerial resources for which technical assistance may only partially compensate.
- Technical assistance can have immediate cost consequences for its recipients that may not be offset by revenue increases in the short-run.

- Development of financially viable service plans requires sustained, organization-specific technical assistance.

- Political and personal factors are at least as important as the technical quality of an organization's business plan in the acquisition of local capital to support service expansion plans.

2. Marketing

- Project/donor data demands should contribute to the sustainability of the organization being assisted rather than fulfill general reporting requirements.

- The marketing function -- in terms of both organizational structure and individual orientation -- requires special attention from the earliest stages of the technical assistance program.

- The effective utilization of marketing information in developing financial and service delivery plans requires sustained, group-specific technical assistance.

3. Project Design

- "Creating demand" for health care services begins with identifying current client expectations and demands, and includes attention to issues affecting service availability, quality, and accessibility.

- Donor provision of initial start-up capital in the form of grants, time-limited subsidies, or shared financing of basic equipment may be required under certain circumstances.

- The traditional prerogatives of private ownership can limit the role of the community in the determination and delivery of basic health services.

- The level of local coordination among donor policies and actions has important implications for the viability of private health care services.

Implications for Future Assistance are the results of the most significant outcomes of the past five years. Five primary needs were discovered over the life of the project. These needs express both opportunities and constraints for future programing by USAID and other donor organizations.

1. Need to be Clear about Reasons for Working with the Private Sector

Clearly articulating the reasons for working with the private sector, as well as the amount of resources available to support private sector development and expansion, is a critical foundation for private sector project design. If access is the key concern, then one must carefully weigh the effort required to increase access through the private sector versus the public sector. If sustainability is the key concern, then one must be willing to compromise some expansion goals and to understand that sustainability is a long-term objective that cannot be addressed through minimal interventions.

2. Segmenting the Private Sector

Understanding how the health care market is divided and identifying which segment is most suited to achieve your goals are critical aspects of private sector program design. The private sector is not homogeneous and each of its various elements requires differing approaches (large commercial, social enterprises, nonprofit charity organizations). The current capacity and technical assistance needs of a large commercial organization differ considerably from a small social enterprise.

3. Skill Requirements for TA Providers

The requirements for technical assistance changed considerably over the life of *Initiatives*. The ability of the project team to adapt to the changing needs of technical assistance coupled with judicious use of local expertise was one of the primary reasons for its overall success.

4. Identifying and Nurturing Entrepreneurial Behavior

Identifying and nurturing entrepreneurial behaviors was found to be more complex than anticipated. The value of marketing, client orientation, profit and social mission motivation, business practices, physical location, and quality assurance were just some of the factors which reflect entrepreneurial behavior.

There were two primary interventions which did improve health care delivery by the private sector, and which were desirable from the private provider point of view. These were improved marketing techniques and better business practices to more efficiently run their organizations.

5. Donor Requirements versus Market Dynamics

Market dynamics, which are sensitive to user and provider preferences, are not necessarily responsive to donor objectives. These objectives may have been formed years

earlier, and based purely on the public interest in preventive health services. To be able to effectively work together, both parties (public and private) have to understand the motivations of the other side.

Through the understanding of the private sector gained by *Initiatives* -- how it operates and who it serves -- USAID and others involved in private sector development will be better able to identify the proper role, if any, the private sector will play in future programs. Additionally, they will be better equipped to guide the type of assistance required to support private sector efforts. The private sector can serve as a vehicle to provide basic health services to low income populations if properly supported and strengthened.

I. Project Design and Approach

Private Initiatives for Primary Healthcare (*Initiatives*), a component of the U.S. Agency for International Development (USAID) Health Financing and Sustainability (HFS) Project, was managed under a cooperative agreement by the JSI Research & Training Institute. The project began on September 18, 1992 and was completed on September 18, 1997.

Initiatives was designed by USAID as a flexible mechanism to test the extent to which private providers can make quality basic health services accessible to low-income urban residents in developing countries. The project was a response to the growing realization among host country governments that ministries of health, the historical providers of healthcare in developing countries, are becoming increasingly unable to satisfy the need for health services in the face of smaller budgets and increasing populations. Although a private health sector exists and is functioning in most developing countries, little has been known about who it serves, its efficiency and effectiveness, or the quality of the services provided.

Accordingly, the *Initiatives* project investigated various aspects of private sector functioning in the course of strengthening the ability of local private groups to provide primary and preventive care to low-income residents of urban and peri-urban areas. This included collecting and disseminating information about private health sector characteristics, the health seeking behaviors of the populations intended to be served, and the effectiveness and sustainability of alternative forms of private health service delivery.

Over the course of its five year implementation, *Initiatives*' objectives remained unchanged. Far more fluid, however, was the nature and timing of the technical assistance provided, the project's staffing and structure, and the approaches taken in its monitoring and research activities. These changes responded to developments in the project's institutional environment at the global and country levels, as well as to an evolving understanding of the nature and special technical assistance requirements of private health providers.

A. Description of Project Objectives and Components

1. Project Objectives

As a component of the HFS Project, *Initiatives* shared its overall goal "to improve the health status of target population groups in LDCs through improvements in the allocation and use of resources within the health sector." The focus of *Initiatives*' operational

activities, however, was specifically limited to the private health sector, particularly in urban areas. Consequently, its objectives were to:

- assist host country governments and institutions in the area of the private provision of health care services;
- test different approaches to providing sustainable private preventive and basic clinical healthcare services to low-income urban and peri-urban populations;
- analyze through assessments, studies, and operations research, the characteristics of the private provision of health services, especially those services available to peri-urban poor and working class communities, and;
- support the on-going dialogue regarding the respective roles and responsibilities of the private and public sectors in the provision of preventive and clinical health services.

2. Project Components

The project's initial design provided for three groups of implementation activities: targeted field assistance, comprehensive field assistance, and information dissemination.

Targeted field assistance was intended to provide relatively short-term (18 months or less) technical expertise to either governments or local institutions in order to address their concerns with issues related to the private provision of healthcare services. This assistance was to be funded primarily through "add-ons" from individual USAID Missions and Bureaus.

Comprehensive field assistance was to be the heart and soul of the project's technical assistance program. It was intended to provide long-term technical support to a variety of approaches to the private provision of health care services in four to six countries. This assistance was to be centrally financed with "core" funds from USAID's Global Bureau.

Dissemination of the information generated and captured by the project concerning the private provision of health care services was intended to inform the ongoing discussion of the appropriate roles of the public and private sectors in the provision of those services. The intended audience was broad, taking in national and local health authorities, service providers, researchers, and international donors. The origin of this information in the project's comprehensive field assistance program implied that dissemination would be financed mainly with "core" funds.

The project was not designed to provide funds to facilitate or expand the provision of private health care services. Its support of service development and expansion was limited to the provision of technical expertise as required by its local collaborators.

However, the initial design of this technical assistance (TA) program did have a number of noteworthy features that became distinguishing characteristics of *Initiatives*' approach to its field-level activities.

a) Technical Assistance

Initiatives' technical expertise was intended to be provided over a wide range of areas. Anticipated activities included assistance in: assessments and studies of the characteristics of the private health sector; developing the managerial capacities of private sector groups; capital acquisition; commodity procurement and logistics; quality assurance; marketing; and, interfacing with public sector authorities.

The nature of this assistance was conventional, but its mode of delivery was not. It had two main distinguishing features:

- collaboration was restricted to existing organizations, which would be referred to as "local initiative groups" (LIGs).
- much of the anticipated TA was to be provided by in-country "local management groups" (LMGs).

Local Initiative Groups were to be local private organizations already providing health care services, but who were interested in expanding either or both the range of these services to include primary and preventive care, and their accessibility to low-income groups. The assumption was that these LIGs were interested in developing their operations in these directions, but were prevented from doing so mainly by the lack of capital or managerial capacity. As existing private sector organizations they were demonstrably sustainable at their current level of operations. *Initiatives*' role was to facilitate the LIGs' implementation of *their* plans — whose objectives were congruent with those of *Initiatives* — through the provision of the specific technical expertise required.

Local Management Groups were local private organizations that would work directly with the LIGs, providing them with the support they required to fully develop and implement their service expansion plans. It was through them that *Initiatives*' TA was to be provided to the individual LIGs. The intention was to facilitate the development of an LMG within a country to become a multi-faceted provider of services to local private health organizations. These could include management consulting services, bulk procurement of commodities, training, facilities management, and financing. The development of these LMGs was seen as a key element in the sustainability of the private health services whose expansion they supported.

The implicit assumption underlying the initial conceptions of both the LIG and the LMG was that private sector dynamics could be harnessed to support their sustained development. The challenge was to facilitate the appropriate linkages between the supply of existing and potential services and the demand for them. LIG development was the

keystone of this strategy. LIG services that could meet the demands of the under-served low-income populations would contribute to an expansion of the market for private health care. The LIGs, in turn, represent a growing market for the services supplied by the LMG. Most of the required elements were in place; *Initiatives*' own modest inputs would serve as the catalyst for this natural, self-driving process of private sector development.

b) Research Activities

Initiatives' design included a variety of research activities intended to contribute to a better understanding of factors affecting the provision of health services by the private sector. These included assessments, studies, and surveys related to the context in which private sector services are offered and used, and to the areas of management, marketing, service delivery and quality assurance that can enhance the impact and sustainability of the services offered.

The activities we expected ranged from straightforward description and documentation of specific interventions, to more complex analyses of operational issues and project impacts at several levels, e.g. household and community. A similarly wide variety of methodologies was implied, including the collection of operational and administrative data, key informant interviews, focus groups, observation, and surveys based on both purposive and randomized samples of individuals and households.

The project's earliest translation of these research activities into an operational plan was in the form of its "Evaluation Framework." The Framework provided two-levels for the project's evaluation: external and internal. The external dimension referred to factors that are beyond the control of individual LIGS, but which impact on health status. The internal dimension consisted of the LIGS' internal operations and characteristics. The data system design reflected three guiding principles: (1) creation of longitudinal panel data sets (pre- and post-intervention measurements); (2) common data elements for monitoring and evaluation purposes, and; (3) collection of population and facility (provider) data, linked by utilization patterns. Data collected were to be used to develop *statistical models* of the determinants of health service utilization and health outcomes. The causal model proposed was:

provider characteristics → ***utilization patterns*** → ***health outcomes***

As with *Initiatives*' other components, unforseen developments beyond the project's control would require multiple revisions in its overall research strategy and its specific activities.

c) Information Dissemination

Information dissemination was the final component of the original project design. Its purpose was to capture and share information on the workings and impact of the private provision of health services in developing countries. The specific dissemination activities included routine technical and administrative reporting, recording and presenting the results of studies, assessments, operations research and service delivery activities, and three workshops/conferences.

Under the original design, the conferences had the highest priority as they would provide a forum in which the experiences of providing basic health services through the private sector would be examined and would contribute to the ongoing dialogue pertaining to the redefinition of the roles in the private and public health sectors. However, both the advent of field support and new technology, i.e. increased access to the Internet, altered the modes used for information dissemination. While information dissemination continued to be an important component of the project, *Initiatives* shifted its activities to reflect these changes in its operating environment.

3. Project Structure

Fourteen months into implementation, it became necessary to revise the content and configuration of both the technical and administrative roles in the project in order to address the evolving demands of project operations. Among the more critical of those demands were:

- ***the emergence of financial and business planning activities as critically important to project success.*** Beginning in mid-1994, and continuing through the project's third year of operation, the identification and accessing of capital by the LIGs was planned to be the focus of staff activity. Thereafter, efficient management of that capital in terms of LIG business plans was expected to demand increasing staff attention.

- ***increased attention to the identification and development of local management groups (LMGs).*** Secondary to LIG identification, the importance of the LMG was expected to grow as LIG operations were initiated or expanded.

- ***the anticipated growth of LIG-specific technical assistance needs as LIGs began implementation of their respective business plans.*** Given the wide range of needs likely to demand attention, the project's response was expected to entail an increased role for consultants with specialized skills. Accordingly, coordination and follow-up of these consultancies was expected to consume considerable core staff attention.

- ***the reformulation of the current "Evaluation Framework" as a broader "Analytical Framework" encompassing a full program of operations research and assessment.*** Given the wide range of methodologies and activities expected to be undertaken, coordination of this function was expected to become an increasingly complex task over the next several years.

- ***the anticipated intensification of country activities.*** An unambiguous assignment of backstopping responsibilities among administrative staff would be required in order to avoid duplicated staff efforts and to ensure appropriate continuity in communications with the project's country liaisons.

These unfolding and anticipated changes led to the delineation of three core operational areas — strategic business planning and development, LIG operations, and research — each to be coordinated by a Program Manager. This entailed:

- replacing the Deputy Director position with that of a "Program Manager/Strategic Business Planning & Development" in order to add financial analysis and business planning skills to the project's core staff capabilities;

- dedicating the existing Program Manager position on the support of LIG operations in order to maximize project responsiveness to field needs;

- adding the responsibility for the management of the project's various research and information gathering activities to the existing Evaluation Specialist/WID Advisor in order to enhance the project's utilization of multiple approaches in these activities.

There were, in addition, several changes to administrative support positions that were designed to strengthen the project's ability to respond effectively to LIG technical and operational needs.

B. Description of Activities & Outputs, 1992-1997

1. Overview

Initiatives has worked in six countries: Ghana, Nigeria, Ecuador, Guatemala, El Salvador, and Egypt. Its activities in Egypt and El Salvador were limited. In Egypt, the project carried out case studies of two private health provider organizations in Ismalia. In El Salvador, the project conducted a survey of private providers that was intended to provide the basis for local discussions of the feasibility of introducing private managed health care in that country. It was in the remaining four countries that *Initiatives* developed programs of comprehensive technical assistance.

Initiatives primarily worked with 15 provider groups in these four countries. Referred to by the project as its "local initiative groups" or "LIGs," they encompassed a range of

service types, from independent physicians and nurses, to networks of providers, to insurance schemes.

Year One:

The *Initiatives* project's first year focused on identifying and selecting these local initiative groups. The process included a series of business and organizational development workshops that brought together all the potential LIGs in each country. By the end of 1993, organizations that remained interested in participating in the project submitted their plans for expanding their services to address the basic health needs of low-income populations in their respective communities. The project selected its local collaborators based on the congruence of these plans with *Initiatives*' own mandate.

Highlights of Ecuadoran Initiative Groups

Insalud, a private for-profit organization in Guayaquil, proposes to take over operation of public health clinics as well as establish new clinics to service middle to low income populations. Their experience highlights the process of subcontracting with private organizations to operate health facilities, and the implications this transfer of management has for the quality and delivery of health care services to low-income populations.

Funcacion Eugenio Espejo (FEE), a private nonprofic organization, was developed to support a wide range of community development initiatives in low-income areas. They intend to expand their coverage of basic health services in Southern Quito through the develoment of a network of clinics. They offer an example of how the link between basic health services with community develoment activities can contribute to the sustainability of those services.

Funcacion Metrofraternidad was founded to provide access to specialized clinical care at Hospital Metropolitano, the most modern and technologically sophisticated private hospital in Quito. Metrofraternidad's current efforts to develop outreach services to provide sustainable, low cost, high quality, basic healthcare services in periurban communities surrounding Quito highlights the challenges these new primary-level activities post for the larger organization's strategic mission and efficient operations.

Cofradia Medica Hombre Redentor, a group of specialists from the medical school of Guayaquil, have plans to develop a network of clinics staffed with residents and interns who want to practice primary healthcare.

AMEDICA (Medical Assistance C.A.) proposes to establish low cost, basic health care services for middle- and low-income communities in south Quito. It offers an example of the processes by which a private health care organizaiton balances its need for economic viability with a commitment to maximize service accessby low-income residents through the develoment of a pre-paid managed care program

Year Two:

In its second year, the project re-directed its activities toward providing the LIGs with the organizational and technical resources needed to develop financially viable service-delivery plans. Over the course of the year, the project's methodology for providing technical assistance also evolved, from a reliance on workshops (grouping together several initiative groups) to providing individual technical assistance that addressed each group's specific needs.

This progression led to a re-examination of the project's approaches to the development of its partner LIGs and LMGs, as well as to the documentation and dissemination of this experience — process and outcomes. The result was a greater emphasis on the LIGs' organizational needs to succeed as self-sustaining private organizations. These needs are shared by both profit and nonprofit groups. This progress was manifested in the project's concentration of resources on developing the LIGs' marketing function. Initially this entailed a series of marketing studies to assess the groups' market potential. In addition, the project's research component was modified to give appropriate attention to the market surveillance aspects of any management information systems supported by the project.

Highlights of Guatemalan Initiative Groups

Guatesalud provides basic health services to over 40,000 finca (farm) workers and their families. The program is self-financed through contributions from finca owners and their employees. Similar to a prepaid "peasants HMO", Guatesalud offers an example of the process through which a self-supporting, employer-based managed health care organization can expand it geographic coverage and extend its operations to include community-based services.

Clinica Rxinn T'namet is small community-based facility offering medical, laboratory, x-ray, pharmaceutical services as well as family planning and curative and preventive care. It provides an example of the lengthy and complex process through which a private organization can lessen its dependence on donor support and move toward sustainability.

The main objective of these activities was to position each LIG to acquire capital needed to implement its service delivery plans. The acquisition of capital, and the expansion or initiation of services was expected to be the focus of *Initiatives*' activities during the following year — the project's third. *Initiatives* expected that by the beginning of its fourth year, it would be able to step up this technical support of the LIGs' implementation through its intensified development of LMGs. At the same time, in late-1995, and continuing throughout the project's remaining two years, *Initiatives* drew upon its accumulating experience from working with both the LIGs and the LMGs to enrich its ongoing discussions of health sector reform in *Initiatives*' six countries.

Year Three:

In fact, *Initiatives*' third year did prove very productive, with steady but varied progress in each of its programmatic areas — capital acquisition, organizational strengthening,

and policy-oriented documentation of the effectiveness, sustainability, and replicability of the local initiative groups receiving technical assistance. However, several elements of the specific plans developed the previous year required a number of revisions in response to significant changes in the project's global and local operating environments.

Highlights of Nigerian Initiative Groups

The Lawanson Health Plan, which currently operates five small, independent private facilities, proposes to start a financing and managed care scheme in the Lawanson area of Lagos. Trade associations would be invited to join a prepaid program of managed care that would assure members basic primary care services from one of five participating area physicians. In addition, a mutual fund would be established against which members can borrow in time of acute illness.

The Nigeria Private Nurses & Midwives Association (NPN MA) branch in Osogbo, an association of independent primary care practitioners, has seen a decline in patient load due to economic hard times. To increase the use of their services, the association members would like to increase community outreach and health education, and lower their fees by sharing resources. Ideas for lowering costs include bulk drug purchases and sharing a diagnostic and referral center.

The Association for Reproductive and Family Health (ARFH) currently operates a family planning clinic in Ibadan. ARFH would like to expand its services to include primary care, financed through sliding-scale fees and cross-subsidization. This expansion would entail the establishment of a new health and family planning facility, now proposed for a site in the central Idi-Arere district of Ibadan, which would serve both community residents, market traders, and employees of nearby companies, such as banks and mercantile shops.

Armour Health Insurance is an ambitious expansion of what began as a pre-paid health plan of a single insurance company. A consortium of private insurance companies is working to develop a health maintenance organization that will be jointly owned and funded by them. The intention is to offer the insurance plan to employers and their family members— in size from small traders in the market, to large companies — as a means of maintaining a healthy and productive workforce, while containing the costs of these benefits to the subscribing companies.

The acquisition of the capital needed by the LIGs to implement their service delivery plans remained an important objective during the year. Accordingly, *Initiatives* concentrated significant effort on assisting the groups to utilize the marketing information and business planning skills they developed in the previous year. The high degree of support required for this, however, did delay the finalization of viable business plans, which in turn delayed the capital acquisition process.

The project's efforts in the area of organizational strengthening continued to focus on improving the efficiency of the local initiative groups' operations. These activities ranged from rapid assessments of current administrative and financial systems and procedures, to implementation of management information systems designed in the project's second year. As varied as the technical assistance was, however, it shared the common objective of supporting the development of the LIGs as efficient, adaptive service providers.

Initiatives' ongoing assistance in the area of marketing information and planning included profiles of private sector health facilities in two of its countries (Ecuador and Ghana). These profiles were among the project's initial contributions to country-level discussions of the potential role that the private sector can play in meeting the health needs of those countries' low-income urban populations.

Documentation of the process and outcomes of strengthening the local initiative groups remained firmly on track. The project began its first two comprehensive case studies, in Ghana and Guatemala. Case studies of two provider organizations in Ismalia, Egypt, were completed. These case studies, and the experience gained over the first three years, allowed the project to significantly expand the dissemination of its lessons learned regarding the design and implementation of activities intended to promote private sector participation in the achievement of public health goals.

A noteworthy development in the third year was *Initiatives*' initial articulation of its own, distinctive approach to organizational sustainability. Based on the project's accumulating experience in providing technical assistance in marketing and business skills development to its local for-profit and not-for-profit partners, *Initiatives*' approach addressed the development community's current interest in how donor-assisted organizations can continue producing benefits for their intended client populations after the cessation of donor technical, managerial, and financial support. Consequently, the potential impact of the project's lessons learned was expected to extend beyond the development of the private health sector, to activities in other sectors in which sustainable development is an area of active concern.

Highlights of Ghanaian Initiative Groups

The Superior Medical Center offers an example of how the private sector can increase low income clients' access to quality basic health services. Superior plans to build a small hospital on the outskirts of Accra in order to provide quality medical care to Ghanaians, a private sector training site for the University of Ghana Medical School, and to attract Ghanaian physicians, educated and practicing overseas, to return to Ghana.

The Nationwide Mutual Medical Insurance Program, the first health insurance program in Ghana, provides an example of how the private sector can provide an alternative financing mechanism for basic health and family planning services in a developing country. Launched in August, 1993, Nationwide currently has over 60,000 beneficiaries associated with 20 companies enrolled in the plan.

Ghana Registered Midwives Association (GRMA), is a non-profit organization with approximately 400 member nurse midwives. The members are private practitioners who provide a range of services including child health, pre-natal, delivery, and family planning services. GRMA has been strengthening the association by enhancing their continuing education courses and developing a national secretariat, in order to more support to their members.

Year Four:

Initiatives' approach to sustainability, which was to be further elaborated during the following year, combined elements of the development community's experiences in institutional and private sector development. This combination yields a *dynamic* model of organizational functioning that firmly roots sustainability in the organization's interaction with the economic and political markets in which it operates. As a result, emphasis is placed on the manner and extent to which the organization can adapt to its competitive environment and to the changing needs of its intended clients —

that is, the extent to which it is a market-driven, client-centered enterprise, regardless of whether it is for-profit or not.

Continued support to the LIGs' initiation and expansion of services and the continuing documentation of that process were to be the twin foci of *Initiatives*' activities in its fourth year. The plan was to maintain the project's demonstrated responsiveness to the practical service delivery needs that were the primary concern of USAID Missions in the countries in which *Initiatives* was working, while continuing to contribute to the more general knowledge-building mandate of the project's original design.

In fact, *Initiatives*' fourth year saw even more significant adjustments in its activities in response to funding and political changes in two of the five countries in which the project was working. Nevertheless, the project continued to make progress in the organizational strengthening of its local partners, and in the policy-oriented documentation of the effectiveness, sustainability, and replicability of the LIGs receiving technical assistance.

The development of *Initiatives*' local partners as efficient, adaptive providers of basic health and family planning services continued to be the common objective of the project's activities in the area of organizational strengthening. Consequently, the project's technical assistance focused on improving the quality of its local partners' administrative, financial, and program operations. This included providing assistance in using the information provided by management information systems developed the previous year, as well as training in quality assurance, pharmaceutical management, and health education. Changing circumstances, however, led to significant changes in these technical assistance activities in two countries.

Technical assistance to *Initiatives*' local partners in Ecuador was gradually phased out in response to inadequate field support funding that made the continuation of these activities untenable beyond the end of 1996.

In Nigeria, the project effected a major reorientation of its technical assistance activities in response to USAID's decision to phase out its assistance to health and population projects over a 18-month period. *Initiatives*' ended its comprehensive technical assistance to its established partners in May 1996. Subsequent technical assistance, at the USAID Mission's request, was directed to enhancing the financial sustainability of the local partners of other U.S. cooperating agencies, who were expected to phase out their own assistance programs by late-1997. By mid-1996, this *sustainability initiative* quickly grew into a major area of project activity.

The policy-oriented documentation of the process and outcomes of *Initiatives*' technical assistance to its local partners was enhanced by the commencement of two additional comprehensive case studies. The establishment of an *Initiatives* website (**www.jsi.com/intl/init**) significantly increased the project's capacity to disseminate information about its activities, and, in particular, the lessons it has learned to date from its work with private sector providers of basic health services. These lessons were the

subject of numerous presentations at international meetings of health professionals in 1996.

Year Five:

The project's fifth and final year focused on the completion and gradual phase out of *Initiatives*' remaining technical assistance to its local partners, and the successful completion of its five remaining comprehensive case studies. Its technical assistance program closed with a number of significant activities. *Initiatives*' completed a survey of private health providers in El Salvador, and coordinated the dissemination of its findings within a local meeting of high-level private and public health authorities who were actively exploring the feasibility of introducing managed health care in that country.

The sustainability initiative in Nigeria culminated with a meeting that brought together *Initiatives*' local consultants, the NGOs to which they provided TA, and interested donor representatives. Together they reviewed the progress the NGOs made in the previous 12 months toward enhancing their financial viability, drew lessons from their experience working with *Initiatives*' local experts, and outlined their plans for sustaining their efforts in the years ahead.

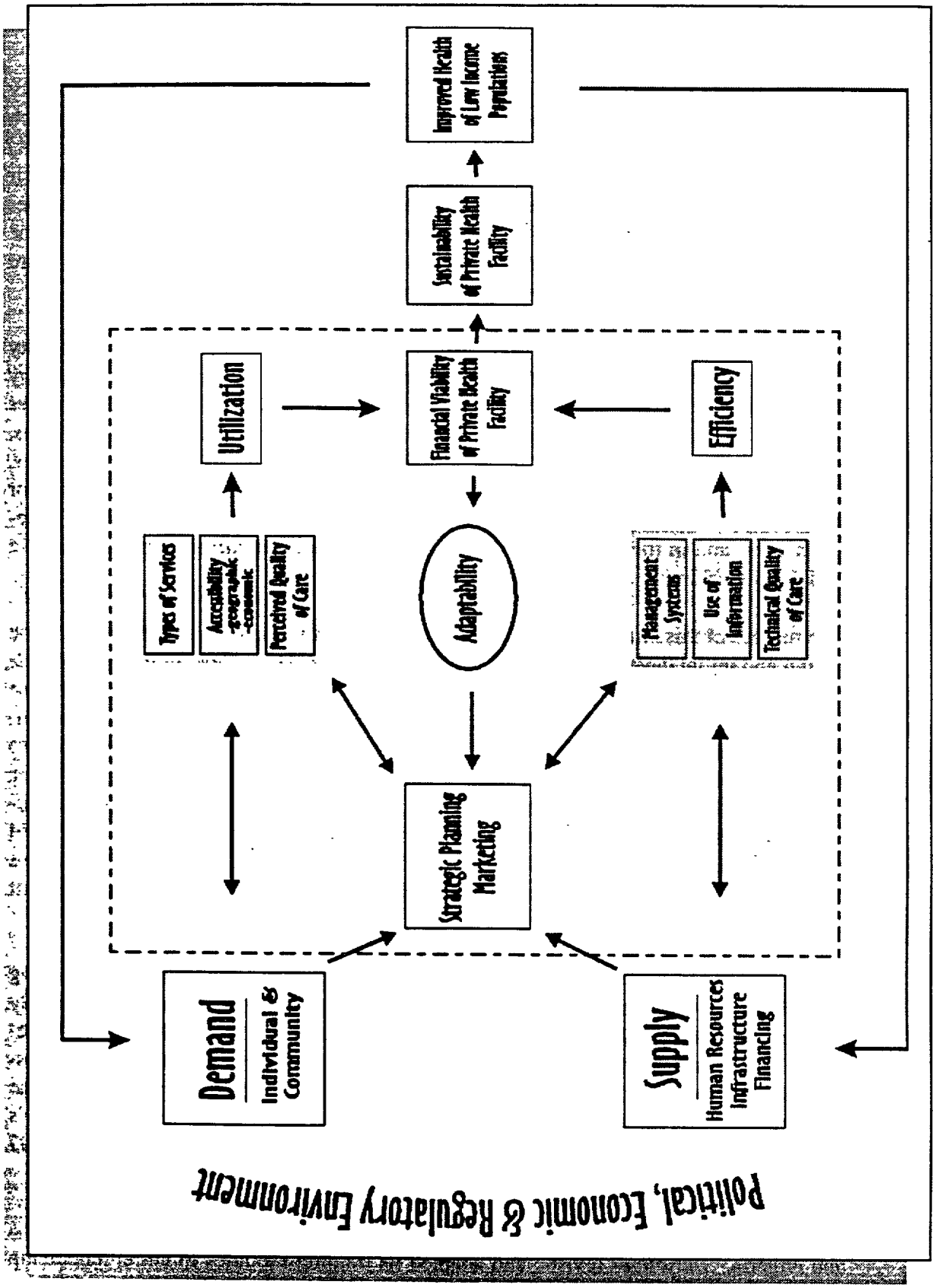
Country specific activities and detailed descriptions of *Initiatives*' local partners are provided in Appendices I-V.

2. Sustainability Initiative

Initiatives' approach to the development of sustainable services emphasizes the manner and extent to which they are provided by an organization that can adapt to its competitive environment and to the changing needs of its intended clients — that is, the extent to which it is a market-driven, client-centered enterprise, regardless of whether it is for-profit or not. Initially articulated at the end of the project's third year, this approach reflects *Initiatives*' cumulative experience in providing technical assistance in marketing and business skills development to its local for-profit and not-for-profit partners.

Figure 1 presents *Initiatives*' conceptual model of its approach to sustainability. Within the constraints posed by its political, economic, and regulatory environment, the organization processes as inputs both demands by individuals and communities for services, and the human, material, and financial resources it will need to satisfy those demands. The organization's strategic planning and marketing capacity determines the extent to which these inputs contribute to the utilization of the services provided, as well as to the efficiency of its operations, and ultimately the cost of its services to the intended clients. Service utilization and operational efficiency, in turn, determines the immediate financial viability of the organization. The organization's ability to monitor this performance and to feed it back into its strategic planning and marketing processes — its "adaptability" — has obvious implications for the organization's long-term sustainability.

Figure 1. *Initiatives'* Conceptual Model



By its fourth year, *Initiatives* was able to begin operationalizing elements of this approach in activities specifically designed to enhance the sustainability of non-governmental organizations (NGOs).

In January 1996, *Initiatives* conducted a rapid assessment of the financial sustainability of a sample of NGOs participating in USAID/Lagos' integrated health program, which led to the development of *Initiatives' NGO Sustainability Technical Assistance (TA) Program*. The TA program focused on enhancing the capacity of NGOs to sustain their services beyond the anticipated discontinuation of USAID-provided support in late-1997. *Initiatives* assisted thirty NGOs to strengthen their financial viability, with the focus on identifying and exploring the feasibility of revenue generating options. More details on this program are provided in Appendix VI.

Initiatives developed training modules in entrepreneurial management, sustainability assessment, and revenue generation that were used in several workshops conducted by the Center for Development and Population Activities (CEDPA). All of the modules were used in the *NGO Workshop on Planning Strategic Reproductive Health Programs*, which was co-sponsored by the Ghana Social Marketing Foundation and *Initiatives*, that was held in May 1996 in Ghana. The revenue generation modules were adapted for use in the *NGO Strategic Planning for Sustainability Workshop*, that was held in Nigeria in May, and in the *Institution Building* and *Women & Management Workshops* in CEDPA's Washington, D.C. headquarters in July 1996.

The success of this *Initiatives*/CEDPA collaboration led, by late-1996/early-1997, to the design and initial development of a workbook, *Thinking About Sustainability: A Guide to Organizational Empowerment in an Age of Diminishing Resources*, intended for use by senior NGO/PVO managers and others concerned with enhancing institutional empowerment, e.g. NGO/PVO board members, trainers, and consultants. Its purpose is to build the entrepreneurial consciousness of these intended users by serving as a learning tool for communicating concepts they can use to address key issues affecting the capacity of their organization to sustain its programmatic benefits for intended clientele. Field testing with a small group of CEDPA-affiliated NGOs began in June 1997. The success and inevitable further development of this *Guide* is expected to be an important element of *Initiatives'* legacy.

Initiatives' approach to sustainability, as well as its cumulative experience in adapting its approach to the practical needs of local healthcare providers and health- and family planning-related NGOs, led to its participation in the design and facilitation of the "Creating Change Strategies for Sustainable Development Workshop" sponsored by the Sustainable Development Services Project (SDS). The SDS Project is managed by the Institute for Development Research (IDR) under a cooperative agreement with USAID's Office of Private and Voluntary Cooperation. The workshop was held in January 1997 in Warrenton, Virginia.

Several of the SDS workshop sessions drew heavily from *Initiatives'* work in Ghana and Nigeria. *Initiatives* revised and adapted its training modules in entrepreneurship

and revenue generating options, and prepared an initial write-up of its approach to developing a technical assistance program in NGO financial sustainability in Nigeria. Joe Sclafani, *Initiatives* Project Director, and Lisa Hare, *Initiatives* Program Manager/Africa, participated as workshop staff, and as facilitators in several sessions. The description of the Nigeria program, "Key Considerations in Designing a Technical Assistance Program for Financial Sustainability: The *Initiatives* Experience in Nigeria," and a background paper, "Sustainability: A Client-Driven Model," are available through the project's website: **www.jsi.com/intl/init**.

3. Utilization-Driven Research & Documentation

a) Capturing Process — A Case Study Approach

By the end of *Initiatives*' second year, it had become apparent that the evaluation framework developed to address the project's three core areas of research — effectiveness, sustainability, and replicability — would be an inadequate analytical framework for the full range of the project's anticipated research activities.

The initial evaluation framework had several deficiencies in its approach to the project's research needs or its larger objectives. The more salient were that:

- ***it required the development of unsustainable data collection systems.*** The methodological approach was entirely expert-driven, externally imposed, and oriented to collecting information only incidentally related to the data needs of independent social enterprises — as the project had come to view the LIGs and LMGs. The framework's proposed monitoring data was unlikely to be easy to collect, timely, or relevant to practical day-to-day management decision-making. Nor would the system required to collect this data be sustainable given the LIGs' likely inability to assume its financial and managerial costs following the cessation of *Initiatives*' assistance.

- ***it gave inadequate attention to the collection and analysis of process oriented data.*** It focused on measuring outcomes and impact. No attention was given to documenting and analyzing the process by which individual LIGs and LMGs develop and implement their plans, adjust their internal management and operational procedures, monitor and respond to their market opportunities and challenges, and interface with their communities. Consequently, it held little promise of contributing to the understanding of the internal dynamics of the LIG's operations — a critical gap in terms of *Initiatives*' objectives.

- ***its emphasis on statistical modeling of the data collected was no longer appropriate for the project.*** Both the geographic scope and the number of individual initiatives were less than what was anticipated at the outset of the project. To the extent that this limited the range of variation in the factors examined, the usefulness of making this an important methodological approach was increasingly doubtful.

It had become clear that the project would require a research framework that could collect enough relevant information to characterize the private provision of basic health services to urban populations in developing countries. The methodologies used would have to strike a compromise between technical rigor, available resources, and the timeliness and relevance of the information sought to the needs of the service providers specifically, and the project in general. A draft analytical framework was prepared in June 1994 to help conceptualize this new approach to achieving the project's research objectives.

This new analytical framework incorporated a case-study approach to the project's core research activities. This new approach was seen to be more appropriate for the project, which is charged with developing insights into "how" and "why" the private provision of basic health services is a viable approach for reaching the intended populations. The case studies were to be designed to document project outcomes from two perspectives:

- the first would examine the LIGs and the LMGs from a business perspective — as *social enterprises* — examining the marketing strategies and information systems required to improve their operations and opportunities for achieving sustainability;

- the second would assess the local initiative groups in terms of their effectiveness in delivering preventive and curative services to low-income populations, the likelihood of sustainability, and the potential for replicating successful models, or aspects of successful models, in another local context or country.

Initiatives convened an in-house Research Working Group in September 1994, at the beginning of its third year, to help operationalize the draft analytical framework for the project's research component. The framework is used to guide the design and implementation of case studies of the LIGs. The Working Group defined the three criteria to be used in assessing the operations of the local initiative groups — effectiveness, sustainability, and potential for replication — and identified their implications in terms of the common lines of inquiry to be pursued and issues to be addressed in each of the case studies.

Effectiveness was conceptualized as a function of the local initiative group's provision of basic health services to low income urban populations in urban and peri-urban areas. The study of a LIG's effectiveness was to focus on its ability to:

- remain focused on the target population and not redirect services to the more affluent upper and middle classes;

- provide services that address both public health needs and client demands;

- achieve a high standard of service quality in terms of technical criteria and client perceptions.

Sustainability was a function of the capacity of the local initiative groups to provide ongoing delivery of services. LIG sustainability would be examined in terms of:

- the efficiency of its management and service delivery operations;
- the financial viability of the enterprise;
- the organization's ability to adapt to change;
- the support it requires and receives from its host community.

Replicability was regarded as a function of the effective delivery of services, the sustainability of operations and the external factors which negatively or positively affect success. The potential for replication would be assessed by examining:

- the outcome of the factors affecting effectiveness and sustainability;
- the external factors (macro and micro environment) which positively or negatively affect its delivery of services.

Based on this general framework, protocols were developed for individual local initiative groups to guide the case writers during data collection. The protocols identified the components which make up each criteria and guided the case writers in synthesizing the data to assess the effectiveness, sustainability and potential for replication of each LIG studied. To enhance study validity, multiple data collection methods and sources were used, triangulating these sources to corroborate findings. First drafts of the case studies were to be submitted to *Initiatives* by the end of the project's fourth year. Final drafts of the cases were scheduled to be received in mid-1997.

A total of 13 case studies were included in the project's original core research program. Of these, seven were to be "comprehensive" in nature, i.e. studies that would examine the entire spectrum of activities undertaken by the LIG over time. Data for these would be collected at three points over an 18-month period. Five of the remaining six studies were to be "partial," i.e. examinations of a particular aspect of each LIG that is unique and useful to document and share. Included in this second category were LIGs whose implementation was delayed, and therefore were unlikely to be established and operational long enough to warrant a comprehensive case study. The remaining case study was to be limited to the problems encountered by a particular LIG — Metrofraternidad — and was to be very narrow in scope.

The planned "comprehensive" case studies and the types of social enterprises they were to illuminate were:

- **Superior Medical Centre, Ghana** — a self-financing private urban clinic seeking to expand the outreach of its clinical and preventive services to a surrounding low-income community

- **Nationwide Mutual Medical Insurance, Ghana** — Ghana's first private health insurance program, which was organized as an immediate response to large employers' concern over rising health care costs, but which would become the nucleus of a managed care network in the long-term

- **Lawanson Health Plan, Nigeria** — a network of private physicians seeking to develop with a local community bank a pre-paid and health savings program that would expand the accessibility and utilization of quality health services among the members of the program's participating community groups

- **Fundacion Eugenio Espejo, Ecuador** — a not-for-profit foundation seeking to expand the reach and utilization of the services of its clinic in a low-income peri-urban area by linking the services to its micro-enterprise program serving the same population

- **InSalud Cia. Ltda., Ecuador** — a group of physicians seeking to take over and improve the management of an existing public health clinic, which would serve as the nucleus of a network of clinics, in order to expand the availability of affordable, quality basic health services in a dense low-income urban community

- **Guatesalud, Guatemala** — a self-financing, not-for-profit managed care provider of basic health services to plantation workers and their families that is seeking to increase the number and diversity of the plantations contracting for its services

- **Rxiin T'namet, Guatemala** — a not-for-profit community-based provider of basic clinical and preventive health services seeking to transform itself from being a project of an international PVO to an indigenous NGO as a means of enhancing its long-term sustainability

These were in addition to case studies of two private healthcare providers in Ismalia, Egypt, which were started in the project's first year. These organizations were:

- Group Practice of the Faculty of Medicine, Suez Canal University

- The Abu Bakr El-Siddique Mosque Clinic

Since these two studies were commenced before the case study approach became the core of the project's research program, they did not use the common protocol that was developed for the cases that followed. The project's experience with these two early studies, and the value of their findings, however, had a significant influence on the development of the common protocol.

The planned "partial" case studies and the types of issues they were expected to illuminate were:

- **Nigeria Private Nurses & Midwives Association/Osogbo, Nigeria** — a network of private providers of basic health services seeking to lower its costs through increased operational efficiencies as a means of expanding the accessibility to, and utilization of its services by low-income populations within reach of its services

- **Association for Reproductive & Family Health, Ibaden, Nigeria** — establishment of a new clinic offering both basic health and family planning services to residents and workers in Ibaden's central market area

- **Armour Health Insurance** — establishment of a health insurance program tailored to meet the special needs of market traders and informal sector workers in Lagos

- **Ojota Employers Association** — establishment of an employer-sponsored private health care network to provide services to employees and their families

- **StopAIDS** — establishment of STD/HIV testing and case management services in long-distance lorry parks

The "limited" case study was to be of Metrofraternidad's efforts to establish a clinic on the outskirts of Quito. The study was intended to focus on the critical importance of appropriate and realistic market and financial information in planning financially viable basic health and family planning services.

A summary of the original case study program is provided in Table 1 on the following page.

This planned case study program was significantly scaled back in mid-1995 in response to two developments. The first was USAID's introduction, in FY95, of its new field support system which translated into significantly less core funding than anticipated for *Initiatives*. The second was the radical reorientation of the USAID country program in Nigeria, which resulted in the discontinuation of *Initiatives*' ongoing technical assistance program, which included two comprehensive and three partial case studies as its evaluation/documentation components, and its redesign as an NGO sustainability program. Consequently, by the end of the project's third year, its case study program had been limited to five comprehensive studies, and no partial studies.

In September 1996, the project convened a two-day workshop in Arlington, Virginia, which brought together the five case writers to review as a group the first drafts of their respective study reports. Other participants included *Initiatives*' own program staff, and representatives from USAID's Health Policy and Sector Reform Division, and the Partnerships for Health Reform Project. At that time, a sixth comprehensive case study was commissioned for the privately financed and operated Aninwah Medical Clinic

Table 1. *Initiatives'* Case Study Profile: Local Initiative Groups and Case Study Themes

Country	Full Case Studies	Partial Case Studies	Limited Case Studies	No Case Studies
Ghana	Superior Medical Centre: Self-financing urban private health center Nationwide Health Insurance/Society of General Medical and Dental Practitioners: Employer-based national private health insurance program			Ghana Registered Midwives Association (GRMA)
Nigeria	Lawanson Health Plan: Banking for health: linking community savings and preventive health services	NPNMA, Osogbo: Bulk-drug purchasing as a mechanism for improving clinic efficiency ARFH: Expanding a family planning program to include basic health services StopAids: STD/AIDS testing and case management for long-distance transport workers through the private sector Armour Health Insurance: Basic health coverage to the informal sector in major urban centers		
Ecuador	Fundacion Eugenio Espejo: Linking micro-enterprises and basic health services	INSALUD: Management of a clinic network in low income communities	Metrofraternidad: The importance of market and financial data in health care planning: applying business principles to the health field	Cofradia Medica PROSALUD Ecuador (HMO Medica)

Table 1. *Initiatives'* Case Study Profile: Local Initiative Groups and Case Study Themes (cont.)

Country	Full Case Studies	Partial Case Studies	Limited Case Studies	No Case Studies
Guatemala	Guatesalud: Self-financing rural private health care program Rxiin T'nameť: Indigenizing a NGO for health: a case study in organizational change			
Egypt	Group Practice Role of strategic management in sustaining private health facilities Mosque-Based Clinic Role of community linkages in sustaining private health initiatives			

located in Emina, Ghana. Although it had not received direct technical assistance from *Initiatives*, its similarity to the Superior Medical Center in Accra, which did, suggested that the Aninwah case could serve as an appropriate and illuminating companion study. The subsequent involvement of Superior's principals in Ghana's national elections in 1996 resulted in the discontinuation of that case study. Thus, while the comparison of these two healthcare providers could not be done, the completion of the Aninwah study ensured the continued representation of the private clinic model in *Initiatives'* case study program.

b) Marketing-oriented Research

Studies of Health Seeking Behavior Among Peri-Urban Populations

In working to strengthen the financial and institutional capabilities of local providers, *Initiatives* noted that marketing information critical to the development of a viable business was often missing from the business planning process. Market factors such as client perceptions of quality, service pricing, location of clinic sites, competitor information, etc., frequently received insufficient attention in the planning stages. This often led to an over-estimation of demand which skewed financial projections. Prompted by this knowledge, *Initiatives* commissioned marketing studies for the provider groups

supported by the project to acquire accurate market information to strengthen the group's business plans.

Initiatives contracted with local market research firms in Ecuador, Ghana and Nigeria to conduct market studies for each of the *Initiatives*-supported LIGs. These studies were designed to collect information on the health seeking behavior of potential clients and their preferences for public or private care. Using this information, the groups could make informed decisions about services required at each facility, assess client willingness to pay for specific services, project clinic utilization rates, and identify potential obstacles to service delivery at, and the financial viability of, each facility.

The information collected through the studies proved instrumental in forming viable business plans and initial marketing approaches. Other health professionals and organizations working or intending to work in the study areas will also find the information on health-seeking behavior of men and women useful when planning appropriate health services to meet the needs and demands of this population.

A summary of the results from the market studies is provided under Section II.A of this report.

Surveys of the Private Health Sectors in Ghana, Ecuador, and El Salvador

As little is known about the private health sector in many developing countries, *Initiatives* undertook a number of surveys to collect data on the history, operation and management of private health facilities in order to better understand the composition of this sector, the range of services offered, and to provide some insight into how such facilities sustain their services in economically challenging times.

In Ghana, *Initiatives* surveyed 164 facilities owned by the physician members of the Society of General Medical and Dental Practitioners, a professional organization for doctors and dentists in private practice. In addition to providing significant baseline data on the management and operations of these facilities, the results challenged a number of prevailing stereotypes of private providers. The study provides useful information to the LIGs for planning purposes, and for the Ministry of Health in its on-going discussions on expanding the role of the private sector to meet public health goals.

In Ecuador, 300 facilities were surveyed in Quito and Guayaquil. While the sample included both public and private facilities, it was biased toward private hospitals and clinics providing both in-patient and out-patient care. The survey revealed some encouraging results regarding the private sector's role in serving low income populations and offered useful information on expanding coverage to this population using strategies already familiar to many private providers. This survey will serve as a useful planning tool for the LIGs in Ecuador as well as the Ministry of Health and USAID as they pursue health reform goals.

The El Salvador survey, described in detail in Appendix V, sampled approximately 200 private providers in the San Salvador Metropolitan Area. The survey was envisioned as the first step in assessing the feasibility of linking private providers into managed care networks and for introducing management efficiencies that could improve client access through lower service costs. The findings of the study were presented in April 1997 at a meeting attended by representatives of private providers, relevant government officials, potential owners/managers of managed care networks and USAID.

A summary of the survey results are provided under section II.B of this report.

4. Efficient Dissemination of Project Results and Lessons Learned

As the project entered its third year, it became apparent that a number of the planned information dissemination modes were no longer appropriate given the limited availability of core funds to support the activities. In addition, the Health Financing and Sustainability Project had come to a close and its predecessor, the Partnerships for Health Reform Project was in its start-up. These events impacted the dissemination activities in two ways: 1) the planned mid-project conference was canceled and 2) the planned joint task force/technical advisory group meetings were no longer held.

During this same time period, however, *Initiatives* identified several additional dissemination opportunities. These included:

- development and maintenance of the *Initiatives* web site (**www.jsi.com/intl/init**) which makes available summaries of all *Initiatives* documents and provides a mechanism for ordering additional materials.

- design and production of a booklet series which presents key research findings in an accessible, low cost manner. Booklets are available on: health-seeking behavior in Nigeria, Ghana and Ecuador; profiles of the private health sector in Ecuador and Ghana; summaries of five *Initiatives* case studies; and health insurance in Nigeria.

- presentation of project activities and findings at professional conferences including NCIH and APHA;

- submission of an article on low income women's utilization of private health care services to *Social Science and Medicine* and an article on private health insurance in Ghana to the *International Journal of Health Planning and Management*; and

- a day-long meeting to share project findings and lessons learned with colleagues at USAID and other cooperating agencies.

A copy of our publications list is provided in Appendix VII.

C. USAID Funding Mechanisms

1. Core & Field Support

In 1994, USAID reoriented its funding mechanism to reflect its efforts to become more field driven. The new system, named field support, meant that projects which had primarily been centrally-funded were now primarily field-funded. This severely reduced the amount of available core funds, restricting the use of these funds to supporting technical leadership, special initiatives, and research. *Initiatives*, designed prior to the field support system, was to fund its key activities — comprehensive field assistance, research and dissemination — using core funds. It had only a limited provision to attract field funds through an add-on mechanism. It was envisioned that add-on funds would cover targeted field assistance.

With the advent of field support, *Initiatives* found its funding drastically reduced. By the end of the project, *Initiatives* had received obligations totaling less than 80% of its authorization. Field support effected not only the total amount of funding available, but also the flexibility of the funding received. Under field support, the USAID field missions became *Initiatives* key clients; the project needed to provide services which were in demand by the missions. One of the key activities impacted was our research component as many missions perceived research as a core responsibility. Fortunately, *Initiatives* was able to reorient its implementation activities to address mission-specific needs, i.e. the redesign of the Nigeria program as an NGO sustainability program. This reserved the limited core funds for research and dissemination activities. Even so, the resulting research program was scaled back from the planned case study program as is described in section I.B.3.a. In addition, project activities in Ecuador were phased out prematurely in response to inadequate field support funding.

2. Cooperative Agreement

Initiatives was designed as a cooperative agreement to allow the necessary flexibility to respond to, and reflect in its activities, the new understandings of the private health sector and how it operates that developed during the course of the project. This same flexibility, along with the support of the *Initiatives* COTR, allowed the project to survive both the significant changes in the USAID funding mechanism as well as the radical reorientation of individual mission programs. A project operating under a contract, with a fixed set of deliverables, would find itself more limited in the types of responses it could make to adapt to the changing environment.

II. Programmatic Findings

After five years of experience working in six countries, *Initiatives* has gained substantial knowledge of how the private sector works to provide basic health services to low income urban populations in Africa and Latin America. Outcomes include a number of programmatic findings, of which the most significant have concerned: A) health seeking behaviors, B) private providers: characteristics and capabilities, C) effectiveness and efficiency of private health care providers, and D) lessons learned.

A. Health Seeking Behaviors

In 1994-95 *Initiatives* conducted qualitative studies of client health-seeking behavior in Ghana, Nigeria and Ecuador to test and refine market assumptions in the business plans of private health providers. Quantitative studies of the operations and management of the formal private health sector in Ghana, El Salvador and Ecuador were also conducted. These studies (available in summary form) revealed a wide range of health seeking behaviors by clients; with notable differences found by gender, socioeconomic status, and age.

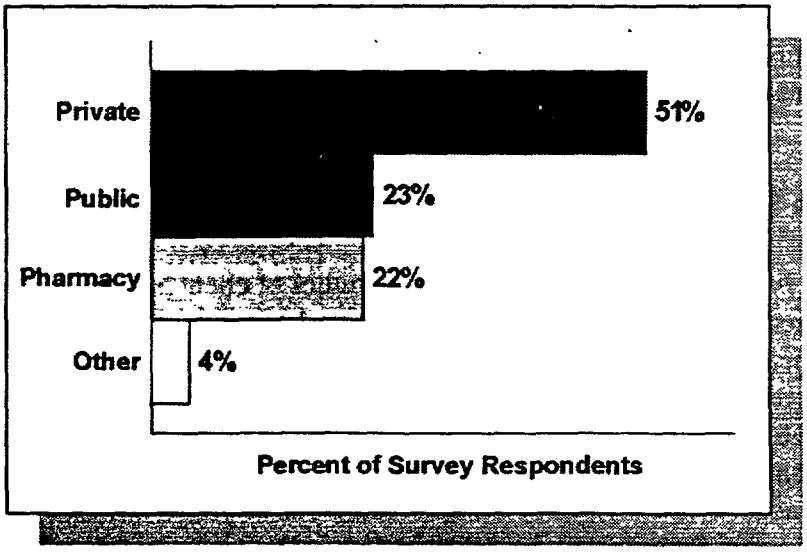
There is common thread, though, among health seekers. None are dedicated exclusively to the public or the private sector, but, rather, will "shop around" for health services. For example, low income families will go first to more costly private providers if quality of services are perceived as better. This can include availability of more costly up-to-date technologies, shorter waiting times, or simply "friendlier" reception. These same clients may also use public health services which they feel are of better quality (immunizations). Similarly, higher income families will, at their discretion, use less costly public services for many of the same reasons — better services which are easily accessible. In all cases, choices made are logical, and oftentimes with costs not being the primary factor.

1. Perceptions of Different Types of Public and Private Providers/ Services

The findings of *Initiatives* studies show that generally seekers of health care services used three criteria to choose a health facility/provider: 1) perceptions that specific services are appropriately provided by one sector or another, 2) quality of care received, and 3) cost. Distance to the clinic/provider was also considered as an important factor, along with waiting times.

For the initial visit, respondents in Lagos used services from both private (51%) and public (23%) health facilities or pharmacy/chemists (22%), depending on the type of illness presented and perception of the treatment they received (See Figure 2)[1].

Figure 2. Type of Health Facility First Visited



The quality of service was the number one reason (55%) for choosing a health facility followed by distance to the clinic (17%), waiting time (8%), and cost of services (7%). Patrons of private clinics were most concerned about quality, distance and waiting time, whereas patrons of public facilities placed more weight on cost than distance and never cited waiting as an issue.

Table 2[2] provides a summary of perceived advantages of each sector.

Table 2. Advantages of Private and Public Sector Care

Private Sector Care	Public Sector Care
Prompt service High quality of treatment Flexible and longer hours Caring/respectful personnel Available drug supply	Lower treatment costs Availability of equipment Comprehensive services/trained specialists Free preventive care

[1] *Demand and Utilization of Health Services among Four Housing Estates in Lagos, Nigeria Summary of findings.* JSI/Initiatives 1996

[2] *Acceptability of a Pre-paid Healthcare Plan among Informal Sector Workers in Lawanson, Nigeria.* JSI Research and Training Institute /*Initiatives* 1996

Clients segmented the health provider marketplace based on where they seek services for specific ailments (see Table 3)[3]. Most visits to health providers, in either the private or public sectors, were for basic and reproductive health reasons.

Table 3. Services Sought from Different Health Care Providers

Provider	Services Sought
Physicians (private / public)	malaria, headache, fever and general body pain, injuries, deliveries, immunization, well-baby check-ups
Nurses / midwives (private / public)	deliveries, minor ailments (e.g. fever, head-aches)
Traditional healers	STD treatment, pregnancy "development" (i.e. infertility), socio-spiritual problems
Traditional birth attendants	pre-natal care, deliveries
Pharmacists	first aid, minor ailments

Women generally take responsibility for health care for their children, and will take their children to the provider of their choice. When men take their children to providers, they tend to take them to their own provider; which often is not the same as their wives. Both men and women generally are satisfied with their health care provider, and usually do not change providers. However, both parents, and especially women, do not hesitate to change providers if quality of care is perceived to be below acceptable levels. Interestingly, clients evaluate quality of care by each procedure, rather than an overall assessment of their provider. For example, a women who lost a child during birth changed clinics for subsequent births, but still patronized the original clinic for minor ailments and first aid.

In summary, the perceived quality of service was a dominant consideration of all respondents without regard to gender, socioeconomic status or location. Basic and reproductive health care were the services most in demand by respondents of the various surveys. Physicians are regarded as the best providers of health services, whether they are in the public or private sectors.

[3] *Demand and Utilization of Health Services among Low Income Residents of Osogbo, Nigeria.* JSI Research and Training Institute/*Initiatives* 1996

2. Women's Health-Seeking Behavior and Access to Private Health Care Services

The *Initiatives* studies found that, regardless of income, women are discriminating purchasers of health care, using health services in both public and private sectors depending on the type of services sought and the perception of the quality of the care delivered. While cost was a factor in this decision, for many women it was not considered as important as service quality.

Quantitative studies of health service utilization in southwestern Nigeria showed that women of all income levels use the private sector more often than the public sector, with 60 percent of women reporting using private facilities most often in the past year compared to 45 percent of women who reported using public facilities most often during the same period. Services purchased from the private sector included general curative care for mother and child, and reproductive health services for women such as gynecological consultations, prenatal care and family planning.

In focus group discussions with low income women on their preferences for public and private care in the same areas of Nigeria, quality of care was the factor cited most often as their reason for preferring private health services. Compared to public facilities, private clinics were seen to offer effective treatment, prompt service, courteous staff and facilities in convenient locations, the exact opposite of factors cited by the same women as the short-comings of the public health sector. These factors clearly address women's concerns about the opportunity cost of time spent waiting for health services; for these women, time is money. Since many low income women work in the informal sector, hours spent at a public facility waiting for service translates directly into lost income, at times exceeding what would have been spent purchasing the same services at a private clinic. When such issues are weighed, the convenience and perceived quality of private care is a preferable option for them.

These public/private choices for specific health needs are important to note. Low income women have acquired, through use and the resultant positive and negative experiences, an understanding of the strengths and weaknesses of services delivered through both the public and private sectors. Using these experiences, they make informed choices about where to purchase care. Neither sector is seen as being all bad or all good; rather, both sectors have perceived advantages over the other. When women need health services, they purchase them from the sector where that service is perceived to be the best quality.

The results of the *Initiatives'* studies of the private sector have corroborated many of the findings reported in the literature on the utilization of private health care, willingness to pay for services, and quality of care issues:

- significant proportions of low income people, and women in particular, use the private health sector for basic and curative care, and often as their first choice for health services;

- low income populations are prepared to pay for private care when the quality of the services meets or exceeds expectations; and

- fees are acceptable to low income people if the services received are tangible.

Given that low income women perceive the quality of private services to be superior to public services but the constraints to using them (mainly cost) restrict some women, especially in Ecuador, specific interventions are necessary to improve low income women's access to private sector care.

B. Private Providers — Characteristics & Capabilities

In order to better understand the composition of the formal private health sector, the range of services it provides and how such services are sustained in economically challenging times, *Initiatives* supported surveys to profile the history, operations, and management of private health facilities in Ecuador, El Salvador and Ghana. The findings shed new light on a number of commonly held perceptions about the private health sector. These include issues related to provider characteristics, facilities, services, and efficiency and effectiveness.

1. Provider Characteristics

Private providers are primarily motivated by maximizing their profits. This perception raises concerns that private physicians may provide services which are in greatest demand, disregarding both the public's broader health needs and good clinical practice. The assumption that profit drives most private providers underlies many of the common perceptions about the private health sector.

The *Initiatives* surveys explored a number of issues which relate to provider motivations. The first area examined was **why providers entered into private practice**:

In Ghana, the majority of physicians interviewed (52%) said the main reason for wanting to enter into private practice was the desire for autonomy in their work. Only 17% mentioned greater financial rewards as their prime reason for entering into private practice. This desire for autonomy is supported by the large number of solo practices — 82% of the total facilities surveyed — among private providers in Ghana.

In Ecuador, 39% of the respondents stated that they entered into private practice for financial reasons. However, it was closely followed by the number (33%) which stated that their desire for a better work environment was the main reason for entering private practice.

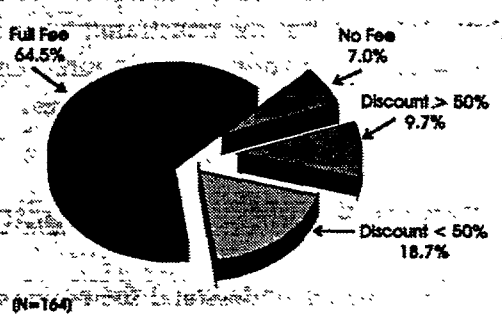
The majority of respondents (70.3%) in El Salvador did enter private practice for financial reasons. However, approximately one quarter (22.2%) entered because of the desire for a better work environment.

The *Initiatives* survey also examined **discounting practices among the facilities**:

In Ghana, nearly 60% of facilities surveyed discounted their fees to some clients, typically those clients whom the provider believed were unable to pay the full fee. During the week prior to the survey, 45% of patients seen were provided a discount on the fees charged.

The study found similar findings in Ecuador where half of the private facilities surveyed provided fee discounts. 28% of their patients received some level of discount on the fees charged during the preceding week.

GHANA: Percentage of Clients Receiving Fee Discounts From Private Facilities



In El Salvador, the majority of the facilities surveyed provided fee discounts of some level, with only 22% of patients not receiving a discount.

Finally, we explored the **profitability of the facilities**:

In Ecuador, only 78% of the facilities reporting financial data appear to have either broken-even or generated a surplus in the month preceding the survey. 31% percent of the facilities in Guayaquil and 7% in Quito actually operated at a loss.

A comprehensive analysis of profitability was not possible in Ghana because complete sets of revenue and expenditure data were available from only 9% (14 out of 164) of the facilities surveyed. Of these, less than half appeared to have generated a profit.

ECUADOR: Profitability of Private Sector Facilities During the Last Month by City and Type of Facility

	Operate at a loss	Reached breakeven/ made profit
All Respondents (N=68)	20.6%	79.4%
Guayaquil (N=39)	30.8%	69.2%
Quito (N=29)	6.9%	93.1%
Inpatient facilities (N=35)	25.7%	74.3%
Outpatient facilities (N=33)	15.2%	84.8%

2. Facilities

Private providers primarily serve upper income populations. Related to private providers' profit motivation is the perceived tendency to serve only those in the highest income bracket.

The surveys in all of the countries collected data on patient characteristics of the facilities studied.

Of the 136 patients seen on average each week in the Ghanian facilities surveyed, over 50% (71) were considered low income. The study also found that the revenues and expenditures of the facilities which serve low income clients were not significantly different then those which did not, indicating that serving low income clients does not adversely effect a facility's income.

In Ecuador, nearly half of the private inpatient facilities estimate that more than 50% of their client base are poor (make less than the minimum wage) and 25% of these said that the poor constitute at least 80% of all their patients. Facilities which served low income clients were no more likely to operate at a loss than those which only served middle or upper income clients.

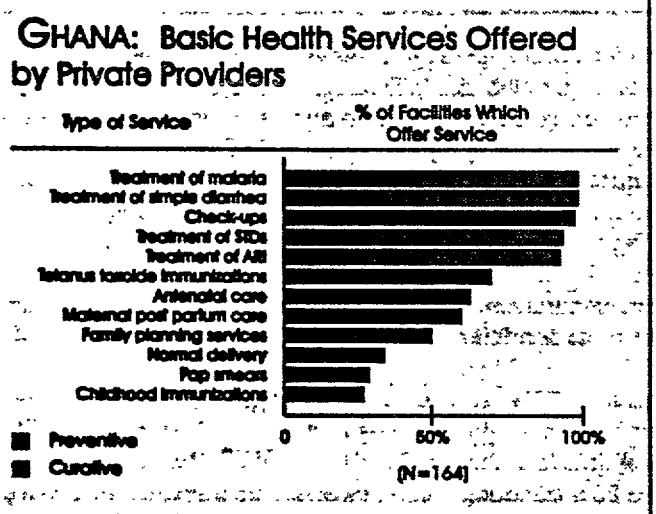
In El Salvador, the facilities surveyed estimated that 61% of their patients are low income.

3. Services

Private providers primarily offer curative services. The perception is that private providers, assumed to be market-driven, mostly provide curative services as there is little or no demand (or profit) for preventive services.

The surveys examined the type of services offered, and found that most of the facilities surveyed in all the countries provided a full range of services including basic curative and preventive care.

In Ghana, almost all facilities offered treatment for malaria, diarrhea, sexually transmitted diseases, acute respiratory infections, and check-ups. Over half provided preventive services such as tetanus toxoid and antenatal and post-partum care. Around 50% of the facilities provided family planning services; the most common being the provision of oral contraceptives and IUD insertion and removal.



In Ecuador, over 60% of the facilities surveyed offered a range of preventive and curative care from treatment of diarrhea to pap smears. 69% of the facilities provided family planning services with around 86% of those providing oral contraceptives and 78% providing IUDs.

Almost all of the 185 facilities surveyed in El Salvador provided check ups (98.4%) and assisted normal deliveries (89.7%). Around three quarters of the facilities provided basic curative care such as treatment for acute respiratory infections, diarrhea, STDs, and malaria. Approximately half of the facilities provide preventive services such as pap smears, antenatal care and maternal post partum care. 38% provided family planning services, while around a quarter provided immunizations.

4. Efficiency & Effectiveness

Private sector is more efficient than the public sector. This underlying premise is the foundation for many of the health sector reform efforts worldwide.

The surveys in Ecuador, El Salvador, and Ghana did not directly explore the efficiency of the facilities studied. However, in Ecuador, where some public facilities were also included in the sample, the data indicate significant differences between the productivity of public and private facilities. Physicians in private facilities were 12 times less productive than their public sector competitors. These striking figures across sub-sectors are largely attributable to the extraordinary low patient attendance levels in private facilities (on average only 500 patients per year at outpatient facilities).

Facility Productivity in Ecuador

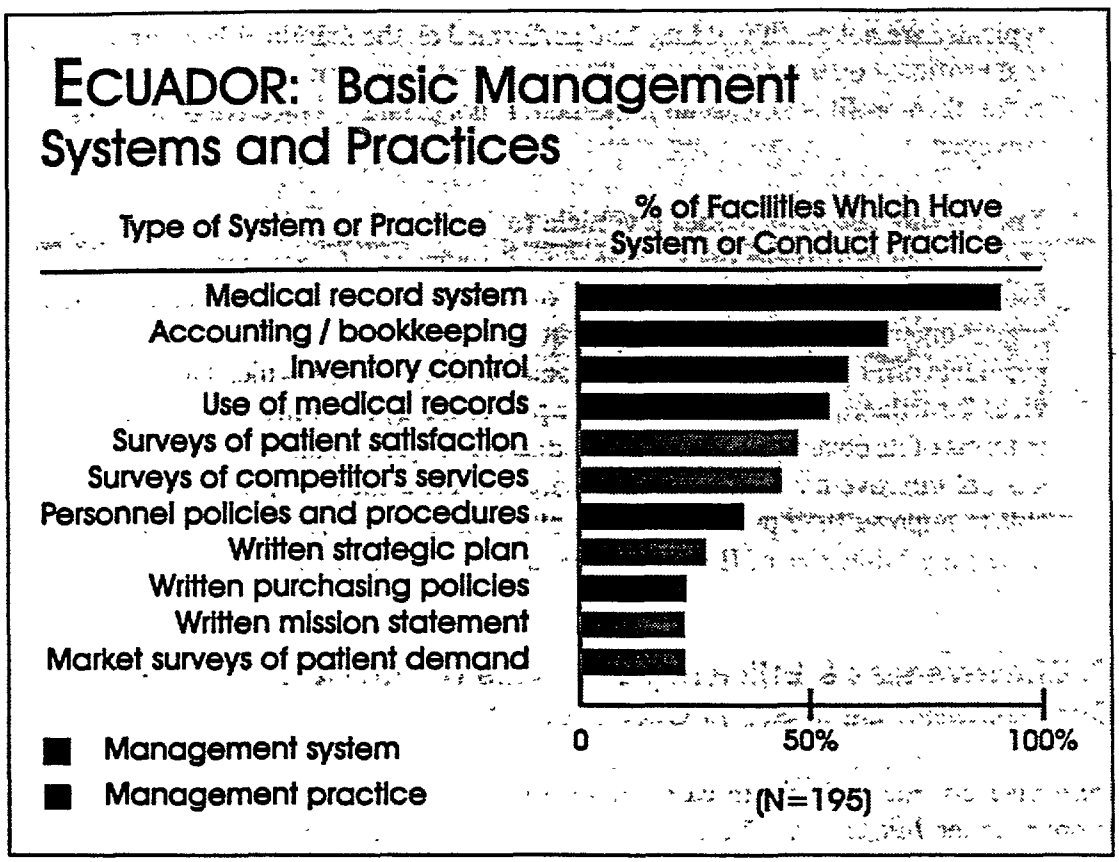
	Number of Patients Seen Per FTE Physician Per Week
Public	58 (1 every 40 minutes)
Private	5 (1 every 8 hours)

The surveys did examine the management systems and practices of the facilities, both of which impact the extent to which a facility can monitor and regulate its efficiency. While most of the facilities surveyed had some basic management systems in place, many did not regularly update them nor did they systematically generate basic management reports.

In Ghana, almost all of the facilities surveyed claimed to have medical records and bookkeeping systems. However, only around half of the facilities analyzed the information kept in the medical records and only 9% were able to provide complete expense and revenue data. This suggests that periodic management reports are not produced on a regular basis. The facilities surveyed were much less likely to undertake management practices than have basic management systems. Less than 10% of the facilities conducted routine marketing surveys (demand or competition), and only 34% conducted patient satisfaction surveys. When comparing the existence of management systems and practices to revenues and expenditures, the study found that facilities which had written procurement policies and those which conducted competitor surveys were significantly more likely to have higher revenues. The other systems did not appear to impact either revenues or expenditures.

In Ecuador, less than 70% of the surveyed facilities claimed to have an accounting or bookkeeping system. Like Ghana, while most of the facilities had medical records only around half systematically analyzed the medical data. A little less than half collected information on patient satisfaction and competitors services, and only around 20% conducted surveys of patient demand. Besides a slight negative relationship between written purchasing and personnel policies and the profitability of outpatient facilities, the existence of management systems and practices had no significant impact on a facility's profitability.

In El Salvador, the facilities surveyed were much more likely to have basic management systems then undertake basic management practices. All the facilities surveyed claimed to keep medical records, and most (85.9%) had a basic accounting system. Only half of the facilities had an inventory control system, and less than 20% had written personnel policies. Slightly more than 10% of the facilities surveyed had a written mission statement and a strategic plan, and less than 10% conducted any type of market research including patient satisfaction, market demand, and competitor's surveys.



5. Conclusions

The results of various studies in the *Initiatives'* countries reveal three important conclusions about private health sector providers:

- **The private health sector is not homogenous.** *Initiatives* found differences in profitability, existence of management systems and practices, services offered, and low income populations served both between the countries that were studied and the cities within the countries. While hardly anyone would find this surprising, there is a tendency to fall back on many of the commonly held perceptions about the private sector — some of which are not supported by *Initiatives'* findings — rather than consciously approaching each situation as unique and requiring fresh investigation.

- **Many of the private health facilities studied operate as social enterprises — that is they pursue a social mission while utilizing many traditional business practices.** Social enterprises differ from traditional businesses in that achieving their social objectives takes priority over generating profits or increasing financial rewards for their stakeholders. The facilities studied served a significant number of low income clients, discounted their fees, provided preventive services which

typically are not profit yielding, and performed on the margin either earning minimal profits or operating at a loss. These characteristics suggest that social service rather than profit is at least an important, if not primary, objective of the facilities surveyed.

- **The private sector provides a vehicle to reach vulnerable populations.** Most of the facilities surveyed in El Salvador, Ecuador and Ghana currently serve low income clients and provide a mixture of curative and preventive care. Although improvements in management are required to maximize their potential, private providers offer governments an additional channel through which basic health services for vulnerable populations can be provided. The significance of that channel in terms of its coverage and reach into disadvantaged populations will require substantial improvements in its productivity and efficiency. If private providers are able to improve their productivity and efficiency, they could play a significant role in helping Ministries of Health achieve national public health goals.

C. Effectiveness & Efficiency of Private Health Care Providers: Consolidated Case Study Conclusions

Initiatives conducted in-depth case studies of five organizations which had received support under *Initiatives*. The case study program is described in more detail under section I.B.3. The case studies were designed to provide insights into "how" and "why" the private provision of basic health services is a viable approach for reaching the intended populations. The cases assessed the organizations in terms of their effectiveness in delivering basic health services to their intended population and their likelihood of sustainability.

1. Long-Term Sustainability of the Enterprise

The durability of health care providing organizations has been an issue closely followed by *Initiatives*. The ability to deliver important health services to the urban poor by the private health sector can only be assured if providers have established themselves for the long term. In fact, *Initiatives*' studies found that 8-10 years was a typical "gestation" period required for health provider organizations to fully established themselves. This was true for profit-making and non-profit organizations.

Interestingly, the characteristics of private sector for-profits and non-profits oftentimes overlap when issues of sustainability are considered. For example, both types of organizations strongly desire to deliver high quality health care to a specific population. As discussed in section II.A this is the primary basis on which consumers select their health care provider. However, after this major goal, providers' abilities to sustain their practices differs greatly.

For-profits are motivated by market forces which allow them to charge patients at a profit, thus allowing them to sustain a practice which includes paid personnel, facilities, supplies, and which builds their reputation. Clients pay for services which are priced at market rates, and owners of profit-making provider organizations control how their organizations function. For-profits take advantage of the economic system (or, at least they try their best), raising operating capital from client fees and banking organizations.

Non-profits have a social mission as their primary motivating force. Of the organizations surveyed, providing health services to the urban poor was typical. These organizations depend upon their mission to appeal to volunteers, who provide their labor force, and charitable organizations for working capital and facilities. Grants generation and management are essential for their survival. However, the weakest aspects of non-profits were often these important areas. An assessment conducted in Nigeria of the factors which facilitate or hinder NGO sustainability supports these findings (Table 4, next page).

2. Effectiveness & Accessibility of Services to Low-Income Populations

One of the most surprising findings from the *Initiatives*' studies was that clients served by the private and public sectors were similar. There was little difference in income levels of families seeking health services, and reasons for using each service were the same: quality services at "correct" cost and provided in a timely manner.

Low income clients were as likely to use private health services, for a fee, as they were to use "free" public services. A major reason, in fact, for not using private providers more often was that these providers usually established themselves in neighborhoods where clients had higher incomes; sometimes at considerable distance from lower income areas.

The quality of services, perceived to be higher in the private sector, was the primary reason that low income urban residents sought services outside the less expensive public sector.

D. Lessons Learned

Through assessments, research and experience, *Initiatives* has gathered a number of lessons learned in working with the private health sector. These lessons relate to the provision of technical assistance, the role of marketing, and project design.

1. Technical Assistance

a) The strategic vision of a private organization's leader(s) is a key element in the development and implementation of a service expansion program.

The wide range of technical assistance that *Initiatives* has provided to its local collaborators has been most effectively utilized by those whose leaders have a clear, long-term strategic vision of where they want to move their organization. Such vision, and the strategic thinking supporting it, is more likely to

Table 4. Factors which Facilitate or Hinder NGO Sustainability

Facilitate	Hinder
Age of Organization	**Organizational Structure and Processes**
Donor Support for Start-up Capital	Strategic Planning (unsystematic, focused at project level, does not incorporate financial information)
Infrequent Change of Leadership	Management Information Systems (systems stronger at project level)
Promotion of Services	Use of Information for Decision Making (information not used for planning and monitoring)
Monitoring Efficiency	Leadership (leaders change often, no protocols for transferring leadership)
Fewer Low Income Clients	Marketing Function (no formal marketing function, information collected not used)
Trained Financial Personnel	Not-for-Profit Orientation (absence of charges or low charges, rely on members to contribute time and materials, reliant on donor support)
Monitor Cash Flow	Volunteer Based Organizations (reliance on volunteers to govern and manage organization)
External Audits	**Sources of Revenue**
Fees for Service	Local Fundraising (not successful at raising significant funds, no clear strategies or targets)
Belonging to a Network	Income Generating Activities (surplus generated rarely covers revenue gap)
	Fees for Service (cover operating costs - not capital improvements)
	Sale of Drugs and Contraceptive Commodities (not priced to cover inflation, low market price for contraceptives)
	Revenues (no reserves)
	Membership Dues (membership dues cannot support organization; often organization does not provide members perceivable benefits)
	International Fundraising (main source of revenue, proposals not targeted to donor interests, donor support tied to specific projects, fund availability not timely)

derive from a leader's experience and personal ability to identify program opportunities, than from a formal, thoroughly documented strategic planning process.

b) Non-governmental organizations providing basic health and family planning services are genuinely interested in increasing their financial independence from donor grants and subsidies (i.e. financial sustainability), but require sustained, intensive technical assistance to move in this direction.

Most of the NGOs the project has been cooperating with in Nigeria have accepted the need to develop their financial sustainability and have been enthusiastic about the technical assistance being provided for this purpose. However, the legacy of past practices, which is reflected in organizational deficiencies in strategic planning, management information systems, data-based decision-making, and marketing, do not lend themselves to "quick fixes."

c) Experience with donor-supported "development" projects can hamper efforts to develop or enhance the sustainability of service operations.

A sustainable organization adapts to its competitive environment and to the changing needs of its existing and prospective clients. It is, and must be, a market-based, client-centered enterprise. It requires managerial skills and an entrepreneurial orientation that are unlikely to have developed in an organization dependent on external grants and subsidies. A grant-dependent organization is more likely to be donor-driven and relatively sheltered from competitive pressures. Consequently, its managers, in addition to their lack of relevant experience, may also be indifferent, if not resistant, to efforts to introduce the efficiencies that are needed to achieve organizational sustainability. These managerial characteristics had as much to do with halving the final number of *Initiatives'* local partners — from 16 to 8 — as did the financial and organizational constraints of their service expansion plans.

d) The orientation of health and family planning providers to a client-based model of service sustainability can be done effectively within a workshop format.

Entrepreneurial management is the life-force of the client-driven model of sustainability. It is the process that focuses familiar organizational functions such as strategic planning and information management on the paramount task of providing services that meet the changing needs of its intended clients. When presented within the context of a participatory and experiential approach to adult learning, the concept of "social entrepreneurship" can serve as a useful and stimulating starting point for addressing a wide range of issues related to the sustainability of private health care services.

e) The ability to utilize technical assistance depends on key organizational and infrastructural prerequisites.

Development of a sustainable operation requires that basic procedures and equipment be in place before technical assistance can be utilized effectively. Prerequisites range from bank accounts and basic telecommunications equipment to management information systems that can generate basic data on expenses and revenues. Consequently, where these prerequisites are absent or significantly deficient, they should be made the subject of a project's early, if not initial, interventions in terms of both technical and material assistance.

While this would appear obvious to just about anyone, it still deserves emphasis. The fact that one's local partners are already established, functioning organizations *does not necessarily mean that expanding the range or scale of their services — typically the basis of the donors' interest in the organization — requires only an incremental bit of training or some relatively minor adjustments in existing procedures.* You cannot begin to develop estimates of unit costs if accounting systems consist of little more than a receipt book and a cash box kept in a desk drawer. Simple off-the-shelf software is unlikely to be used if existing computer hardware is obsolete or unreliable. Accessing credit, even on soft terms from a social venture fund, for example, still requires a financial track record in the form of audited accounts. The simple act of opening a bank account can raise fundamental and time-consuming issues regarding an organization's legal status. All of these were situations *Initiatives* encountered at the outset of its work with its local partners.

f) Expanding service coverage through the development of private provider networks can be significantly constrained by a lack of adequate managerial resources for which technical assistance may only partially compensate.

The financial and managerial requirements of establishing and maintaining a private provider network are significant and can be easily underestimated. Effective network coordination requires not only appropriately skilled and motivated staff, but also basic capital equipment to support the collection, and the internal communication and analysis of information about the operations and competitive environments of the network's various units. Neglect of these basic infrastructural needs can lead to the underutilization and limited effectiveness of technical assistance provided to support network development.

g) Technical assistance can have immediate cost consequences for its recipients that may not be offset by revenue increases in the short-run.

The cost implications of technical assistance can be deceptive or easily overlooked. Strengthening organizational capacities, such as management information systems, may improve financial performance in the long-run through lowered costs or higher revenues. However, the immediate impact is likely to increase an organization's *fixed* costs, e.g. salaries for staffing new or upgraded operations, and the insurance, maintenance, and security costs created by new equipment-based management systems. Developing reliable estimates of these costs should be included in the process of identifying and designing the technical assistance to be provided.

h) Development of financially viable service plans requires sustained, organization-specific technical assistance.

Preparing a business plan is significantly different from preparing grant proposals. Familiarity with the latter does not necessarily facilitate the former, which is typically directed to demonstrating the financial viability of the proposed activities. *Initiatives* adopted a somewhat conventional approach to its early technical assistance in this area. The project brought its local partners together in a series of logically sequenced workshops directed at enhancing these partners' financial and institutional sustainability. The objective of these workshops was the development of viable "business plans," i.e. financially and operationally sound plans for the expansion of sustainable basic health services.

The workshops were an efficient and appropriate means of establishing a foundation — basic financial concepts, vocabulary, business plan information requirements — for the development of business plans. However, the preparation of financial analyses and demand estimates proved to require intensive technical assistance *throughout the business plan development period.* In Ecuador, for example, a local consultant with extensive experience in working with *start-up* enterprises worked one-on-one with the appropriate senior officers of each of the local partners. Over a period of four-to-six weeks, historical financial statements were analyzed, assumptions regarding the anticipated demand and other market conditions for the services to be provided were examined in the light of available information, projected financial statements (e.g. profit and loss, cash flow) were prepared, and the physical, financial and human resource requirements of the plan, as well as strategies for meeting them, were identified. Similar arrangements were made for local partners in Ghana, Nigeria, and Guatemala.

The earliest casualties of this intensive technical assistance were the plans that proposed to expand service coverage through the development of private provider networks. There were several of these: three organizations in Ecuador proposed networks of 15, 10, and 8 clinics; in Nigeria, one provider proposed a network of 12 clinics in Lagos. The financial and managerial requirements of establishing and maintaining such networks were grossly underestimated, and, in the end, proved prohibitive. While in some cases, the individual clinics appeared to be programmatically and financially viable, effective coordination of the *network* required not only appropriately skilled and motivated staff, but also basic capital equipment to support the collection, and the internal communication and analysis of information about the operations and competitive environments of the network's various units. Technical assistance can only partially compensate for such organizational deficiencies.

Throughout this period of intensive technical assistance, the importance of relevant information for planning purposes was repeatedly driven home — primarily by its absence.

i) Political and personal factors are at least as important as the technical quality of an organization's business plan in the acquisition of local capital to support service expansion plans.

The technical quality of a business proposal is one of several factors considered in assessing its financial viability. The establishment or expansion of private health care services can be a real or potential challenge to existing individual and organizational relationships within and without the health sector. Local lenders can be expected to consider the nature and implications of such a challenge in assessing the credit worthiness of the service plans for which their capital is being sought. No less important are the personal characteristics of the principal(s) seeking the loan. All of these factors can be reflected in an organization's capital acquisition plan.

2. Marketing

a) The marketing function — in terms of both organizational structure and individual orientation — requires special attention from the earliest stages of the technical assistance program.

Marketing information was the component most frequently absent from the initial business plans of private groups that sought *Initiatives* technical assistance. Market factors such as competitors, location, pricing, ability to pay, and client perceptions of quality, frequently receive insufficient attention in planning. Demand is frequently overestimated; consequently, the assumptions on which the business plans are based lack a firm empirical foundation. Much of this information is not available through secondary data sources. Consequently, whenever possible, appropriate marketing studies should be done in advance of financial planning activities.

The importance of this information cannot be overemphasized. Particularly critical is information on client health seeking behaviors, which are complex, situation-specific, and, in some cases, incongruent with common assumptions about the provision of, and access to, private health and family planning services. These services will be purchased from *both* the public and private sectors based on *client perceptions of quality and treatment efficacy* relative to the condition to be treated. Such patterns of client choice emerged in a number of marketing studies *Initiatives* supported in Nigeria and Ghana (described in detail in section II.A).

Less important to a private health care provider is the association of a specific service sought with a particular type of provider, than the fact that clients *do make such associations* based on information available to them, and act accordingly.

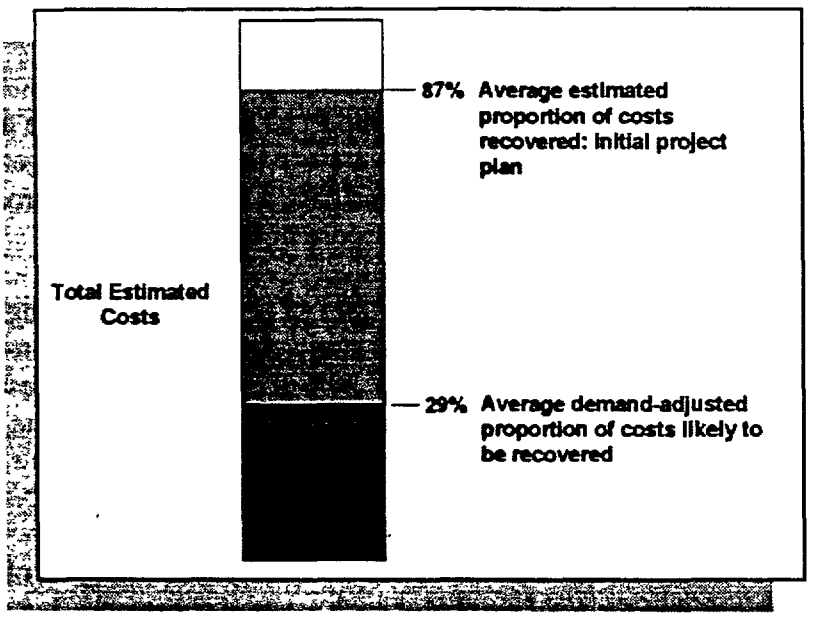
b) The effective utilization of marketing information in developing financial and service delivery plans requires sustained, group-specific technical assistance.

The availability of relevant marketing information is a necessary but not sufficient condition for effective planning and management. Its appropriate utilization can be prob-

lematic. Information about potential clients' objective and perceived needs, and their actual and likely behavior in satisfying those needs, requires careful analysis in order to yield reliable estimates of market size and potential share. In addition, satisfaction of the cash flow requirements of a viable financial plan typically creates pressures for inflating either, or both, service pricing and anticipated client volumes without reference to realistic market potential. Addressing these issues requires technical assistance in the actual analysis and utilization of the information available to the client organization's managers.

In *Initiatives'* experience, the consistent overestimation of market size, and the underestimation of competition are critical impediments to the sustainability of the non-governmental health and family planning service providers.

Figure 3. Estimated Cost Recovery: Proposed vs. Demand-Adjusted



Initial implementation plans submitted to the *Initiatives* project by private providers of health and family planning services typically estimated that they would be able to recover between 70-100% of the costs of their service operations by the end of their third year. Analysis of the projected demand for the services to be offered yielded much lower estimates, which ranged from 9-66% of their operational costs.

Stimulating demand is not a viable option if an operation's revenue requirements exceed the actual size of the market itself. This was the case in a plan to establish clinics to provide basic health and family planning services in several low-income housing estates of different sizes in West Africa — the maximum total revenues achievable in even the largest housing estate fell short of covering the estimated recurrent costs for the proposed clinic under a range of market share assumptions.

Table 5. Estimation of Market Demand
(Naira Revenues)

Number of Households	Market Size		Market Share			
	Total Market (100%)	Current Private Clinic Users (70%)	30%		80%	
			Total	Private	Total	Private
70	490,000	343,000	147,000	102,900	393,000	274,400
115	805,000	563,500	241,500	169,050	644,000	450,800
145	1,015,000	710,500	304,500	213,150	812,000	568,400

The population of the three housing estates ranged from 500-1,000 residents, averaging 800 residents. Using an average household size of 7 persons, this yielded 70, 115, and 145 in each of the estates respectively. The business proposal reports that estate household incomes range from N20,000 - N50,000.

The market definition was vague, but it appeared to be the housing estate and at least some of the surrounding community. However, since the estates' managements may hinder or restrict in some way entry by non-residents, a conservative approach was to take the market to be the estate itself for the purpose of this analysis.

Based on the RMS survey, we have the proportions of households reporting patronage of private health facilities (70% - 78%). Market size is defined (and measured) in terms of *estimated* annual health care expenditures (i.e. 20% of estimated average estate household income: N35,000 * 20% = N7,000). This approximates total per capita household health expenditures of $15 reported in other published sources: $15 * N70 * 7 persons/ household = N7,350.

The project plan's estimated annual revenues (for one clinic) in the first year of N406,560 appears achievable within the ***total market*** of each estate size category, but remains so only for the total number of private clinic patrons in the largest estate.

Looking ahead to the target market share of 80%, the revenue target does appear reachable in the middle size and largest housing estates, both as a share of the total market and, more conservatively, as a share of the private clinic market.

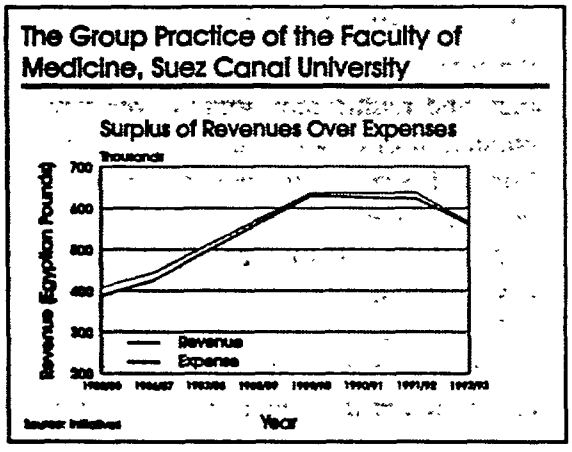
However, the estimated total revenues achievable in even the largest estate still fall short of covering the estimated recurrent costs of N1.2 million for one clinic.

3. Project Design

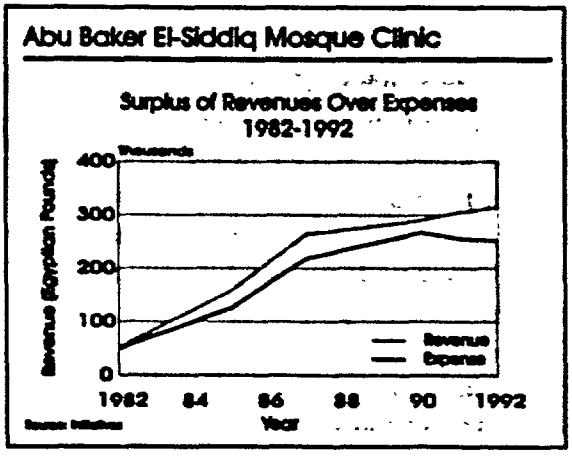
a) The process of supporting the development of private sector health care organizations has important implications for any program that includes sustainability as an objective.

Supporting the development of private sector organizations typically involves strengthening one or more functional areas that contribute to the organization's ability to respond efficiently to the changing needs and demands of its intended clients. Success is reflected in levels of service utilization and operational efficiency that underlie the financial viability of the enterprise. The inter-relationship between utilization and efficiency is clearly illustrated in the *Initiatives* conceptual model which is presented in Section I, Figure 1.

The model focuses on an organization's ability to mobilize resources, and to organize and manage production in order to realize a financial surplus within the constraints posed by its environment. This focus is as relevant for not-for-profit organizations as it is for commercial firms.



This lesson was driven home to us by *Initiatives*-supported case studies of two private health provider organizations in Ismailia, Egypt. One organization was the *Group Practice* that is a subsidiary of the Suez Canal University Faculty of Medicine. The other was the *Mosque Clinic* that is a subsidiary of the Abu Bakr El-Siddique Mosque Society. The case studies provided an overview of the development and evolution of both organizations since their beginnings in 1982 and 1981 respectively — 15 years of sustained operations! Their experience is clear and unambiguous. The *Group Practice* quickly achieved programmatic and financial success as a provider-driven organization with little or no competition from other organizations. But its lack of a strategic management system that monitored and adapted to a rapidly changing regulatory and competitive environment ultimately translated into declining financial fortunes that are expected to result in its discontinuation, or in its transformation into a radically different form of provider organization.



On the other hand, the *Mosque Clinic*, while not immune to the consequences of greater competition, had sufficiently close ties to the communities it served to anticipate and appropriately respond to changes in its environment.

b) "Creating demand" for health care services begins with identifying current client expectations and demands, and includes attention to issues affecting service availability, quality, and accessibility.

Demands by individuals and communities for services are the starting point for effective health care service planning. They can guide service providers in determining the mix, quality, and ways of delivering services that individuals and communities will utilize, including services that address their real but currently unrecognized needs. Responding to such demands necessarily entails giving attention to the provider's operational efficiency, which ultimately translates into the cost of the services, and thus their accessibility, to the intended clients. In contrast, an approach that starts with a provider-driven determination of the services offered, and that "creates demand" primarily through the communication of service availability, is unlikely to be sustainable.

c) Data demands should contribute to the sustainability of the organization being assisted.

The data collection efforts of the project must try, as much as possible, to contribute to the decisions affecting the sustainability of operations, in addition to capturing the complex and multidimensional development process. *Initiatives'* initial approach to the collection of baseline information and the design of data systems was fairly conventional. It stressed the generation of monitoring and evaluation data, and "to the extent possible," the provision to its local partners of "data useful for their market assessments and analysis." Insofar as the ultimate objective of all this activity is the establishment of sustainable health services, this approach turned out to be almost exactly backwards. It reflected the extent to which the design of technical assistance can be influenced, if not actually driven, by donor information requirements and health providers' supply-side biases, rather than the intrinsic needs of the organization to be assisted. Consequently, *Initiatives* adjusted its technical assistance program to focus on how its local partners interfaced with their volatile and challenging environments — i.e. marketing.

d) Donor provision of initial start-up capital in the form of grants, time-limited subsidies, or shared financing of basic equipment may be required under certain circumstances.

Private capital is unlikely to be available to enterprises whose financial returns do not adequately reflect the risks inherent in new ventures or in high capital investment costs. Donor interventions targeted at reducing these specific risks can contribute to an enterprise's long-term financial viability without necessarily increasing donor dependence. Such interventions may yield a financial return within an acceptable time frame that is sufficient to fund current operations and to secure financing for capital investment, or, in the case of profit-seeking enterprises, to attract private investors.

This may entail relatively modest capital investments in the organization's infrastructural prerequisites mentioned earlier. Examples include: accounting and financial management software (either off-the-shelf, or locally developed) where computers are available

(Rxiin Tnamet, Guatesalud, Superior Medical Centre, Nationwide Insurance, GRMA), or forms and various ledger books where manual systems are appropriate (NPNMA/ Osogbo); reconstruction and auditing of financial records (Lawanson Group); local legal assistance in satisfying various requirements such as registration with the appropriate authorities, or negotiation of a provider network's service prepayment and health savings program with its partner bank. Underwriting market research is an especially important investment given that it tends to be shortchanged or inappropriately deferred in organizations already operating with little or no financial surplus. And, since most organizations typically will need two-to-three years to reach a break-even point, working capital, either in the form of a grant, or a revenue-generating asset (such as a building that can be rented, or an endowment) will be unavoidable when commercial credit cannot be obtained.

e) The traditional prerogatives of private ownership can limit the role of the community in the determination and delivery of basic health services.

The importance of community involvement in meeting the public health needs of any population is widely accepted, to the extent of being considered a *sine qua non* of primary health care services. However, except for when a community actually owns the organization, its role in the decision-making processes of a private provider is unlikely to be more than advisory in nature. This can be the case for both for-profit and not-for-profit organizations, although the extent to which community input influences decision-making can vary according to the nature and mission of the organization.

f) The level of local coordination among donor policies and actions has important implications for the viability of private health care services.

Donor support for the development of private health care services can be undercut by the simultaneous efforts by the same or different donors to strengthen or expand similar services provided by the public sector. When this support to the public sector enables the continuation of heavily subsidized services to populations otherwise able to pay for the services they receive — either all or in part — it creates a competitive environment within which the private provision of services is unlikely to survive, let alone grow over time. In addition, uncertainty about both the commitment of various donors to promote a balanced partnership between public and private health care providers, and the complementarity of the donor-supported programs that result, can be expected to discourage private initiatives to establish or expand private health care services.

III. Implications for Future Programming

A. Working with the Private Sector — Opportunities & Constraints

Among the most significant outcomes of the past five years was that of learning how a project such as *Initiatives* could most effectively work with private sector health providers. The initial intent of the project was to test the capacity of the private sector to provide basic health care to poor urban populations. As the project progressed, it became apparent that more specific questions had to be addressed:

- how could the private sector increase coverage and service delivery points?
- how could issues of health policy, health reform, and health resource reallocation be considered to increase the private sector's involvement in national basic health priorities?
- how could quality of services be improved in the private sector, and who decides standards for those improvements?
- how could business practices of private sector providers (for profit and non-profit) be improved to ensure sustainable and independent practices into the future?

Throughout the life of *Initiatives* a series of recurrent needs emerged regardless of whether the project was working in Africa or Latin America. These needs illustrate both opportunities and constraints for future programing by USAID and other donor organizations.

1. Need to be Clear about Reasons for Working with the Private Sector

As *Initiatives* was the first USAID centrally-supported project to examine basic health care and the private sector, part of the original intent was for the project to identify and examine some of the above issues to benefit the targeting of future ventures between the private sector and donor organizations.

In working to better understand the issues surrounding these key questions, *Initiatives* found that often the reasons for working with the private sector were not clearly articulated nor was the effort required to support private sector services fully appreciated. Often private sector programs were based on an underlying assumption that harnessing private sector forces minimizes the amount of resources required to achieve public health goals -- i.e. a short infusion of technical assistance would be sufficient to expand private sector health services to low income populations. Another common premise was that the private sector was inherently sustainable.

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Initiatives found that neither of these assumptions were necessarily true. The private sector required a significant amount of assistance, both technical and capital, in order to expand services to low income populations. While *Initiatives* selected organizations which appeared sustainable, the efforts of expansion often put the organization at risk due to the additional management and financial burden.

As such, it becomes critical to clearly articulate the reasons for working with the private sector, as well as the amount of resources available to support private sector development and expansion. If access is the key concern, then one must carefully weigh the effort required to increase access through the private sector versus the public sector. If sustainability is the key concern, then one must be willing to compromise some expansion goals and understand that sustainability is a long-term objective that cannot be addressed through minimal interventions.

2. Need to Segment the Private Sector

The first step in working with the private sector is to undertake a "market map" which will indicate distribution channels for health services by identifying various providers as well as indicate basic health care purchasers and final users.

A market map will reveal important information from which to begin relations with private sector health providing enterprises and users of health services:

- definition of roles within the health market: suppliers, distributors, providers, and customers;
- organizational scale: whether they are large or small, and whether they target individual clients or groups through their employers, etc.;
- organizational motivation: profit making, not-for-profit, or social enterprise with a defined mission
- strategic focus: seeking low-income customers, providing minimal basic health services, or community-based, etc.

Understanding how the health care market is divided and identifying which segment is most suited to achieve your goals are critical aspects of private sector program design. The private sector is not homogeneous and each of its various elements requires differing approaches (large commercial, social enterprises, not-for-profit charity organizations). *Initiatives* primarily worked with small social enterprises and nongovernmental organizations, as these were already serving the low income population. Their technical assistance needs differed considerably from what a large commercial sector organization, such as a pharmaceutical company, would require.

3. Skill Requirements for TA Providers

The requirements for technical assistance changed considerably over the life of *Initiatives*. The first year was devoted to identifying local initiative groups (LIGs) and later to local management groups (LMGs) through which the *Initiatives* team would channel its resources to reach the private sector.

After identification of LIGs and LMGs, the second and third years were spent on providing business skills, and to a limited extent, improving management abilities of the groups. In addition, technical assistance was valuable for seeking out local sources of business capital. This variety of technical assistance demands, from marketing to financial management to quality of care, required a wide range of technical expertise which could not be addressed given the limited staff size. Instead, the project hired program managers with strong technical backgrounds who could identify and manage a range of technical assistance activities undertaken by local and international consultants. Many of the initial local consultants identified had strong medical backgrounds coupled with management. Even so, the project found that many were not suited for the type of assistance required by the private sector. Instead, *Initiatives* pulled consultants from other sectors including business, banking, and small business development and worked with them to apply these skills to the private health sector.

While the second half of the project continued to support the ongoing business skills development and improving management capacity, the project began to focus on mining research results which were practical and useful for understanding the dynamics of the various levels of the private sector in basic health care. This, too, was a change from the original view of research, which was conducting complex longitudinal studies on various questions pertinent to private sector providers. To reach the project's objectives of understanding the private sector, more focused research of an operations nature was useful. Consequently, technical assistance was changed from institutional support of a well known research firm capable of conducting complex research to the support of individual consultants with specific expertise which could be used according to identified needs.

Also, dissemination of project findings was given greater importance in the second half of the project. At this point, a change of project directors took place. The important contribution of the first director was an impressive medical background, which was essential in making contacts with health providers in both the private and public sectors, and a good understanding of national health systems -- public and private. The second project director had a strong business background which, combined with his substantial development and marketing experience, moved the project toward a comprehensive dissemination of results to a wide audience.

The ability of the project team to adapt to the changing needs of technical assistance was one of the primary reasons for its overall success.

4. Need to Identify and Nurture Entrepreneurial Behavior

Conventional wisdom is that public institutions' main purpose is to provide goods for a common (public) goal, while private business exists to meet individual goals and/or to generate profits for the organization. Improving entrepreneurial skills in the private sector, especially through a publicly financed project, was not unlike bringing coals to Newcastle. Who would learn more -- project staff or private providers? Perhaps the greatest lesson from the *Initiatives* project is that this paradigm oversimplifies the actual situation in the field. Often potential private partners did not exhibit entrepreneurial characteristics, and in some cases the public sector did. The project found private health providers who have a strong public health mission but lack basic business skills and savvy, while the ministry of health was positioning itself in full competition with the private sector for clients.

Identifying and nurturing entrepreneurial behaviors was more critical and complex than anticipated. The value of marketing, client orientation, profit and social mission motivation, business practices, physical location, and quality assurance were just some of the factors which reflect entrepreneurial behavior. Deciding on which areas to focus interventions which would encourage entrepreneurs to improve and increase their abilities to provide basic health care to poor urban residents was a challenging task for the *Initiatives* team.

There were two primary interventions which did strengthen the entrepreneurial capacity resulting in improved health care delivery by the private sector and which were desirable from the private provider point of view. These were improved marketing techniques and better business practices to run their organizations more efficiently. There is no doubt that there are other valuable interventions, but over the life of this five year project, these two were the most beneficial, and ones which outside assistance could provide.

5. Need to Understand Donor Requirements versus Market Dynamics

The project had to come to terms with two different requirements: donor needs and realities versus market forces and dynamics. Even with a clear intent to understand and support the private sector's ability to provide basic health services, these did not always match.

Initially, the *Initiatives* team needed to make a convincing argument to the private sector as to what value could be created to improve their practices. Possibilities included expanding their current market, developing new markets, and reducing operation costs. This was a time-consuming, and not always successful, process, especially when they realized that the assistance did not include grants they had come to expect from donor agencies.

In some cases, particularly among non-profit organizations, a considerable amount of energy was required to overcome suspicious beliefs about working with public organi-

zations. A common reason that these organizations formed was due to identified gaps in public sector services. Their investigations led them to understand the weaknesses of the public system, and they reacted to these deficiencies in their early period of development.

These same organizations also reacted to for-profit structures as they identified their social missions as more significant than a need to generate income. Non-profits at later stages of development often had a clear mission statement, but had unrealistic plans for sustaining their activities for lack of resources generated.

Private sector for-profit groups tended to be staffed at the higher decision making levels by medical technicians (physicians) who did not possess adequate business training. Convincing them that they needed to improve their business practices was a lengthy process, compounded by the self-identified need to run a profitable organization within a short amount of time. They were often in a hurry to learn how to correctly organize a successful venture.

For donors, needs were considerably different and at odds with private sector realities. Donors, who manage public monies, are required to overtly monitor and account for project actions. This creates reporting requirements for which private groups have little need or appreciation. In some cases, provider groups are run by a single individual who has little time or desire to report information on activities s/he is undertaking to the donor.

Market dynamics, which are sensitive to user and provider preferences, are not necessarily responsive to donor objectives. These objectives may have been formed years earlier and based purely on the public interest in preventive health services. To be able to effectively work together, both parties (public and private) need to understand the motivations of the other side.

Initiatives reference here is clearly to the scale of the project, which was felt to be severely constrained by a lack of resources, other than technical assistance, to work effectively with the private sector. Future projects will gain credibility and produce better results by making appropriate levels of non-technical assistance resources available for the private sector groups. An appropriate mix of both is desirable.

B. Conclusions — Significance of *Initiatives'* Experience to USAID/PHN

As a flexible mechanism to test the extent to which private providers can make quality basic health services accessible to low-income urban residents in developing countries, the *Initiatives* project accomplished its intended objectives.

- *Initiatives* assisted host country governments and institutions in the area of the private provision of health care services;

- *Initiatives* tested different approaches to providing sustainable private preventive and basic clinical health care services to low-income urban and peri-urban populations;

- *Initiatives* analyzed through assessments, studies, and operations research, the characteristics of the private provision of health services, especially those services available to peri-urban poor and working class communities, and;

- *Initiatives* supported the on-going dialogue regarding the respective roles and responsibilities of the private and public sectors in the provision of preventive and clinical health services.

In working with the private health sector over a five year period, *Initiatives* has found that the private sector can serve as a mechanism to achieve public health goals as a viable provider of basic health services to low income populations. However, in order to reach its full potential, the private sector must improve the efficiency and management of its services. In doing so, it can complement the services of the public sector and contribute to realization of national health goals.

Through the understanding of the private sector gained by *Initiatives* -- how it operates and who it serves -- USAID will be better able to identify the proper role, if any, the private sector will play in future results packages. Additionally, USAID will be better equipped to guide the type of assistance required to support private sector efforts. A step-by-step approach to working with the private sector and tools developed under *Initiatives* are provided in volume two of this report, *Initiatives Private Health Sector Toolkit*.

Appendix I: Country-level Activities/Ecuador

Initiatives began activities in Ecuador in January 1993 in support of USAID/Ecuador's objective to improve the effectiveness and sustainability of child survival programs by fostering public sector policy reform and private sector development.

Initiatives initiated its work in Ecuador with five local private providers of basic health and family planning services. Based on a review of the groups' ongoing and proposed activities, and on specific requests from the groups themselves, *Initiatives* identified a range of technical assistance areas with a heavy focus on business planning and management. In April 1993, *Initiatives* began its program to strengthen the organizational capacities of its local initiatives groups (LIGs) so that they could develop, secure finance for, and implement their plans to expand the scope and reach of their basic health services to low income urban populations.

The technical assistance program consisted of a series of workshops, a study tour, and sustained individualized assistance to support the participants' application of the workshop concepts to their individual organizations, as well as their eventual development of a viable business proposal. The areas in which assistance was provided include: organizational strengthening, financial planning, marketing, clinic management and quality assurance, and information systems. In addition to these technical assistance activities, *Initiatives* sponsored a series of market research studies to gather information on health seeking behavior and the attractiveness of the services to be offered to the local groups' intended clients.

Together, these two sets of activities resulted, in mid-1995, in the development of business plans for each LIG that could be used to secure financing from various sources -- as grants, loans, or some combination of both -- for implementation. Beginning in May 1995, *Initiatives* began the process of incorporating the completed business plans into "funding packages" that could be presented to potential investors or funders of the proposed projects. These "packages" included not only the business plan, but the legal documentation and marketing information typically required for a comprehensive risk assessment of the project. During project year 3, *Initiatives* also began working closely with USAID/Quito's APOLO/CARE bi-lateral child survival project to support their NGO strengthening activities, sharing with them the lessons learned in working with the LIGs over the last three years. This support prepared the APOLO/CARE team to provide technical assistance to the NGO community.

During the fourth year, *Initiatives* gradually reduced and eventually phased out its technical assistance to the LIGs in response to insufficient field support funding. This corresponded with USAID/Quito's increased reliance on APOLO/CARE as the main provider of technical assistance to the local NGO community.

Local Initiative Groups of Ecuador

The initial local initiative groups in Ecuador were:

- Cofradia Medica (later split into Hombre Redentor and Prosalud Guayaquil; Prosalud Guayaquil later changed its name to *InSalud*)
- Fundacion Eugenio Espejo (FEE)
- Fundacion Metrofraternidad
- Prosalud-AMEDICA
- Multiservicios Medicos (later changed its name to Provida)

The ***Institute for Integral Health (InSalud Cia. Ltda.)*** is a private, for-profit organization, located in Guayaquil, that proposed to take over the operation of public health clinics as well as open a number of new clinics, in order to provide financially sustainable, basic health care services to middle- and low-income populations in urban and peri-urban areas. *InSalud's* experience highlighted the process of subcontracting with private organizations to manage and operate health facilities, and the implications this transfer of management responsibility has for the quality and delivery of health care services to low-income urban populations.

InSalud was formed in May 1994 by a group of young, highly motivated physicians who were trained in public health and have been involved in a Ministry of Health family and community health program serving the low-income areas of Guayaquil. Its first facility is a health center in the El Guasmo area south Guayaquil, which it administers under a ten-year agreement with the Catholic University of Santiago de Guayaquil. The center's original operations were limited — open eight hours per day, it targeted children under twelve years of age. Under *InSalud* management the clinic significantly expanded its reach to the 90,000 inhabitants of its surrounding community. In addition to its direct services, *InSalud* plans to develop the clinic as a training site for healthcare professionals, psychologists, social workers, and managers from the Catholic University of Santiago de Guayaquil, and, through separate agreements, for personnel from the Ministry of Health and other non-governmental organizations.

Sliding scale fees and cross-subsidies are used to ensure that low-income clients have access to clinic services. In the future, as the program develops, an important contributor to these subsidies will be revenues generated through a prepayment mechanism targeted to organized groups such as trade associations and employee organizations in the surrounding communities. Staff compensation is linked to the volume of business generated in a "shared risk" system that reduces the clinic's fixed costs, and increases the resources available for debt servicing.

Initiatives has provided technical assistance to *InSalud* in the areas of organizational

development, strategic planning, financial analysis, business plan development, and marketing. *Initiatives* also sponsored a series of marketing surveys designed to profile the needs, demands, and health seeking behaviors of the clinic's potential clients, as well as its competitive environment. The information produced was incorporated into a comprehensive marketing plan for the clinic. The importance of maintaining a viable marketing capacity was underscored by potentially significant changes in *InSalud's* competitive environment during the project's fourth year. FASBASE, a World Bank-funded project, intends to expanded the heavily subsidized public health care facilities in *InSalud's* market area.

Initiatives also brought *Insalud* together with PATH's Lending for Health program, a social investment facility that is a potential source of financing. Although *InSalud* was not able to negotiate a loan with PATH, one of its founders was able to secure a loan from a local bank. Due to funding constraints, *Initiatives* gradually phased out its support of *InSalud* in 1996.

Fundacion Eugenio Espejo (FEE) is a private, national, not-for-profit organization, founded in 1978 to support a wide range of community development initiatives in low-income areas. *FEE* planned to expand the coverage of its existing basic health services in southern Quito through the development of a network of clinics. It offered a potential example of how linking basic health services with other social development activities in a community can contribute to the sustainability of those services.

FEE operated a community health clinic in the Chilibulo area of southern Quito. It is planning to replace this clinic with a larger, more centrally located facility that would offer a wider range of services, such as a birthing unit and 24 hour emergency services. It would serve approximately 10,000 people, focusing in particular on the needs of mothers and children.

Given the low purchasing power of the Chilibulo community, *FEE's* innovative approach to sustaining its health services without limiting access for low-income residents has been to develop a financing mechanism that links the clinic to *FEE's* credit lending for micro- enterprise activities in the same community. Under this approach, a portion of the surplus earned from these micro-enterprise loans would be placed in a fund that would subsidize the health services provided to low-income families participating in *FEE's* community development projects. Eventually, *FEE* planned to develop a prepaid mechanism for community residents. In this way, *FEE* would be integrating health, community development and credit activities in one single program.

Initiatives' technical assistance has been directed to complementing and building on *FEE's* extensive experience in community research, health service delivery, financing, micro-enterprise development, and community participation. *Initiatives* concentrated its efforts in the areas of organizational development, strategic planning, business plan development, and marketing. *Initiatives* sponsored a series of marketing surveys designed to develop a profile of the needs, demands, and health seeking behaviors of the clinic's potential clients in Chilibulo, as well as a profile of its competitive environ-

ment. Assistance in integrating this marketing information into its business and financial plan was also provided. *Initiatives* brought FEE together with PATH, which was a potential source of funding for the Chilibulo project. These discussions were indefinitely postponed, however, following the unexpected interruptions in the operation of the Chilibulo micro-enterprise credit program. Following *Initiatives* withdrawal, the APOLO/CARE project began to assist FEE through the provision of equipment for the Chilibulo project.

Fundacion Metrofraternidad is a private, not-for-profit institution founded in 1987 to provide low income patients requiring specialized clinical care access to Hospital Metropolitano, which is the most modern and technologically sophisticated private hospital in Quito. *Metrofraternidad's* efforts to develop outreach services to provide sustainable, low cost, high quality, basic health care services in peri-urban communities surrounding Quito highlights the challenges these new primary-level activities pose for the larger organization's strategic mission and efficient operations.

Metrofraternidad started its Calderon clinic in June 1994, in collaboration with the Rotary Club and the Calderon community. Its purpose was to enhance the quality of life while fostering community participation and introducing gradual changes in the health behavior of the participating families. The project targeted the indigenous population, informal sector workers, and low-wage formal sector workers. It planned to reach at least half of the area's estimated 34,000 inhabitants during its first five years.

The services being offered were a mix of preventive and curative, including pediatrics, gynecology, family medicine, odontology, and in the near future laboratory and pharmacy. The center also provided training in preventive health to the families. With the provision of these services, the Calderon clinic hoped to reduce the high prevalence and incidence of acute respiratory infections, malnutrition and diarrheal disease.

Initiatives' technical assistance to *Metrofraternidad* and its Calderon project consisted of several workshops in organizational development, strategic financial planning, marketing, and business development, as well as a series of marketing studies of the perceived health needs, demands, and health seeking behaviors within the community the clinic will serve. This collaboration resulted in *Metrofraternidad's* business proposal for the Calderon clinic, which has been presented to potential sources of capital. *Metrofraternidad* also was pursuing discussions with APOLO/CARE for future support when *Initiatives* phased out its support in early 1996 due to inadequate field support funding.

AMEDICA (Medical Assistance C.A.) is a private, for-profit provider of medical management and clinical services which proposes to establish low-cost, basic health care services for middle- and low-income communities in south Quito. Founded in 1989, it offers an example of the processes by which a private health care organization balances its need for economic viability with a commitment to maximize service access for low-income residents through the development of a prepaid managed care program.

AMEDICA managed PROSALUD, a multi specialty medical center that offered, in addition to traditional fee-for-service health care, a prepaid managed care component. Located in north Quito, this facility served mainly middle-income clients. Convinced that its managed care approach could be adapted to serve low-income populations, plans were developed to establish PROSALUD/South, a diagnostic and basic health care center in south Quito. The facility would be established as an independent company, which *AMEDICA* would manage.

Initiatives' technical assistance was initially provided through a series of workshops focused on organizational development, financial planning, marketing, and strategic business planning. *Initiatives* also supported marketing studies that profiled health demands, health-seeking behaviors, and the understanding and acceptability of prepaid health care among the proposed facility's potential clients. The outcome has been a sophisticated financial plan for which capital is being sought. *Initiatives* phased out its support of *AMEDICA* in project year four, as APOLO/CARE became the main provider of technical assistance to the Ecuadorian NGO community.

Project *Apoyo a Organizaciones Locales* (APOLO)

Project APOLO is a bi-lateral project of USAID/Quito that focuses on child survival. *Initiatives*' involvement with Project APOLO began with input into its design by the *Initiatives*' Health Financing Advisor, who was based in USAID/Ecuador from June 1993 to January 1995. The objectives and modalities of technical assistance in Project APOLO drew heavily from the valuable lessons learned during *Initiatives*' initial work with its LIGs, particularly regarding the importance of establishing a local managerial and technical support organization for the NGO health providers selected to participate in APOLO. CARE was selected in early-1995 by USAID/Ecuador to fill that local support role in APOLO.

Initiatives focused its technical assistance on developing CARE's organizational capacity to support the local NGO health providers. This included the development of Project APOLO's initial workplan, the development of its NGO selection criteria and their application in the review of NGO proposals and site visits to NGO health facilities, and rapid organizational assessments of the first group of NGO health providers that may qualify for small grants under Project APOLO. After an initial year of support, APOLO/CARE became the main provider of technical assistance to local NGOs.

Policy Research & Analysis

Initiatives' initial activities in this USAID Mission's priority area have entailed, as with Project APOLO, the design of the Mission's support to CEPAR in order to develop that Ecuadoran NGO's capacity to function as a private, independent research, analysis, information dissemination and advocacy institution that can address public and private sector constraints to health sector reform.

Most significant to date has been CEPAR's involvement in the *Initiatives*-supported survey of the 400 private and public health facilities in Quito and Guayaquil that was undertaken as a component of the market research program for *Initiatives*' LIGs. CEPAR was sub-contracted to carry out the survey in both cities and to participate in the analysis of the information collected. The survey was supplemented with a historical overview of the evolution of the health sector in Ecuador.

Apart from its involvement with CEPAR, *Initiatives*' contribution to the ongoing local dialogue concerning health sector reform was the development of a discussion paper ("Opciones para majorar la dirección y manejo de centros de atención primaria en Ecuador") outlining a range of options for handling the transfer of management responsibility for government health facilities to local non-governmental organizations.

Appendix II: Country-level Activities/Guatemala

Initiatives began its activities in Guatemala in May 1993 with an initial assessment visit to identify potential local initiative and management groups. A primary health care business development workshop in December 1993 yielded several proposals, two of which became the basis for the project's sustained cooperation with Guatesalud and Rxiin T'namet since mid-1994.

Local Initiatives Groups of Guatemala

GuateSalud, the popular name for the "Association for the Promotion of Rural Health", is a not-for-profit, non-governmental organization formed in late-1989 to provide basic health care services to *finca* (farm) workers and their families in several agricultural regions of Guatemala. It offers an example of the process through which a self-supporting, employer-based managed health care organization can significantly expand the geographic coverage of its current services, and to extend and adapt its operations to include community-based services.

GuateSalud operates like a prepaid "peasants HMO." Revenues are received from both *finca* owners and their employees. *Finca* owners make a one-time contribution to establish a clinic on their farm, to make the initial purchase of medicines, and to pay for the training of a local part-time health worker, called a "Health Promoter," who is selected from among the farm's resident employees. Each clinic is designed to service up to 500 people. The *finca* owner pays a flat fee each month to *GuateSalud* for its services, as well as the salary of the health promoter, who devotes approximately three hours per day to the clinic; all other recurrent costs (materials and supplies) are covered by user fees charged by the health promoter, and a supervising physician who visits twice monthly. The medicines are sold at a significant discount, slightly above cost, which makes them about half of what they would cost at a private pharmacy. The *finca* owner receives the revenues generated from the physician's fees (less a portion that is paid to the promotor) and the proceeds from the sale of drugs.

The training of health promoters takes place over the course of one month at *GuateSalud's* headquarters office in San Lucas Sacatepequez, which is a 30-minute drive from Guatemala City. Each promoter is supported and supervised by a physician who visits for a full day twice each month. During these visits, the physician sees patients referred by the promoter, provides continuing training to the promoter, reviews the promoter's work since the last visit, and replenishes the small stock of medicines maintained in the farm clinic.

GuateSalud's clients include coffee, banana, and sugar cane farms, and large sawmills. Initially, its services were concentrated in coffee and sugar cane *fincas* located along the mountain slopes of Guatemala's Pacific coast. Operations have since been expanded

into the eastern and northern portions of the country, reaching the banana plantations on the Caribbean coast. It is serving a population of approximately 40,000 people through its network of 39 clinics, all but three of which are located on *fincas*. The services provided include: treatment of diarrheal illnesses, respiratory infections, tuberculosis, cholera, malaria, family planning, child immunization, growth monitoring, de-worming and vitamin A supplementation for under-5 children, water quality control and sanitation, and health education.

Initiatives' technical assistance focused on supporting *GuateSalud's* efforts to expand coverage of its services to approximately 400,000 people by the end of 1997. This entailed an initial focus on reviewing and strengthening *GuateSalud's* organizational structure and management. The review, which was done in mid-1994, encompassed all aspects of the organization's accounting and financial management systems -- bookkeeping, cost data, billing and collections, cash flow management, purchasing and inventory, information management, staffing -- as well as its organizational design. The outcome has been the installation, completed in May 1995, of a computerized, integrated management information system supporting the organization's financial, inventory, and health information needs; adjustments in organizational structure to better differentiate between clinical and business management functions; and strengthened staffing of the accounting function.

With this infrastructural strengthening in place, *Initiatives* directed its technical assistance to two new areas of activity: supporting the design and implementation of an organization-wide quality of care program, and improving pharmaceutical management. The quality activities were launched with a five-day seminar for *GuateSalud* staff on total quality management (TQM), which led to a number of quality activities within *GuateSalud*. The resulting interventions have demonstrated that quality services can be achieved under widely differing circumstances and within the context of *GuateSalud's* low cost structure.

Initiatives supported a consultancy to assess *GuateSalud*'s current pharmaceutical management and suggest improvements. This resulted in the development of a spreadsheet package which allowed *GuateSalud* to compare brands, prices and utilization figures by drug, and order and price their pharmaceuticals accordingly. *Initiatives* assistance to *GuateSalud* was completed in spring of 1997.

Rxiin T'namet is a local, non-governmental organization formed in 1992 in Santiago de Atitlan to maintain a maternal and child health program that had been developed and supported for two decades by Project Concern International (PCI), a U.S.-based international non-governmental organization. It offers an example of the lengthy and complex process through which a private organization can lessen its dependence on donor support and move toward sustainability.

The program serves over 40,000 residents located in 15 communities within the municipalities of Santiago de Atitlan and San Juan de la Laguna. Approximately three-quarters of this population lives in urban areas. The majority of the population belongs to

two Mayan linguistic groups — Tzutuhil and Quiche. The program's anchor is the *Clinica Rxiin T'namet* — a small primary care facility providing medical, laboratory, x-ray, and pharmacy services — located close to the town center of Santiago de Atitlan. A key feature of this clinic is the "*Casa de Partos*," which provides a safe and confidential environment for women seeking family planning services. In addition to the clinic, the program includes over 300 volunteer community health workers to provide outreach and health education services through routine household visits. They also provide referrals to the community contraception counselors/distributors. The Population Council provided technical assistance to strengthen all aspects of the program's family planning interventions, from the development of unified pregnancy related protocols for medical staff and midwives, to educational materials and increased services for both natural family planning and injectable contraceptive methods. *Rxiin T'namet's* funding comes from a combination of service fees, private donations, and grants from private foundations and international organizations.

Initiatives' technical assistance to *Rxiin T'namet* was directed at supporting its identification and development of cost-recovery options, diversification of its funding base, and strengthening its management structure and strategic planning capabilities and fundraising skills. This was provided over a 20-month period by a two-person team of *Initiatives* consultants. The technical assistance was programmed in three distinct areas: development of a realistic financial plan, which included the development of a draft sub-contract with the Ministry of Health that would provide annual funding to support *Rxiin T'namet's* role as a core provider of primary healthcare services in the Santiago de Atitlan community; implementation of the financial plan; and, development of a grant management capability. These three strands of technical assistance converged in late-1995 with the development of a business plan that included a viable balance between local and external resource generation.

Initiatives' also provided assistance to *Rxiin T'namet* to improve the quality of the care provided and pharmaceutical management.

A number of *Rxiin T'namet* managers were included in the one-week TQM workshop for GuateSalud in order provide them with an initial orientation to the nature and requirements of an organizational quality assurance program. This was followed by a series of six one-day quality management workshops for *Rxiin T'namet* staff on-site in Santiago de Atitlan. These workshops were conducted over a six-month period beginning in August 1996.

Initiatives' also supported an initial assessment of *Rxiin T'namet's* pharmacy operation, which represents its greatest potential for financial sustainability. The assessment identified a number of issues requiring attention from *Rxiin T'namet* staff. Several of these issues -- drug utilization and inventory control, and improved pricing -- were addressed through *Initiatives'* support for the development of a PC-based pharmaceutical management system. *Initiatives* support was completed in 1997.

Appendix III: Country-level Activities/Ghana

Initiatives conducted the first assessment trip to Ghana in February 1993. During this assessment, five groups were identified for potential project support. After a workshop, tutorials, and a proposal review process, three groups were selected to become local initiative groups (LIGs): the Superior Medical Center, the Ghana Registered Midwives Association (GRMA), and Nationwide Mutual Medical Insurance.

Initiatives' first two years in Ghana were focused on assisting the LIGs to prepare business plans outlining their strategies for expanding their services. Assistance included workshops and tutorials on *Strategic Business Planning*, *Organizational Strengthening* and *Strategic Financial Planning*. To collect the information necessary for the business plans, *Initiatives* designed and conducted market studies on the demand for health services from potential clients. *Initiatives* also identified several potential sources of capital for the LIGs, both in Ghana and abroad.

Project activities in year 3 shifted from a planning to an operations orientation. *Initiatives* focused its technical assistance strategies on the specific operational needs of the local initiative groups. While the form varied, *Initiatives*, through the local management group, designed and implemented information systems for each of the local initiative groups. *Initiatives* also explored the feasibility of a revolving supply system within GRMA.

In project years 4 and 5, funding shortages significantly impacted the breadth of *Initiatives* activities in Ghana. The delayed obligation of FY96 field support funds in September 1996, due to congressional restrictions on the disbursement of family planning funds, limited the funding for *Initiatives'* Ghana activities to its remaining 1995 field support pipeline. Consequently, *Initiatives* was unable to implement its planned program to assist the LIGs to further develop their market planning and monitoring capabilities. Instead, *Initiatives* focused its efforts on completing the activities already begun.

Local Initiative Groups of Ghana

The Superior Medical Centre (SMC) offers an example of how the private sector can increase low income clients' access to quality basic health services. SMC plans to build a small hospital on the outskirts of Accra in order to provide quality medical care to Ghanaians, a private sector training site for the University of Ghana Medical School, and to attract Ghanaian physicians, educated and practicing overseas, to return to Ghana.

SMC is owned and operated by the Superior Medical Foundation, a private, non-profit organization established in Ghana in March 1990 as the counterpart of the Ghana Medical Foundation in Chicago, Illinois. Currently, SMC operates a seven-bed, temporary

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facility in Christian Village, north of Accra. SMC provides a range of services including maternal/child health, family planning and laboratory testing. SMC also has an active outreach program. They have sponsored several health fairs in the neighboring villages as a forum for health and family planning education. They also coordinate with the Ministry of Health to provide immunizations at their facility. With the support of chiefs in the surrounding villages, traditional drumming has been used to notify villagers that it is immunization day. SMC has found that outreach can serve as an effective marketing tool by raising people's understanding of health issues and increasing SMC's name recognition within the community.

Initiatives initial technical assistance to SMC focused on the development of a fundable business plan outlining their proposed expansion. The business plan attracted several potential investors, including PATH's Fund for Technology Transfer and the Social Security National Investment Trust (SSNIT) of Ghana. Although commitment letters were provided from both investors, one offer was withdrawn and the other offer, which was contingent on the involvement of a second investor, remains inactive.

Once the business plan was complete, *Initiatives* support of SMC focused on improving their operations, including installation of a management information system. *Initiatives* commissioned Deloitte and Touche/Ghana to install its Hospital Attendance, Billing and Statistical System (HABS) in SMC. The system achieves several objectives: (1) determination of SMC's cost structure; (2) upgrading its day-to-day management; (3) monitoring service delivery patterns and related costs, and; (4) establishing a demonstration site for an information system appropriately priced for adaptation by other private practitioners. The improvements in the operational efficiency that will result from the installation of HABS has enabled SMC to keep their costs lower, making their prices more affordable for low income clients.

In 1996, *Initiatives* worked to improve SMC's marketing capabilities. This built on basic marketing information collected in 1994 and early-1995, including a series of client and laboratory record reviews, as well as patient exit interviews to develop a profile of SMC's current client base and service patterns. An *Initiatives*-supported survey of private health facilities in Ghana provided SMC with key information on how their competitors operate in terms of their client base, service mix, utilization, management and financial viability. This, in combination with the information on the characteristics of current and potential clients, was incorporated into a marketing plan.

In late 1996, the founder of SMC announced his campaign for President of Ghana. Although unsuccessful in his bid, the election diverted his attention from SMC's business development activities. This, along with severely constrained field support funding, led to a phase out of *Initiatives* support in early 1997.

The Nationwide Mutual Medical Insurance Program (NMMI), the first health insurance program in Ghana, provides an example of how the private sector can provide an alternative financing mechanism for basic health and family planning services in a developing country. Traditionally, fee-for-service has been the only payment mechanism

available in Ghana for consumers of private sector health services. This can limit access by the mid- to low-income population who may not have sufficient funds available when they require care. With the addition of a pre-paid mechanism there is the potential to increase consumer access while providing stable revenues for the participating providers, supporting the development of sustainable services.

NMMI is a mutual insurance company jointly funded by physician members of the Society of General Medical and Dental Practitioners (SGMDP) and Vanguard Insurance. Launched in August, 1993, NMMI had approximately 60,000 beneficiaries associated with 11 companies enrolled in the plan by the fall of 1997.

Insurance benefits are established by a Technical Committee consisting of Nationwide executives, physicians and dentists. The fee reimbursement schedule is revised annually by the SGMDP Congress. The health plan includes physician office visits, laboratory and radiology services, outpatient care, pharmacy, and basic dental treatments. Optional benefits available for an additional premium include inpatient hospital care, maternity, and extra dental, vision, and accident coverage. There are per visit co-payments and maximum insurance payment and coverage limitations by type of service. Nationwide staff administer and market the health plan. Primary health services are provided in the offices of SGMDP's member physicians and dentists. As of 1997, 171 physicians were participating in the program.

Initiatives support began during the start-up phase of the insurance program, with several visits made by an insurance consultant. At that time, NMMI was advised to target large employers in order to limit their risk while collecting the required data for accurate actuary calculations. To investigate the demand for health insurance, *Initiatives* funded a market survey of large employers to determine their perceptions of health insurance, in general, and of the NMMI benefits package, in particular. Most employers were interested in NMMI's potential to reduce the companies' overall health care costs without reducing the type of benefits available to employees and their dependents. In addition, *Initiatives* conducted a survey of private health facilities in Ghana. The survey results provided NMMI with valuable information on services, utilization rates and the management of their member facilities, and how they compare with other private facilities operating in Ghana.

Once the plan was launched, *Initiatives* directed its activities toward enhancing NMMI's long-term sustainability through improved operational efficiency. NMMI required the development of a personal computer-based information system to manage reimbursement claims, maintain a treatment database, and track benefit utilization. To address these needs, *Initiatives* supported the adaption and installation of a management information system in NMMI's central office in Accra which can eventually be linked to an enhanced accounting system. This approach explicitly recognized the critical role that timely, relevant, and actionable information plays in effective organizational management — tracking (and adjusting) performance against strategic objectives, financial and marketing management, resource utilization, market forecasting, inventory management, and so on. Beyond the simple monitoring of operations, such information could in-

crease access to private basic health services through the NMMI's lowered operational costs and strategic service extension. The early operation of the system has begun to achieve its objectives, including tracking any excess use of services by an employee over the benefit levels selected by the employer. The MIS reports have enabled NMMI to recover these lost revenues for the first time.

After its initial year, NMMI broke even and has been operating in the black since then. Its company clients continue to grow and NMMI anticipates having approximately 100,000 beneficiaries by 1998. *Initiatives* support was completed in early 1997.

Ghana Registered Midwives Association (GRMA), is a non-profit organization with approximately 500 member nurse midwives. The members are private practitioners who provide a range of services including child health, pre-natal, delivery, and family planning services.

Over the years, midwives have been struggling with increasing competition from physicians at one end of their market, and traditional birth attendants at the other. GRMA offers member midwives the support they require in this competitive environment — continuing education programs, development of promotional campaigns, advocacy of member interests among decision makers, and development of a quality of care awards program.

As market pressures place a premium on the efficient management and delivery of services, GRMA has begun to focus on areas which could improve the efficiency and quality of their members' services. GRMA updated a business management training course originally provided to GRMA midwives during 1988-1990 through the Enterprise Program. *Initiatives* also prepared a management quality module for inclusion in the baseline and assessment instruments GRMA developed for its new quality of care awards program.

GRMA strengthened the association by developing a national secretariat and enhancing their continuing education courses. Through support from USAID, the American College of Nurse Midwives provided an advisor who worked closely with the executive director of GRMA. *Initiatives* assisted the secretariat to design and implement a management information system (Midwives Management Information Control System) which combines membership information and service statistics in an integrated database. In 1997, *Initiatives* assisted GRMA to upgrade their database to include pre- and post-natal care, management of HIV, diagnosis and treatment of STIs and post-abortion care.

In 1995, *Initiatives*' assisted GRMA to explore the feasibility of establishing a medical supply purchasing and distribution cooperative. As envisioned, the cooperative would purchase supplies in bulk thereby lowering the cost of supplies for member midwives while providing income to the association. It would also ensure a more reliable supply than the midwives currently obtain from the open market. Based on the results of the needs assessment and feasibility study, GRMA was able to attract donated supplies from UNICEF and ODA to launch their purchasing cooperative.

Local Management Group of Ghana

Deloitte & Touche Consulting (D&T), an affiliate of Deloitte, Touche and Tohmatsu International, is committed to meeting the management needs of Ghana's emerging private health sector, which makes it a natural *Initiatives* local management group (LMG). Its management of the Ashanti Goldfields Company's (AGC) 150-bed hospital in Obuasi is a viable model of how a large employer can reduce its costs and improve the quality of its employee health services through outsourcing. Equally important, development of its Hospital Attendance, Billing and Statistical System (HABS) creates the potential for making an important contribution to the overall efficiency of health services delivered by private sector providers.

HABS is operational in AGC's hospital in Obuasi. It is an MIS software package that reports comprehensive information of patient visits and admissions, diagnosis, prescriptions, and procedures, as well as on their associated costs. The system produces a standard battery of management reports that give hospital and corporate managers a comprehensive picture of both the illnesses affecting AGC employees and their dependents, and the costs of treating those illnesses.

The AGC hospital's HABS is installed on a PC-based local area network of 12 workstations located in the facility's various services departments, e.g. laboratory, pharmacy, records, and outpatient. Over 60,000 patient records are currently stored. In addition, the network is tied into AGC's mainframe, which enables the management to relate hospital operations to AGC supply distribution and accounting records in order to generate actual treatment costs. A non-network version of HABS could be priced at a level affordable to private practitioners with as few as six beds.

In addition to HABS, D&T provided technical assistance in financial management and marketing planning to the *Initiatives* LIGs. This approach facilitated the development of the LIGs in the short run, and will hopefully stimulate completion in the private sector provision of LMG-type health management services in the long run.

NGO Workshop on Planning Strategic Reproductive Health Programmes

At the meeting of USAID/Ghana's cooperating agencies (CAs) in Accra in November 1995, GSMF requested *Initiatives* assistance in enhancing the capacity of the GSMF-supported NGOs to sustain their reproductive health activities. This involved participation, in May 1996, in a CEDPA-led strategic planning workshop for the NGOs, in which the issue of "sustainability" served as a unifying theme that anchored and gave direction to sessions on specific aspects of reproductive health and of the strategic planning process. Two high-level officials (senior executive or board member) from each of ten GSMF-associated NGOs participated in the workshop.

Initiatives approached the workshop as an opportunity to introduce participants to basic concepts of *social entrepreneurship* and its relationship to *organizational sustainability*, and to their critically important role in effective strategic thinking. This approach was reflected in each of the sessions it designed and facilitated.

The workshop proved to be an excellent opportunity for *Initiatives* to translate its evolving and non-traditional approach to sustainability into practical training modules that treat it more as a *state of mind* among NGO managers than as a collection of organizational techniques with little or no clear connection to an organization's motivating vision or core mission. In terms of communicating this approach within a workshop format, leading with an orientation to *social entrepreneurship* proved to be a useful and stimulating starting point.

Appendix IV: Country-level Activities/Nigeria

At the request of USAID/Lagos, an *Initiatives* assessment team visited Nigeria in February 1993 to determine the viability of implementing the *Initiatives* program in that country. The team met with several health policy leaders from both the public and private sectors to determine what they perceive to be the shortcomings of the existing private-sector delivery system. Meetings were also held with potential local initiative groups (LIGs) in the Lagos metropolitan area for the purpose of identifying those with the most likelihood of meeting *Initiatives* goals successfully.

During this assessment, and a follow-up assessment in April, ten potential LIGs were identified. In May 1993, a workshop was held for the potential local partners to provide them with the basic tools for strategic planning. Following the workshop and several weeks of consulting, each organization prepared a business proposal outlining their proposed project. Of the eight groups that submitted proposals, four were selected: B.E. Medical Services, the Lawanson Group, the Private Nurses and Midwives Association branch in Osogbo, and the Association for Reproductive and Family Health (ARFH).

The first two years of the project focused on developing strategic business plans for each of the LIGs. As part of the planning, *Initiatives* conducted several market studies to determine health seeking behavior of potential clients. Widespread political unrest near the end of the second year, however, hampered *Initiatives'* planned redirection of its technical assistance to support the development or expansion of services. These dramatic changes in the programming environment also led USAID to radically reorient its Nigeria program, shifting its support for health and family planning programs from the public sector to the private sector. Consequently, *Initiatives* spent much of project year 3 expanding and revising its original program to include additional geographic areas and to concentrate its activities on the development of pre-paid health services which target the informal sector and small employers.

Initiatives continued to make significant adjustments in its Nigeria program during project year 4 in response to USAID's decision to reduce its in-country presence in 1996. This entailed narrowing USAID/Nigeria's focus to health, AIDS/HIV, and democracy and governance programs, and reducing the number of cooperating agencies operating in Nigeria to five. Under the revised USAID program, *Initiatives* could no longer have an in-country presence, which meant phasing out its subprojects (local initiative groups) by June 1996. However, because of *Initiatives* non-traditional approach to NGO sustainability, USAID/Nigeria requested that it remain active in the program, focusing its efforts on enhancing the financial sustainability of the local partners participating in their program. *Initiatives* responded by developing a short-term technical assistance program for this purpose.

Local Initiative Groups of Nigeria

The Lawanson Health Plan (LHP), is a network of five individually owned clinics in the Lawanson area of Lagos. LHP planned to establish a health financing and managed care scheme targeted toward members of local trade associations (e.g. Taxi Drivers' Association, Market Women's Association) and their families. It offers an example of an innovative model of how the private sector can increase access to quality health services through a community-based alternative financing mechanism.

As envisioned, LHP would enable trade associations to join a prepaid program of managed care that would assure members and their families basic primary care services from one of five participating physicians. In addition, a mutual fund, managed by the local community bank, would be established against which members could borrow in time of acute illness.

The health financing portion of the LHP was modeled after a *esusu* -- an informal savings method common throughout West Africa. Members of participating trade associations would pay a fixed monthly rate into an account held at the local community bank, where it would earn interest. The trade members and their families could go to any of the five participating clinics to receive basic health care. The fees, offered at a discounted rate for LHP members, would be paid directly to the providers from the savings account. The savings plan would only cover primary health care services. If an enrollee required secondary or tertiary care, they would have the option to borrow money from the community bank at a reduced interest rate. The community bank would use the savings plan as collateral for the loan.

The LHP differed from traditional insurance as payment would be treated as a savings contribution rather than a premium. Once an enrollee exceeded the amount in their savings account, they would have to pay out-of-pocket for additional care. They would still be eligible to receive the discounted price for the services.

The LHP's participating physicians would promote preventive services to keep its costs down and the monthly payments affordable to association members. A managed care committee would monitor both the quality of the care provided, and whether the appropriate protocol was followed.

Initiatives assisted the LHP to develop a strategic plan outlining the key components of the proposed health plan. As part of the assistance, focus groups of trade association members and their families were conducted. The focus group participants were enthusiastic about having an alternative to the traditional fee-for-service payment mechanism. Also discussed were the types of services people use and where they currently go for the services.

As its strategic plan was being finalized, the LHP shifted its focus to implementation. With assistance from *Initiatives*, it began developing operating procedures for the plan, and registered the network as a separate organization. *Initiatives* phased out its assis-

tance to the Lawanson Health Plan in May 1996 due to USAID's reduction of its in-country presence. However, LHP was included in the BASICS Nigeria program and continues to receive support from a number of cooperating agencies still operating in Nigeria.

The ***Nigeria Private Nurses & Midwives Association (NPNMA)*** branch in Osun is an association of 25 independent primary care practitioners. It is an example of how such associations can sustain their member services by adjusting to a declining market during a period of economic hardship — a challenge faced by private health professionals throughout Africa.

The association was originally formed to address the problems midwives were facing with local authorities. As midwives became accepted in the community as valued health providers, this role slowly diminished, weakening the association as a whole. More recently, midwives have begun to look again to the association to address a common problem they are facing; a decline in patient load due to economic hard times. *Initiatives* assisted NPNMA/Osun to prepare a business plan which outlines its strategy to strengthen the association and the individual member facilities.

As the health care market in Osun becomes increasingly competitive, midwives are experiencing market pressures from both physicians and traditional birth attendants. With assistance from *Initiatives,* NPNMA explored several options to remain competitive in this difficult environment. To increase demand for their services, members developed outreach and health education programs which teach the importance of basic preventive and curative health care and present midwives as qualified providers of these services. To identity a potential market for the midwives, *Initiatives* funded a series of focus groups with current and potential clients to determine what services people use, where they go to receive these services, how much they are willing to pay for health services, and their impression of midwives as providers of basic healthcare. This information was used to target the outreach services.

In addition to demand generation, NPNMA sought to lower its members costs so their services would remain affordable for low income clients. With *Initiatives* assistance, NPNMA improved the operations of five member facilities in the areas of financial management, administration, record keeping, and information systems. These improvements allowed the facilities to monitor their patient loads, services, expenses, and revenues so they can deliver more efficient, low cost services. NPNMA also explored ways to share resources among members to keep costs low. Approaches to lowering costs included bulk drug purchasing and sharing a diagnostic and referral center. *Initiatives* was unable to support further investigation of these approaches as it was required to phased out its assistance to the Nigeria Private Nurses & Midwives Association in May 1996 due to USAID's reduction of its in-country presence.

The ***Association for Reproductive & Family Health (ARFH)*** is a non-governmental family planning organization based in Ibadan. It offers an example of how such an organization can strengthen the likelihood of its long-term sustainability by increasing

and diversifying its revenue base through an expansion of its service mix to include basic health services.

ARFH was established in 1989 to develop community-based family planning programs with village health workers, market women, and traditional birth attendants. In addition to its community-based distribution, ARFH provides clinic-based family planning services, originally at the Ibadan teaching hospital, and more recently at a clinic located in their administrative offices. Through its efforts, ARFH has established a reputation in the community as a quality provider of family planning services.

While interacting with clients, ARFH found that many were not receiving basic health services, and, of those who were receiving some care, many were not satisfied with the quality of the services. Based on this unmet need, ARFH decided to expand its services to include basic health care. This expansion would entail the establishment of a new health and family planning facility located more centrally than their current facility. ARFH planned on targeting both low income community residents and employees of local companies, financing the services through sliding fee scales and cross-subsidization.

Initiatives assisted ARFH to develop a business proposal which outlined its expansion plans. As part of this assistance, *Initiatives* funded a market study which interviewed potential clients on what types of services they currently use, where they go to receive health services, why they choose one provider over another, and where would be the most convenient site for ARFH's proposed clinic. Based on the results of the study, ARFH considered a site in the Idi-Arere district, a busy market area of central Ibadan. *Initiatives* was unable to support ARFH to launch its planned clinic as it was required to phased out its assistance to the Association for Reproductive & Family Health in May 1996 due to USAID's reduction of its in-country presence.

NGO Sustainability Initiative

In early 1996, *Initiatives* began its Nigerian NGO Sustainability Technical Assistance Program, which concentrated the project's activities on enhancing the capacity of NGOs participating in USAID's program to remain financially viable once their donor support was withdrawn or limited. To better understand the factors which may either contribute to, or impede, NGOs ability to remain financially viable, *Initiatives* conducted an assessment of sixteen Nigerian NGOs to examine their financial sustainability. *Initiatives* presented the assessment's key findings and recommendations to the NGOs which participated in the study, and to their international partners -- U.S. organizations associated with USAID's Nigeria country program.

In June 1996, *Initiatives* began a targeted program of technical assistance which focused on developing the revenue generating capacity of NGOs operating within USAID's country program and enhancing their long-term viability. Thirty NGOs were selected to receive assistance over an eight month period. *Initiatives* identified ten Nigerian con-

sultants and held an orientation meeting to discuss the findings of the NGO sustainability assessment, present *Initiatives*' approach to enhancing the financial viability of NGOs, and review sustainability reference materials which had been designed and compiled by *Initiatives*.

By June 1997, *Initiatives* consultants provided sustainability assistance to 30 NGOs. The project also documented the program through five case studies in the first half of 1997. These brief case studies describe the steps NGOs took to enhance their sustainability and highlight the lessons learned from this process. *Initiatives* concluded its sustainability program in Nigeria with a meeting in Lagos in late-May 1997, that brought together representatives of the NGOs assisted, their associated US CAs, USAID and other interested donors, and the *Initiatives* consultants who provided the TA. The meeting's participants reviewed the successes and shortcomings of the program, and identified areas that required continued assistance in the years ahead.

Appendix V: Country-level Activities El Salvador and Egypt

El Salvador

In El Salvador, *Initiatives* collaborated with the PROFIT Project in a joint program to catalyze the expanded involvement of the private sector in the delivery of basic health and family planning services. This program entails the identification of existing or potential investment opportunities in health and family planning services, and assisting, through short-term technical assistance, the development of private sector interest and capacity to take advantage of these opportunities. This collaboration began at the request of USAID/El Salvador in late-1994.

In November 1995, a joint *Initiatives*/PROFIT field assessment led to the identification of several potential opportunities to expand private sector involvement in health care delivery. These included strengthening networks of employer-based clinics, developing a rural health care network among agricultural cooperatives, expanding health service availability for informal sector workers, and promoting the development of private provider networks that could serve as the foundations of managed care systems. Follow-up work was narrowed to two of these opportunities: the feasibility of establishing a rural health care organization among coffee growers cooperatives and the development of private provider networks.

Initiatives has focused its efforts in El Salvador on gathering information on the current practices of private health and family planning providers. This was conceived as the first step in assessing the feasibility of linking such providers into managed care networks and for introducing management efficiencies that will improve client access through lower service costs. Consequently, *Initiatives* supported a sample survey of approximately 200 private health and family planning providers in the San Salvador Metropolitan Area. Information was collected on: primary provider characteristics, clinic history, services, management systems, staffing, and equipment, patient profiles, services offered, revenues, expenses, service fees, drug costs and supplies, and laboratory services.

Initiatives completed the survey in spring of 1997 and coordinated its dissemination within a local meeting of high-level private and public health authorities who are actively exploring the feasibility of introducing managed health care in that country.

Egypt

In Egypt, *Initiatives* supported the preparation of case studies to capture and share the experience gained with two different innovative approaches to private sector provision of basic health services.

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The first case study of the *Group Practice* (a subsidiary of the Suez Canal University Faculty of Medicine in Ismalia) provides an overview and analysis of the lessons learned from the development and evolution of the *Group Practice* through its 14-year history, from 1982 to the present.

The second case study of the *Mosque Clinic* (a subsidiary of the Abu Bakr El-Siddique Mosque Society, also in Ismalia) presents an overview of the development and evolution of the *Mosque Clinic* over its 15-year history, since its beginning in 1981.

The main "lessons learned" that are highlighted in these two case studies are:

The *Group Practice* of the Faculty of Medicine, Suez Canal University

Four different themes or lessons have been drawn from the factors related to the successes of the *Group Practice* in the 1980s and the causes of the subsequent organizational and financial problems in the 1990s. These are:

- a **sustained strategic vision** is essential to respond effectively to changes in external and internal environments.
- **management -- not administration --** is required for long-term sustainability.
- **subsidies** were essential for establishing the *Group Practice*.
- **mixing governmental and nonprofit activities** is problematic.

The Abu Bakr El-Siddique *Mosque Clinic*

Four different themes or lessons have been drawn from the 15-year experience of the *Mosque Clinic*:

- a **sustained strategic management process** involving all levels of the organization as well as the community is required for a successful response to a competitive environment.
- **aggressive marketing initiatives**, uncommon for nonprofit organizations, are needed in a competitive environment.
- a **more active approach to financing** is required to implement needed strategic changes.
- strong **management can coexist with medical leadership**.

Appendix VI: Key Considerations in Designing a Technical Assistance Program

The *Initiatives* Experience

Purpose of the Technical Assistance

The purpose of the *Initiatives*' technical assistance program was to enhance the capacity of NGOs to remain financially sustainable in the face of declining donor technical and financial support. While our assessment indicated that there were a number of factors common among the NGOs studied which impeded sustainability, we decided to focus on the financial aspects because most of the NGOs were reliant on donor financial support, with often less than 10% of their income coming from other sources. In addition, while the NGOs typically received some assistance from their donors to strengthen their technical capacity and to develop and implement basic management systems, they did not have access to assistance for improving their financial viability.

Content of the Technical Assistance

The focus of the *Initiatives* technical assistance program was to enhance the revenue generation of the NGO. This included: reviewing current sources of revenue and key activities which needed to be covered by the revenue; identifying opportunities for improving efficiency and managing costs; exploring additional options for revenue generation (fundraising, membership dues, charging for services, separate income generating activities such as selling gari, etc.); assessing the feasibility of the options; developing fundraising plans; forming implementation plans; and, identifying sources of start-up capital.

As the consultants worked through the areas above, often other factors which effected the NGOs' sustainability were identified including problems in the organizational structure, weak leadership, lack of appropriate management and financial systems, no marketing function, etc. The consultants addressed what they could given the time frame of the consultancy and highlighted other areas which required additional attention. *Initiatives* would then work with the lead donor organization supporting the NGO to identify strategies to address the issues which were not covered in the *Initiatives* assistance.

Mode of Technical Assistance

The prime mode of technical assistance is one-on-one consulting. *Initiatives* has found this to be the most effective means to transfer skills to an organization. When *Initiatives* is providing assistance to a number of closely related organizations (i.e. state branches of the same organization), we will hold an initial orientation meeting/workshop to provide a foundation and common vocabulary for the organizations. This foundation helps to focus the one-on-one assistance. *Initiatives* has found that a workshop, while an efficient means to share information, is not sufficient to enhance a NGO's sustainability without follow-up technical assistance.

Identification of Technical Assistance Resource People

Initiatives decided to hire Nigerian consultants to provide the technical assistance. We identified ten consultants, all of whom had financial skills including conducting feasibility studies and preparing financial projections. Many of the consultants had not previously worked in the health sector, and a few had not worked directly with community-based, nonprofit organizations. While this was not ideal, we felt that the key skill requirement was the ability to develop revenue generating options, and that *Initiatives*, the NGO itself, and the supporting donor organizations could provide the consultants with any health-specific support they required. In a few cases, *Initiatives* paired up consultants when we were concerned that they individually did not have the necessary skills (i.e. one consultant with considerable NGO experience was paired with a consultant that had extensive financial skills). *Initiatives* also made sure that the consultant pool had consultants from each of the major ethnic groups. *Initiatives* has found that consultants, who come from the same ethnic group as the organization receiving assistance, are much more effective and the organization feels more comfortable providing access to sensitive information (such as financial data).

Initiatives chose to develop an indigenous consultant network for the following reasons: there were plenty of skilled Nigerian consultants (although we had to search outside the USAID network); through the consultancies the consultants could develop their capacity to assist NGOs to strengthen their sustainability, thereby providing a local resource which will be available in Nigeria once *Initiatives* leaves; the amount of time required to work with the NGOs requires a sustained presence which would be difficult to provide with expatriate consultants; and it was less expensive.

Before launching the technical assistance program, *Initiatives* held an orientation meeting for the Nigerian consultants. The purpose of the orientation meeting was to provide a common base for each of the consultants and to share *Initiatives* experience. The participants reviewed and commented on the findings and recommendations from the *Initiatives* NGO Sustainability Assessment, adding their own experience with NGOs. In addition, *Initiatives* provided sustainability materials and tools and discussed how the consultancies with the NGOs were envisioned, including a generic scope of work. The consultants found the meeting useful as it provided them with some tools and introduced them to other resources (including each other) available in Nigeria.

Length/Duration of the Technical Assistance

Originally, *Initiatives* set the consultancies at three work weeks over a two month period. Spreading the consultancy over a two month period allowed the consultant to: begin a number of activities with the NGO; leave them with several activities to undertake while the consultant was away; and, return at an arranged date to review what was achieved, answer any questions, and begin the next set of activities. This process ensured that the NGOs, most of whom rely on volunteers, were not overburdened by the consultants' constant presence. It also allowed the NGO to digest the materials which were shared, and to undertake activities on their own so they could develop their own skills rather than relying on the consultant to complete the work for them.

After the initial consultancies, *Initiatives* increased the amount of work weeks to four and the time period to three months. This was in response to: the number of options the NGOs wanted to explore, the need to often do some initial organizational strengthening/planning before focusing on revenue enhancement, and to allow sufficient time to identify some sources of start-up capital, which was one of the major concerns expressed by the NGOs.

Technical Assistance Materials

Initiatives prepared a large binder for the consultants which included: findings and recommendations from the NGO sustainability assessment; a number of workshop materials designed by *Initiatives* on sustainability, characteristics of sustainable organizations, entrepreneurship, and revenue generation; notes from various articles related to entrepreneurial organizations, not-for-profit organizations with profit making enterprises, and conducting feasibility studies; and, manuals on preparing proposals for funding and strengthening financial viability.

The materials served both as resource materials for the consultants and as handouts and reference materials for the NGOs.

Technical Assistance Follow-up

As originally conceived, *Initiatives* assistance was designed to finish once the NGOs had a detailed implementation plan for enhancing their revenue generation. This was due both to funding constraints and because it was believed that once the NGO had a detailed implementation plan, their lead donor would be able provided any necessary support. However, once the initial consultancies were completed, both the NGOs and lead donors asked that *Initiatives* be available to provide some support during the implementation phase. As such, *Initiatives* added one additional week of assistance (bringing the total up to five work weeks) to be available to the NGO during the implementation stage.

Appendix VII: *Initiatives* Publications List

Information Packet

Input Series ***(Brief abstracts of Initiatives-sponsored research)***

Input Series 1
A Case Study in Institutional Development & Sustainability: The Group Practice of the Faculty of Medicine, Suez Canal University

Input Series 2
A Discussion Note: Policy Options to Improve the Management of Basic Healthcare Facilities

Input Series 3
Private Healthcare Services in Ghana: A National Survey of Private Health Facilities. *Highlights of Findings*

Input Series 4
Private Healthcare Services in Ecuador: A National Survey of Private Health Facilities: *Highlights of Findings*

Policy Dialogue

Options to Improve the Management of Primary Health Care Facilities
Carlos Javier Cuellar and Robert Pattison

Health Insurance: A Viable Approach to Financing Health Care in Nigeria?
Ibukun-Oluwa Ogunbekun, MBBS, MPH, MA

Nigerian NGO Sustainability Assessment: Findings and Recommendations on NGO Financial Sustainability
Lisa A. Hare

Research Papers

Private Sector Healthcare Services in Ghana: Results of a National Survey of Private Health Facilities
(Full report)

Private Sector Healthcare Services in Ghana: Results of a National Survey of Private Health Facilities
(Summary of findings)

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Private Health Care Sector in Ecuador
Three parts include *Survey of Health Care Facilities in Quito & Guayaquil, Evolution of the Ecuadoran Health Care System 1984-1993* and the *Executive Summary* (summarizes both documents).

Research Working Group Report: Process and Framework for Case Studies

El Salvador Facilities Survey (Expected September 30, 1997)

Summary of Facilities Survey (Expected September 30, 1997)

Marketing Research Reports

Acceptability of Pre-paid Healthcare Plan among Informal Sector Workers in Lawanson, Lagos.
Summary of Focus Group Findings

Demand & Utilization of Health Services among Low-Income Residents of Osogbo.
Summary of Focus Group Findings

Demand & Utilization of Health Services among Residents of Four Housing Estates in Lagos.
Summary of Findings

Demand & Utilization of Health Services in Central Ibadan.
Summary of Findings

Demand & Utilization of Health Services among Low-Income Residents in Guayaquil, Ecuador.
Summary of Findings

Ecuador Trip Reports

Initial Assessment, January 18 - 31, 1993
Alfredo Solari, Robert Pattison and Carlos Javier Cuellar

Primary Care Business Development Workshop and Tutorials, April 4 - 30, 1993
Robert Pattison, Susan Kolodin, Nancy Pielemeier and Antonio Arrazola

Proposal Presentations, April 29 - May 6, 1993
Alfredo Solari

Evaluation Assessment, July 15 - 23, 1993
John W. Peabody

PROSALUD Study Tour, October 18 – 22, 1993
Robert Pattison

Organizational Development Workshop, November 14 – 21, 1993
Gary Bergthold, Robert Pattison and Jaime Gallardo

Strategic Financial Planning Workshop and Tutorials, February 21 – March 11, 1994
Robert Pattison, Rolf Stern and Jaime Gallardo

Business Plan Development Assistance, May 30 – June 7, 1994
Robert Pattison

Financial & Marketing Planning, March 6-25, 1995
Joseph A. Sclafani and Walter Gonzalez

El Salvador Trip Report

Initial Assessment, May 6 - 21, 1993
Alfredo Solari

Guatemala Trip Reports

Initial Assessment, May 22 - 28, 1993
Alfredo Solari

Follow-up Assessment Visit, October 5 – 16, 1993
Robert Pattison

Primary Care Business Development Workshop, December 1993
Alfredo Solari, Jaime Gallardo and Marta Mérida

Guatemala Needs Assessment, May 22 – June 3, 1994
Patricio Murgueytio and Alfredo Solari

Activity Report: Technical Assistance Planning, July 20 – September 15, 1994
Patricio Murgueytio

Grantsmanship Training, July 13-19, 1995
Richard Covington

Rxiin Tnamet Case Studies, July 24 - August 5, 1995
Ron Strochlic

Ghana Trip Reports

Initial Assessment, February 21 - 28, 1993
Alfredo Solari, Robert Pattison and Benita Ba

Primary Care Business Development Workshop, May 9 - 25, 1993
Robert Pattison, Lisa Hare, Susan Kolodin and Nancy Pielemeier

Evaluation Assessment, May 12 - 21, 1993
Joyce Mann

Proposal Presentations, June 7 - 12, 1993
Alfredo Solari and Susan Kolodin

Local Management Group Assessment and Organizational Development Workshop and Tutorials, November 7 – 23, 1993
Lisa Hare, Ephraim Kaba, Dale Flowers and Susan Maerki

STD Evaluation Assessment, November 7 – 18, 1993
John Peabody

Second Evaluation Assessment, November 10 – 23, 1993
Joyce Mann

Review of Organizational Plans and Identification of Sources of Capital, January 20 – 29, 1994
Lisa Hare and Virginia Ward

Financial Planning Workshop, February 7 – 18, 1994
Robert Pattison, Susan Maerki and Dixie Cole

Survey Preparation, May 5 – 18, 1994 (Not currently available)
Joyce Mann and Susan Butler

Technical Assistance and Marketing Planning, July 19 – 31, 1994
Joseph Sclafani

Project Implementation Review, October 30-November 3, 1994
Joseph Sclafani

Activity Report: STD Care in the Private Sector, November 1993 - June 1994
John Peabody

Program Planning and Subcontract Development, February 18 - March 3, 1995
Lisa A. Hare and Mary L. King

Implementation of Case Studies, August 5 - 11, 1995
Virginia Ward

Workshop on Planning Strategic Reproductive Health Programmes & Project Implementation Review, May 11-28, 1996
Joseph. A Sclafani

Nigeria Trip Reports

Initial Assessment, February 8 - 21, 1993
Alfredo Solari, Robert Pattison and Margaret Bodede

Primary Care Business Development Workshop, May 21 - June 11, 1993
Robert Pattison, Lisa Hare and Margaret Huff-Rouselle

Evaluation Assessment Follow-up, December 1 – 3, 1993
Joyce Mann

Local Management Group Assessment
Lisa Hare and Virginia Ward

Financial Planning Tutorials
Dixie Cole

Launching NGO Sustainability Technical Assistance, June 14-July 4, 1996
Lisa Hare

NGO Financial Sustainability: Technical Assistance Review, September 27-October 18, 1996
Lisa Hare

NGO Sustainability Technical Assistance Reports (Expected September 30, 1997)

Training Materials

Primary Care Business Development
Facilitator's guide in English
Workbook in English
Workbook in Spanish

Strengthening your Organisational Structure
Workbook in English
Workbook in Spanish

Strategic Financial Planning
Workbook in English
Workbook in Spanish

Marketing Audit Workbook
English
Spanish

Administrative Reports

Annual Report Project Year 1: September 18, 1992 – September 17, 1993

Annual Report Project Year 2: September 18, 1993 – September 17, 1994

Annual Report Project Year 3: September 18, 1994 - September 17, 1995

Annual Report Project Year 4: September 18, 1995 - September 17, 1996

Lessons Learned Meeting Report -- June 26, 1997
(Expected September 18, 1997)

Women in Development Biannual Reports: *Gender Differentiated Impacts of Private Sector Provision of Health Care Services in the Initiatives Project.*

Women in Development Biannual Report: December 1993 – June 1994
Virginia E. Ward, Program Manager, Research/WID Advisor

Women in Development Second Biannual Report: July - December 1994
Virginia E. Ward, Program Manager, Research/WID Advisor

Women in Development Third Biannual Report: January - June 1995
Virginia E. Ward, Program Manager, Research/WID Advisor

Women in Development Fourth Biannual Report: July - December 1995
Virginia E. Ward, Program Manager, Research/WID Advisor

Women in Development Fifth Biannual Report: January - June 1996
Virginia E. Ward, Program Manager, Research/WID Advisor

Women in Development Sixth Biannual Report: July - December 1996
Virginia E. Ward, Program Manager, Research/WID Advisor
(Not currently available)

Initiatives Task Force Meeting Report No. 1: March 3 - 5, 1993

Initiatives Task Force Meeting Report No. 2: March 16 – 18, 1994

Social Enterprise CASE STUDIES (Expected September 30, 1997)

Case Study of Aninwah, Ghana

Case Study of Nationwide, Ghana

Case Study of Rxiin Rnamet, Guatemala

Case Study of Insalud, Ecuador

Case Study of Guatasalud, Guatemala

Summaries of:
- Case Study of Aninwah, Ghana
- Case Study of Nationwide, Ghana
- Case Study of Rxiin Rnamet, Guatemala
- Case Study of Insalud, Ecuador
- Case Study of Guatasalud, Guatemala