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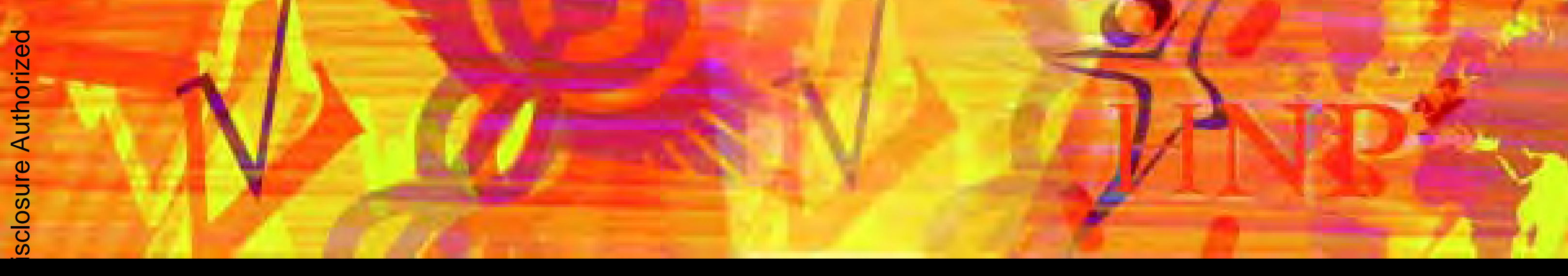

HNP DISCUSSION PAPER

Working with the Private Sector for Child Health

Hugh Waters, Laurel Hatt and Henrik Axelsson

June 2002

Working with the Private Sector for Child Health

Prepared for the SARA Project
and the Inter-Agency Working Group
on Private Participation and Child Health

Hugh Waters
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June 25, 2002

Bureau for Africa, Office of
Sustainable Development

Health, Nutrition and Population (HNP) Discussion Paper

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Prepared for the SARA Project and the Inter-Agency Working Group on Private Participation and Child Health

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The findings, interpretations and conclusions expressed in the paper are entirely those of the authors, and do not represent the views of the World Bank, its Executive Directors, or the countries they represent.

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ARI	Acute Respiratory Infections
BASICS	Basic Support for Institutionalization of Child Survival
CCSS	Costa Rican Social Security Institute
CNW	Community Nutrition Workers
COPRA	Consumer Protection Act, India
CUHCA	Cambodian Urban Health Care Association
DHS	Demographic and Health Survey
IMA	Indian Medical Association
IMCI	Integrated Management of Childhood Illnesses
INSALUD	Instituto Nacional de Salud (Dominican Republic)
IPSS	Instituto Peruano de Seguridad Social
ITNs	Insecticide-treated Nets
KAP	Knowledge, Attitudes, and Practices
LSMS	Living Standards Measurement Surveys
MCH	Mother and Child Health
MOH	Ministry of Health
NGO	Non-Governmental Organization
PHR	Partnership for Health Reform
PHR	Project Partnerships for Health Reform
PRITECH	Technologies for Primary Health Care
PPS	Pre-payment Schemes
PSI	Population Services International
PVO	Private Voluntary Organization
ORS	Oral Rehydration Salts
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
RAP	Resource Allocation and Purchasing Initiative
SARA	Support for Analysis and Research
UNICEF	United Nations Children's Fund
UPA	United Planting Association, Malaysia
UPA	United Planting Association
USAID	U.S. Agency for International Development

Summary

In the majority of low and middle-income countries, the private sector presents significant opportunities for expanding the reach of essential child health services and products. Through better coordination with the private sector, governments and donors can improve the availability, quality, and effectiveness of child health services. Collaboration with the private sector also presents significant challenges. On a practical level, the diversity of private sector providers can make it difficult for governments and donors to identify opportunities and establish mechanisms for cooperation.

This document assesses the current importance—and potential—of the private sector in contributing to child health. The potential is vast. In many countries private and non-governmental providers are more commonly consulted for child health illnesses than public providers are. Even poor families often use private sector services. Families spend relatively large amounts of money for curative services in the private sector, even when there are cheaper public sector alternatives available. However, in many settings private providers are poorly regulated—and the technical quality of the services they provide is questionable.

The document begins with a framework for analyzing the contributions of the private sector to child health care. The framework—based on the work of Mosley and Chen (1984) and the World Bank's Poverty Reduction Strategy Framework—provides a basis for assessing the potential contributions of the different components of the private sector in a given setting or country.

The framework begins at the household level, and then identifies the components of the private sector that can influence child health outcomes and are potential collaborators in public-private partnerships. They include:

- Service providers (formal sector, other for-profit, employers, non-governmental organizations (NGOs), private voluntary organizations (PVOs), and traditional healers).
- Pharmaceutical companies.
- Pharmacies.
- Food producers.
- Shopkeepers.
- The media.
- Private suppliers.
- Health insurance.

The framework then identifies strategies to work with the private sector to improve child health, briefly summarized below:

Contracting to private sector organizations offers promise as a means of improving on or avoiding the limitations of the public sector in delivering services. But there are institutional limitations in lower and middle-income countries on the potential for contracting for essential health care services. As a result, informal "relational" contracting based on relationships and trust between private organizations and governments may be more appropriate in these countries. Senegal and Madagascar have successfully experimented with contracting out nutrition services to NGOs.

Regulation and setting standards. In the context of child health care, regulation and standard setting can include:

- Licensing and accrediting providers, pharmacies, and laboratories. Licensing fees can be used to both raise revenue and influence the geographic distribution of providers.
- Regulation of pharmaceutical products. Public sector essential drugs lists can influence the practices of the private sector.
- Lowering legal and regulatory barriers.
- Involving NGOs and private providers in establishing standards.

Financing support to the private sector for child health services, including:

- Subsidies to encourage the provision of specific services, particularly for poor population groups.

- Public insurance to pay for specific health services provided by the private sector.
- Incentives and tax breaks for the purchase and distribution of essential drugs and vaccines.

Non-financial incentives. With appropriate incentives, corporations may be valuable partners in extending health coverage to working populations. Examples from Malawi, Malaysia, and Central America are presented here.

Coordinating service provision and financing—to ensure that a standard minimum of services is provided across geographic areas and social groups.

Commercialization of child health products. There are several examples in the literature of social marketing and commercialization of ORS. There are also examples of cooperation with private companies to make bednets and handwashing soap more widely available. As with other strategies involving the private sector, the key challenge facing commercialization strategies has been the sustainability of the efforts once external funding support is no longer available.

Training. There are several examples of training of private practitioners. Private pharmacists and their staff are a logical target for training, because of their strong influence on caregivers' behavior in many countries. This type of training can be effective in the short run—as seen by a case study in Indonesia—but there is not much evidence that it has a sustained impact.

Advocacy—including promoting the economic and social benefits of child health services to governments and private companies.

Educating consumers can be a strategy in its own right and is essential to support other strategies for working with the private sector, particularly commercialization.

Community involvement in financing. Community-level prepayment plans have been recently promoted, particularly in sub-Saharan Africa, as an alternative or complement to government financing of essential health services and as a means to encourage community involvement in health care management.

There is a substantial literature available on interventions by governments and international organizations to work with the private sector to improve child health and other essential health services. Examples are provided throughout the document, and this literature is summarized in Appendix 3.

One clear lesson from this review is that the private sector is enormously heterogeneous. At the country level, feasible strategies will depend on the potential of the different components of the private sector and the capacity of governments and their partners for collaboration. This document presents preliminary guidelines for an assessment tool to identify potential strategies and interventions at the country level.

It is also clear that the strategies will work best in combination with each other. Interventions based only on improving private providers' knowledge levels may well not result in changing their practices. The most effective interventions have been those that have included consumer education with incentives to private providers.

In particular, there is a need to balance government's role as "promoter" and "regulator" of the private sector. In several countries, particularly in Africa, an increased reliance on community financing and service delivery by NGOs creates a need for a strong government role in terms of regulation, setting standards, and protection of the poor.

This document focuses on the role of the private sector in the direct provision of child health services. The private sector clearly has a much broader potential role in many other areas related to and supporting the provision of child health services—including the provision of ancillary services, training of health professionals (both pre-service and in-service), communication services, and financing of health care. The potential of the private sector in each of these areas is touched on in this document, but a detailed treatment of each of these important topics is beyond the scope of the paper. Financing of health care and services is a particularly complex topic. In most countries, the private sector has an important role to play in financing both recurrent health service costs and investment costs.

The importance of *sustainability* is highlighted throughout this document. Many of the case studies reported here present results that appear to be successful in the short or medium term, but for which results beyond that point are simply unknown. Other case studies document projects that have clearly proved to be unsustainable.

Introduction — The Importance and Potential of the Private Sector in Child Health

Despite the enormous progress made in child survival internationally, approximately 10.5 million children under five years of age still die each year in lower and middle-income countries. Seventy percent of these deaths are due to five preventable conditions: diarrhea, acute respiratory infection (ARI), malaria, measles, and malnutrition (BASICS, 1999).

Objectives of this Paper

The principal objective of this paper is to identify existing and potential strategies at the national and international level to better harness the potential of private sector to improve child health. The target audiences for the paper include ministries of health in low and middle-income countries, and program managers and technical staff working with child health programs in international organizations. This work is funded by the U.S. Agency for International Development through the Support for Analysis and Research (SARA) Project, and supported by the Inter-Agency Working Group on Private Participation and Child Health—comprised of representatives of the World Bank, the SARA Project, WHO, and the Partnerships for Health Reform (PHR) Project.

The Current Role of the Private Sector

In many countries private and non-governmental providers are more commonly consulted for child health illnesses than public providers are. Appendix 1 provides a detailed accounting of the evidence to date concerning the importance of the private sector in delivering child health services and limitations on publicly provided services. Among this evidence are the following examples:

- In India, approximately 80 percent of registered doctors work in the private sector. A 1988 national survey showed that 93 percent of children taken outside the home for treatment of diarrhea were treated by private providers and unregistered village doctors (Rohde, 1997). The private sector distributes 65 to 70 percent of the Oral Rehydration Salts (ORS) used in the country (Chakrabarty 1998, Northrup 1997).
- In Nepal, a study of 900 households showed that the private providers and drug sellers were the source of care for 65 percent of child diarrhea episodes and 60 percent of ARI illnesses (Kafle, 1998).
- In Egypt, private physicians treat 41 percent of child ARI cases and 22 percent of child diarrhea cases (Hudelson, 1998).
- In Bolivia, Guatemala, and Paraguay, more than 50 percent of child ARI and diarrhea cases are treated in the private sector (Berman and Rose, 1994).

Even poor families often use private sector services:

- A study in Dakar, Senegal found that the total cost of drugs sold in a disadvantaged suburb was 11 times the Ministry of Public Health expenditures on pharmaceuticals in the area (Fassin, 1988).
- Demographic and Health Survey (DHS) data from Dominican Republic indicate that 66 percent of families in the poorest quintile obtained treatment for acute respiratory infections from private facilities.

Families spend relatively large amounts of money for curative services in the private sector, even when there are cheaper public sector alternatives available:

- In Vietnam, 68 percent of health financing comes from the private sector; including households. The private sector accounts for approximately 50 percent of the provision of services (Krasovec *et al.*, 1999).

- In Sierra Leone, most spending on curative care takes place in the private and NGO sectors (Fabricant *et al.*, 1999).
- In Papua New Guinea, a survey of 325 patients attending six private clinics in Port Moresby found that the most common reason cited for choosing private care was that it was faster than public sector care. Many respondents felt that private clinics had better doctors or gave better medicine (Mulou *et al.*, 1992).

There is a demonstrated willingness to pay for services that are perceived to be of higher quality than publicly provided health care. Perceived quality is a complicated concept that includes the availability of drugs, qualifications of providers, confidentiality, and users' preconceptions of what is an effective cure.

Challenges in Working with Private Providers

Despite users' perceptions, in many settings private providers are unregulated and the technical quality of the services they provide is questionable. Appendix 2 summarizes studies that have been conducted to date on the quality of child health services provided in the private sector. In particular, there is a well-developed literature on the treatment of childhood diarrhea and dehydration by different types of providers. The following studies provide examples:

- A compilation of DHS data from 28 countries shows that private providers are a significant source of care for childhood diarrhea in most of the countries—and that they are less likely to use ORS and more likely to prescribe unnecessary drugs than public providers (Muhuri *et al.*, 1996).
- In Egypt, a longitudinal household survey conducted in 1990–91 found that government clinics were more likely than private physicians or pharmacies to prescribe ORS. Children who were seen by private doctors or pharmacists were more likely to be given antibiotics and antidiarrheals (Langsten and Hill, 1995).
- Studies in Nigeria (Igun, 1994), Kazakhstan (Ickx, 1996), and Bangladesh, Sri Lanka, and Yemen (Tomson and Sterky, 1986) have all found that ORS is underprescribed—and drugs heavily overprescribed—for child diarrhea cases.

In many cases there is a discrepancy between private providers' knowledge of appropriate treatments on one hand and their practices and recommendations on the other. This "KAP gap" (knowledge, attitudes, and practices) is particularly evident in the treatment of child diarrhea cases and acute respiratory infections (Murray, 1998). There is a wide variety of factors influencing the interaction between private practitioners and their patients. Interventions based only on improving private providers' knowledge levels may well not result in changing their practices.

In many countries, NGOs have become important sources of health care provision. While this is clearly a positive development in terms of the increased availability of essential health care services, the proliferation of NGOs also leads to concerns about a lack of regulation and standardization of basic treatment protocols (Gilson *et al.*, 1997). Likewise, an increased reliance on community financing—particularly in Africa—creates a need for a strong government role in terms of regulation, setting standards, and protection of the poor.

A Framework for Analyzing the Contribution of the Private Sector to Child Health

This chapter describes a comprehensive conceptual framework that clarifies the components of the private sector that potentially influence child health outcomes. The framework also identifies the strategies that countries can potentially choose to better harness the potential of the private sector to meet child health objectives.

The framework presented here is based on the World Bank's Poverty Reduction Strategy Framework, which in turn is rooted in Mosley and Chen's (1984) portrayal of the determinants of child health outcomes and the interrelationships among these determinants. Mosley and Chen laid out a series of immediate, or proximate, determinants of children's health status:

- Maternal factors
- Environmental contamination
- Nutrient deficiency
- Injury
- Personal illness control

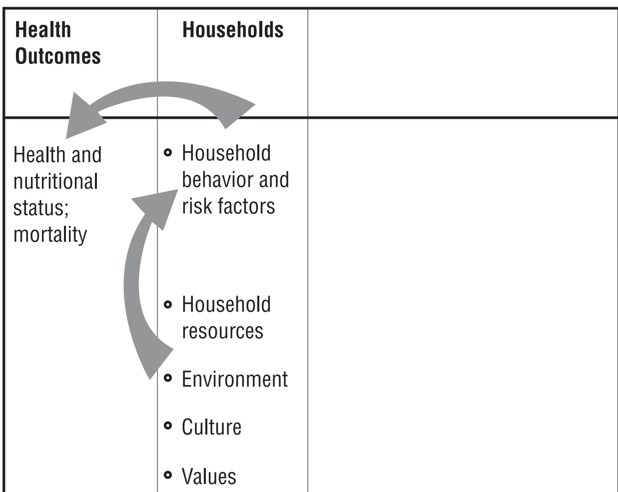
These proximate determinants are themselves influenced by a series of socioeconomic determinants:

- Individual-level variables—productivity, norms, and attitudes
- Household-level variables—income and wealth
- Community-level variables—the ecological setting
- Political economy
- The health system

A child's health and nutritional status, and, ultimately, survival, are most immediately influenced by conditions and actions at the household level, analogous to Mosley and Chen's proximate determinants (Figure 1).

Household's behavior and risk factors directly influence whether children become sick. When children do fall ill, treatment at the home and care-seeking behaviors have a strong effect on the evolution of the illness, and, ultimately, the possibility of death. Household behaviors are in turn influenced by additional factors at the household level—including available financial resources, the physical environment and possible contamination of the household and surrounding community, and cultural attitudes, values and knowledge relative to children and their health (Figure 1).

Figure 1. The Proximate Determinant of Child Health Outcome—Household Level



Once caregivers have made the decision to take a child to a service provider, whether for preventive or curative health care, the provider directly influences the child's health status (Figure 2).

In addition, health care providers directly affect household's behavior—through health education, financial incentives and other channels. Both public and private providers clearly play this role; public providers are omitted from this framework as it focuses on the role of the private sector (Figure 2).

Private sector service providers are grouped here into general categories in order to provide an ana-

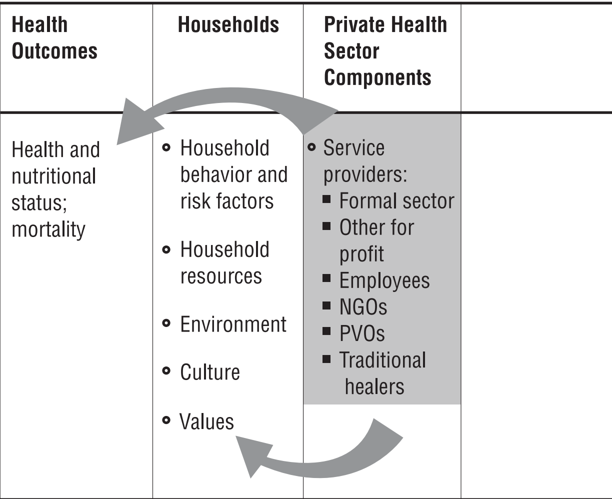


Figure 2. The Proximate Determinant of Child Health Outcome — Household and Provider Level

lytical framework and advance the discussion of feasible strategies to work with the private sector for child health care. Formal sector providers include for-profit physicians and other types of health care workers that are accredited or registered—and thus function within the context of a regulated health system. Other for-profit providers, working outside of the formal sector, are typically outside of the realm of government regulation. In many settings, the quality and consistency of care provided by this group is problematic.

Private employers are a significant source of both health care provision and financing in many countries. NGOs include church-based and other not-for-profit health care providers indigenous to the country or settings. PVOs, on the other hand, are international organizations that have a physical presence and provide health care in a given country. Finally, the category of traditional healers covers many different types of providers, all practicing some form of traditional medicine and typically outside of the purview of government regulation.[1]

There are a wide variety of other actors in the private sector that influences the behaviors of both households and health care providers (Figure 3).

Pharmaceutical companies influence the price and availability of medications. Governments regulate them; in addition, commercialization and social marketing interventions work with pharmaceutical companies to make drugs that are essential for child survival widely available at affordable prices (see Section 6 under "Strategies," below).

In many lower and middle-income countries, private pharmacies and drugs vendors have an enormous influence on household behaviors and, ultimately, children's health status. While private pharmacies are generally regulated by governments, the term "drug vendors" is used here to indicate the considerable drug sales that are unlicensed and unregulated. Such drug sales are widespread in the developing world, in both urban and rural areas. A study by the BASICS Project in Eritrea found that drug vendors are the main source of selling medicine in rural areas (Murray *et al.*, 1998). Overall in Eritrea, the private sector—both regulated and unregulated—dispenses more drugs than the public health system (Orobaton, 1997). Evidence from Dakar, Senegal (Fassin, 1988) and rural Guatemala (Van Der Stuyft *et al.*, 1997) presents a similar story.

Food producers and shopkeepers affect the types of foods produced and sold. Food producers are potential partners in food fortification programs. Shopkeepers can directly influence household behavior related to child feeding and caregiving. In most countries, the media has a strong impact on households and represents one of the principal channels for governments and their partners to affect households' behavior related to child health. "Private suppliers" are a group that includes suppliers of medical equipment to hospitals and private providers as well as the manufacturers and distributors of non-pharmaceutical products used to improve child health at the household level. Examples of such products include handwashing soap and bednets (see Section 6 under "Strategies").

Finally, the private sector plays a major role in the health sector in many countries by pooling financial resources and helping households to insure

1. This categorization is intended to provide a straightforward means of analyzing interventions targeting the private health sector in a variety of countries and settings. More complex categorizing structures are available in the literature. Smith *et al.* (2000) categorize providers by their level of organizational complexity and profit or non-profit status. Slack and Savedoff (2000) organize providers by the type of mechanism used to pay them.

Figure 3. Other Component of the Private Health Sector—Influence on Household and Private Provider

Health Outcomes	Households	Private Health Sector Components	
Health and nutritional status; mortality	• Household behavior and risk factors	• Service providers: ▪ Formal sector ▪ Other for profit ▪ Employees ▪ NGOs ▪ PVOs ▪ Traditional healers • Pharmaceutical companies • Pharmacies • Drug vendors • Food producers • Shopkeepers • The media • Private suppliers • Health Insurance	

against risk. Private health insurance companies also directly affect provider behavior through payment mechanisms, incentives, and setting standards. Because health insurance and contracting mechanisms are of intrinsic importance to health systems in general and go well beyond child health care, they are not treated in depth in this paper.

Strategies for Working with the Private Sector for Child Health

Governments and the international organizations that support them have a variety of strategies at their disposal to work with the components of the private sector with the ultimate goal of improving child health outcomes. These strategies can be characterized by the actors they target. Figure 4 lists the first group of these strategies—a group that targets private organizations and actors influencing child health. A second group of strategies, described later in this document, directly targets households.

The following sections describe experiences to date with these strategies in lower and middle-income countries. Throughout, emphasis is placed on the use of strategies to work with the private sector to improve child health. All of the strategies cited are also important parts of working with the private sector to improve the health of the entire population, and this document does not attempt to provide a comprehensive guide to working with the private health sector. As such, this document is intended to complement, and not substitute for, documents written in support of the World Bank's Resource Allocation and Purchasing (RAP) initiative.[2] Appendix 3 summarizes the available literature on interventions by governments and international organizations to work with the private sector to improve child health. Appendix 3 is organized alphabetically by strategy.

Figure 4. Strategies Targeting the Private Sector

Health Outcomes	Households	Private Health Sector Components	Government and Supporting Agencies—Strategies
Health and nutritional status; mortality	• Household behavior and risk factors	• Service providers: ■ Formal sector ■ Other for profit ■ Employees ■ NGOs ■ PVOs ■ Traditional healers • Pharmaceutical companies • Pharmacies • Drug vendors • Food producers • Shopkeepers • The media • Private suppliers • Health insurance	• Contracting • Regulation and setting standards • Financing support • Non-financial incentives • Coordinating services provision and financing • Commercialization • Training • Advocacy

1. Contracting

While there are several examples of governments contracting with private sector health delivery organizations for a range of services that include child health care, such contracts are rarely for child health services alone. The discussion of contracting for child health services is by necessity placed into a greater context of contracting for essential health services. In this context, *contracting* is a mechanism specifying the type, quantity, and time period of services provided by a private provider on behalf of government. *Purchasing* is a wider term that includes budgeting, regulation, supervision, and a range of market transactions and mechanisms used by governments to acquire a broad range of preventive and curative health services, support services, administrative and technical services, drugs, and supplies (Taylor, 2000).

2. See Preker *et al.* (2000) for a presentation of the RAP initiative.

Preker *et al.* (2000) present a framework for purchasing decisions, based on core policy characteristics, organizational characteristics, and institutional characteristics. Child health services—both preventive and curative—are part of a package of essential health services that are generally cost-effective and carry positive externalities. Governments should therefore ensure that these services are provided, either through direct public service provision or by purchasing them from the private sector. Distinct types of contracting in health care can be usefully distinguished—including health services contracting (with both institutional and individual contracts); contracting for ancillary services; and management contracting.[3]

NGOs may be able to expand health services coverage to areas beyond the reach of the public sector. As detailed in Case Study 1, governments in Senegal and Madagascar have successfully contracted with NGOs to offer nutrition services (see text box). Other examples of contracting for health services that include child health care are described below and are detailed in Appendix 3.

- In El Salvador, the MOH signed a three-year contract with an NGO, FUSAL, which assumed full responsibility for primary health services in the Municipality of San Julian, a difficult-to-reach rural area.
- Similarly, in Guatemala, CARE operates a project in partnership with the MOH and Ministry of Social Welfare. CARE manages seven jurisdictions where formal health coverage is minimal (Rosenthal, 2000).
- In Cambodia, the MOH recently piloted a program to contract essential health services to NGOs and for-profit firms in five districts. The MOH awarded the contracts through competitive tender. In two districts, contracts granted total responsibility for the management and delivery of district health services to the awardee. In the other three districts, contracts granted management responsibilities to the awardee organization, but district health remained under MOH control ("contracted-in"). The contracted-out districts appear to be performing better than those contracted in, but there is no hard evidence of improvements in either quality or efficiency (Smith *et al.*, 2000).
- In 1992, the Instituto Peruano de Seguridad Social (IPSS) established a network of private primary care physicians in Lima. As a result, patients have greater choice of provider and shorter delays—resulting in a reduction in demand for supplementary health insurance and improvements in consumer perceptions of IPSS.
- The Nicaragua Social Security Institute also began to contract with accredited health providers to provide care in 1996. In this case, however, the effort has met with resistance from providers, who must assume risk. The general populace, philosophically opposed to privatization, has been slow to accept the changes (Fiedler, 1996).

Combining public finance with private provision allows resource allocation decisions to be made by the public sector, while encouraging efficiency in service provision. However, there are significant limitations in lower and middle-income countries on the potential for contracting for health care services. Competition may be limited. Designing and monitoring contracts may be constrained by government capacity or corruption. Public finance may be insufficient. McPake and Banda (1994) suggest that significant investments in human resources and information systems are needed to make contracting feasible in most developing country contexts.

Palmer (2000) also points out that there are currently serious limitations on the use of formal contracts in lower-income countries. Competition—provider choice—and the institutional infrastructure necessary to support a comprehensive contract are lacking in most cases. As a result, informal "relational" contracting based on relationships and trust between private organizations and governments may be more appropriate in these countries.

3. Rosen (2000) provides an excellent overview of issues related to contracting for reproductive health care services.

Case Study 1. Contracting out Nutrition Services and Management in Senegal and Madagascar

Strategy: Contracting

Private sector component: NGOs

Intervention: Provision of preventive nutritional services to malnourished children. Services provided include monthly growth monitoring, weekly nutrition and health education sessions to women, referral to health services when needed, home visits, food supplementation to malnourished children, and income generating projects. Both projects were supported by the World Bank.

Description: Senegal and Madagascar have successfully experimented with contracting out nutrition services to NGOs. These governments aimed to expand services to high-poverty areas not served by public or other private providers, thereby reducing childhood malnutrition and freeing up government resources to address other high-priority concerns. International donors, the governments, and local communities provide funding.

In Senegal, the government delegated overall management responsibility for the "Community Nutrition Project" to an NGO called *Agetip* in 1996. *Agetip* signed a "Convention" or contract with the government to implement the project, and it is entirely responsible for project management and results. The government's National Commission Against Malnutrition, a presidential-level task force, is responsible for monitoring the contract. *Agetip* in turn contracts with local NGOs in 14 urban areas for day-to-day supervision of service providers. Each local NGO oversees approximately four workers, who usually are young people from nearby neighborhoods. Local consultants provide training, and workers are paid a minimum salary. As of 1998, 176 Community Nutrition Centers had been established.

In Madagascar, the *Secaline* project has provided nutritional services in rural villages since 1994. The government initially organized a Project Management Unit of individual contractors. These contractors are responsible for project implementation and are monitored directly by of the office of the Prime Minister. Community Nutrition Workers (CNWs) provide nutrition services to women who have been chosen by local community members in the target villages. *Secaline* project staff provide training to the CNWs, and then contract with local NGOs for ongoing supervision. Each NGO oversees around 8–10 CNWs. CNWs are paid with rice, equivalent to a minimum salary.

Results: In Senegal, the community nutrition centers provided services to 131,000 women and 100,000 children under three between 1996 and 1998. Between 1994–1998 in Madagascar, CNWs served 241,000 children under five and their mothers in 534 villages. Rates of severe and moderate malnutrition (measured by weight for age Z-scores) decreased significantly in the target areas of both projects, as demonstrated by cross-sectional surveys. Both projects expanded to the national level after the pilot phase.

Keys to success: In both countries, the government delegated authority for project implementation to non-governmental groups with strong management capacities at the national level. Local supervisory NGOs were contracted via an open tendering process, with stated eligibility criteria. Contracts with these NGOs clearly stated the tasks to be accomplished and specific performance expectations (minimum number of beneficiaries to be served, minimum percentage attendance at nutrition education sessions, etc.). In Senegal, some contracts have been canceled based on poor performance.

Both projects relied on locally available human resources, attempting to build capacity within the local population. Project staff also tried to target the most vulnerable geographic areas. Community participation in monitoring and implementation of the projects was promoted through local steering committees. Simple management information systems were developed for use by local supervisory NGOs; these systems usually targeted three to five main indicators, and were periodically monitored by national-level staff to ensure data accuracy. Overall, high-level political support was essential to the success of the projects, as was the availability of sufficient funding from government and international donors.

Challenges: Since community contributions total only about four percent of the projects' cost, while donors provide almost 90 percent, the long-term sustainability of these projects is a concern. *Agetip* is exploring ways to "graduate" successful communities to greater self-sufficiency through income-generating projects. In addition, it has proved difficult to find ways to refer severely malnourished children to government health services in areas where these services are inaccessible.

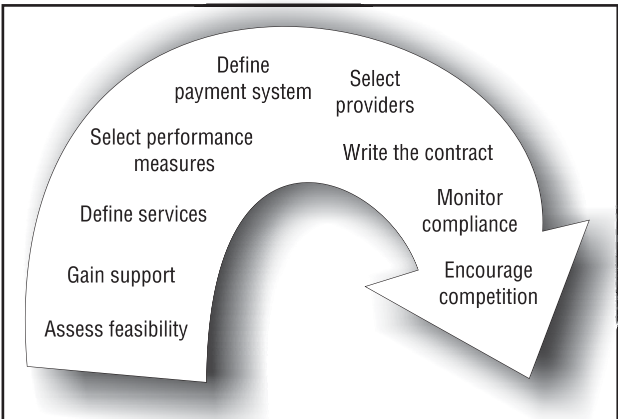
Source: Marek *et al*. (1999)

An example of this type of contracting comes from South Africa—Mills *et al.* (1997) compared costs and quality at two government facilities and two rural mission hospitals receiving substantial government grant money. No formal contract existed between government and mission institutions; the informal relationship was based on goodwill. It was found that the two mission hospitals provided similar services to the government hospitals, but at much lower unit cost.

Contracting is also possible between a government and its own hospitals or health facilities. In these cases, the contribution of contracting may be primarily to increase clarity on objectives and performance expectations, rather than to lower costs. In Costa Rica, the Costa Rican Social Security Institute (CCSS) has entered into management contracts with its hospitals—specifying objectives in terms of production, quality, satisfaction, and allowing for increased managerial and financial autonomy (Coll and Beeharry, 1999).

Mintz, LaForgia, and Savedoff (2001) provide a practical framework for implementing the formal contracting of health services. The steps described in the framework are useful whether the contracting in question is with private organizations, or within government institutions (Figure 5).

Figure 5. Steps in Contracting Health Services



Source: Mintz, La Forgia, and Savedoff (2001).

As described in Figure 5, important steps for contracting health services include:

1. Assess the feasibility of contracting, including costs, political consequences, availability of suppliers, regulatory framework, and readiness to contract.
2. Gain political and institutional support for contracting, including building public support from communities, organizations, and unions.
3. Define service specifications, including services to be purchased and the target populations to be served.
4. Select performance measures.
5. Define payment methods and link payment to performance.
6. Select providers and maximize competition in the bidding process.
7. Negotiate and write the actual contract.
8. Monitor and evaluate the contract, and assure the capacity for contract management.
9. Encourage competition over the long run to avoid monopolistic abuses in contracting.

2. Regulation and Setting Standards

Regulation is clearly one of the principal means by which governments can influence the behavior of private organizations in health and related sectors. Typically, separate regulation and standard-setting regimes apply to the labor market for health care, the markets for pharmaceuticals, medical equipment, and supplies, financial capital investment, physical capital and equipment, support infrastructure, and the quality of health care provision itself.

Each of these areas can in turn be influenced by government regulations in several ways. For example, regulation of the labor market for health care includes pre-service and in-service training, licensing and certification of providers, continuing education, and incentives for professional providers to locate in certain areas. Regulation of the pharmaceutical market includes essential drug lists and their enforcement, the promotion of generic drugs, import regulations, registration, encouragement and regulation of local production, and quality and price regulations for for-profit retailers.

A comprehensive discussion of each of the types of regulation that could influence child health care is clearly beyond the scope of this document. As with contracting, regulation and setting standards for private health care provision is a topic that transcends child health care. This document instead provides some examples of the regulation of private sector child health service provision and financing (as part of a package of essential health services) and examples of initiatives to involve the private sector in setting standards. Appendix 3 provides additional details and examples. In the context of child health care, regulation and standard setting can include (but is certainly not limited to):

- Treatment protocols.
- Licensing and accrediting providers, pharmacies, and laboratories.
- Price controls for health services, if necessary.
- Regulation of pharmaceutical products—essential drug lists and the role of private pharmacies.
- Regulation of private insurance.
- Protecting the poor—targeting children for fee waivers.
- Improving legal and regulatory barriers.
- Involving NGOs and private providers in establishing standards.

Licensing and Accrediting Providers, Pharmacies, and Laboratories

- In India, the Consumer Protection Act, COPRA, came into effect in 1986 to protect consumer interests by establishing consumer councils. The purpose of the act was to promote and protect the rights of consumers, provide accurate information, protect consumers against unfair trade practices, and ensure that consumer interests receive due consideration in appropriate fourms. However, COPRA has not been enforced and has had limited effectiveness for changing provider behavior to improve quality standards (Bhat, 1997).
- In Tanzania, the private health care market is relatively new—private practice was legalized in 1991. Most of the existing regulations focus on licensing requirements for providers and facilities. Regulations are needed to govern new actors in the private sector, such as laboratories, health care organizations, and private health insurance, and to protect consumers. It is important to set up a regulatory structure soon—before stakeholders' interests become entrenched. (Kumaranayake *et al.*, 2000).

Regulation of Drugs—Essential Drug Lists and the Role of Private Pharmacies

- Public sector essential drugs lists can influence the private sector. In Sri Lanka, over 70 percent of the pharmaceutical products registered by the private sector are listed on the essential drugs list, despite the fact that the list is intended to regulate the public sector (Weerasuriya, 1993).
- In Laos, a 1992 initiative to control the quantity of private pharmacies by restricting the opening of new pharmacies failed due to political pressures, demonstrating the difficulties of regulating drug sales in low-income settings. As an alternative, licensing fees could be used to both raise revenue and influence the geographic distribution of providers. The revenue could be used to strengthen the regulatory capacity of the government (Stenson *et al.*, 1997).

Improved Regulatory Environment

Regulations protecting health care consumers are lacking in many lower and middle-income countries. At the same time, existing laws and regulations can limit the population's access to child health care services and products. Some countries are loosening regulations and controls on the sale of public health products in order to increase access to these products. For example, in some Sub-Saharan African and Latin American countries, private pharmacies can provide immunizations after obtaining approval to sell vaccines from the government (Slater and Saade, 1996). Countries such as Malawi, Mozambique, and Tanzania have been successful in increasing private sector participation by eliminating unnecessary regulatory practices (Bennett *et al.,* 1997). When promoting private sector service provision by reducing regula-

tory barriers it is also important to ensure the safety and appropriateness of health care services.

Involving NGOs and Private Providers in Establishing Standards

In countries where NGOs play an important role in service delivery, involving them in the regulatory process can lead to improved public-private coordination and higher standards. In the Dominican Republic, INSALUD, a nodal organization for more than 100 NGOs, participates in the National Commission for NGO Qualification and Accreditation. INSALUD collaborates with the government to develop systems to ensure that NGOs receiving public funding comply with minimum requirements, standards, and norms. Similar examples are available from Bolivia and Mexico. The Ministry of Health in El Salvador has contracted with an NGO to establish quality-of-care requirements and assess compliance (Rosenthal, 2000).

3. Financing Support for the Provision of Services

Financing support to the private sector for child health services can include:

- Subsidies to encourage the provision of specific services or commodities, particularly in disadvantaged areas.
- Public insurance to pay for specific health services provided by the private sector.
- Incentives and tax breaks for the purchase and distribution of essential drugs and vaccines.
- Subsidies to encourage the media to provide health education messages.

Subsidies to Encourage the Provision of Specific Services or Commodities

- Subsidies can be an effective way to encourage the private sector to serve the poor. The government of Rajasthan, India provides allotments of land at subsidized rates, sales tax relief on medical equipment, and eligibility for other fiscal benefits to private health institutions as a means of encouraging private sector growth. In exchange, medical institutions in specific categories are required to provide at least 10 percent of their beds free to poor patients referred by an authorized government officer. They are also required to provide outpatient services free for one hour in the morning and one hour in the evening to poor patients (Winfrey *et al.*, 2000).
- In Bolivia, the NGO PROSALUD, an autonomous, nonprofit Bolivian organization, manages an extensive network of primary health care clinics for low- and middle-income people. The clinics provide free care to 10 percent of their patients. PROSALUD is subsidized by USAID (Cuellar *et al.*, 2000).
- In Thailand the Government's Board of Investment helped encourage the growth of new private hospitals by providing substantial tax breaks. However, Green (2000) argues that this support for private sector development has come at the expense of appropriate regulation and oversight by the Ministry of Public Health, which lacks political clout. Private hospitals now dominate the market in Bangkok and there are significant concerns about the quality of care and cream-skimming practices. There is therefore a need to balance between the government's role as “promoter” and “regulator” of the private sector.
- Pakistan has been successful in using tax incentives to convince private primary health care providers to set up operations in rural areas (Bennett *et al.*, 1997).

Public Insurance to Pay for Specific Health Services Provided by the Private Sector

Public insurance can effectively influence the types of services provided in the private sector, and increase access to child health services through the private sector. The government of South Korea provides medical insurance for most of its population, and this insurance covers the cost of immunization services obtained through the private sector (most health facilities are private) (DeRoeck and Levin, 1998).

Incentives and Tax Breaks for Essential Drugs and Vaccines

In almost all lower and middle-income countries, government regulatory bodies give preferential tax and import treatment to products classified as essential drugs. A recent survey of the tax treatment of three public health commodities—vaccines, ORS and contraceptives—in 22 countries found that vaccines receive the most favorable tax treatment (Krasovec *et al.,* 1998).

4. Non-Financial Incentives

There are several examples available in the literature of governments and donors using non-financial incentives to encourage the provision of specific health services, often in remote areas:[4]

- Corporations may be valuable partners in extending health coverage to working populations. In Malawi, 39 tea estates collaborated with Project HOPE to provide maternal and child health (MCH) services to their employees' families under a USAID child survival grant. The project paid for each estate to hire a health promoter to provide MCH care to all families. The health promoters helped establish specialty clinics, build and maintain water and sewer systems, clean up residential compounds, and provide community education, immunizations, and other preventive measures. A BASICS survey showed remarkable improvements—on the measures of well child visits, exclusive breastfeeding, water, and sanitation—as a result of this program. At present, there are 58 estates owned by 11 companies providing preventive care under this scheme to 55,000 workers and 270,000 family members (Burkhalter, 1998).
- The United Planting Association of Malaysia (UPA) covers seven percent of the Malaysian population through its employees and their families. The UPA agreed to provide free transport to government facilities so that children and pregnant women could be immunized, and to keep track of im-munization schedules. In turn, the government agreed to provide free immunizations, send mobile immunization teams to the plantations, and provide informational materials to plantations (Sinniah *et al.*, 1994).

5. Coordinating Service Provision and Financing

In countries where NGOs and other private sector organizations play a significant role in providing and financing health care, governments can and should play a coordinating role that goes beyond regulation. Such coordination should seek to ensure that a standard minimum of services is provided across geographic areas and social groups. Governments can also actively involve the private sector in public health initiatives.

- An analysis of the insurance sector in Thailand indicates that coverage is expanding, but that private and public schemes overlap and lack risk diversification—demonstrating a need to coordinate coverage and terms among the several public and private schemes. To improve this situation, the Government could adopt a national policy on health insurance, and provide education and training on health insurance principles to policy makers, system administrators, managers, and providers (Sriratanaban *et al.*, 2000).
- In India a "Universal Immunization Program" immunized more than 85 per cent of the children in Calcutta against major diseases, bringing together government, private sector representatives, UNICEF, and the voluntary sector. The organizations pooled their cold chain equipment to increase the effectiveness of their outreach. Collaboration between public and private sectors was essential—private providers provided easy access to the general population, while public sector coordinated logistics. It is however difficult to sustain collaboration on this scale (Chaudhuri, 1990).
- Kirsch and Harvey (1994) examine why private providers often do not participate in surveillance

4. The terminology "non-financial incentives" may lead to some confusion, since in many cases this type of collaboration includes governments and donors providing materials, supplies, or land—all of which have a financial value. The key point is that this type of collaboration does not focus on direct payments to private sector providers.

of diseases like polio. They point to several approaches to increase the role of the private sector in surveillance—strengthening surveillance laboratories, assisting with transportation of specimens to labs, providing incentives to report new cases, establishing awards for private providers, making communication equipment available to providers, and developing simple reporting forms.

6. Commercialization of Child Health Products

Governments and donors have been successful in collaborating with private pharmaceutical companies and suppliers to make ORS, soap, and bednets available to populations at low prices. Slater and Saade (1996) present a framework for assessing the potential for public-private cooperation for commercialization. They identify the following as products that could be promoted through public-private partnerships: Vitamin A and iron supplements, iron-fortified foods, iodized salt or foods fortified with iodized salt, insecticide-treated bed nets, anti-malarial drugs and treatment, soap, ORS, disinfectants, antibiotics, and vaccines.

Public-private initiatives to promote the availability of public health products can be usefully categorized by the level of sustainability of the product in question:

- Some products, such as disinfectants and soap, are fully sustainable as commercial undertakings.
- Others—including ORS and bednets—require a partial subsidy in many settings in order to reach a significant part of the population.
- Other products are naturally sold in the private market but can be positively influenced from a public health perspective through regulation and promotion—for example, food fortification.

These distinctions are important to keep in mind when planning interventions. As with other strategies involving the private sector, the key challenge facing commercialization strategies has been the sustainability of the efforts once external funding support is no longer available. There are several examples in the literature of social marketing and commercialization of ORS, including the following:

- In Indonesia, the PRITECH Project worked to convince commercial firms to invest in producing ORS. PRITECH first conducted market research, and used the data collected to convince the industry of the untapped market potential. Production and sales of ORS increased after just one year. The active involvement of the government and the Indonesian Medical Association were critical to this success. The MOH developed a national logo, messages for specific target audiences, and materials for pharmacies and shops (Ferraz-Tabor, 1993; Ferraz-Tabor and Jansen, 1991).
- In Bolivia, a public-private partnership financed market research and the development of a brand name, resulting in the launching of an ORS product that the pharmaceutical distributors made available in pharmacies and small retail shops. The MOH sponsored media campaigns to promote ORS.
- A similar intervention in Western Kenya in the late 1980s led to the conclusion that a combination of mass communication techniques and commercial distribution can increase the use of ORS, but that—given the population's financial resources—the sale of ORS could not replace free ORS distribution through clinics (Kenya *et al.*, 1990).
- Population Services International (PSI) established a social marketing program for ORS in Bangladesh. Sales revenues covered the cost of manufacturing and some operating expenses, while USAID supported marketing, training and education. The product was marketed by the PSI-affiliated Social Marketing Company (SMC), which promoted the product through pharmacies and other outlets at government-fixed prices. More than 87 million sachets of ORS were sold between 1986 and 1993. The name “ORSaline” became the generic term for ORS (PSI, 1994).

There are also examples of cooperation with private companies to make bednets and handwashing soap more widely available:

- The Rotary Net Initiative in Tanzania used five different channels to sell and distribute insecticide-treated nets (ITNs)—public hospital pharmacies, public health clinics, “net committees,” village health workers, and retail shops. Each outlet was essential in increasing the availability of ITNs, but none had much success in encouraging the treatment of nets with insecticide (Fraser-Hurt and Lyimo, 1998). After 18 months, a survey of 312 families with children under five found that 46 percent of the children were sleeping under treated nets. By the end of the second year of the marketing campaign, only 17 percent of children in the area were without a net (Schellenberg *et al.*, 1999; Abdulla *et al.*, 2001).
- The Gambia implemented a National Impregnated Bednet Programme in 1992. Rates of insecticide treatment dropped sharply when user fees began to be charged for the insecticide (Muller *et al.*, 1997).
- In Indonesia, USAID promoted the use of a leading soap, Lifebuoy, as a handwashing and hygiene product, thereby increasing its market share significantly (Slater and Saade, 1996). As reported in Case Study 2, the BASICS Project also promoted soap and handwashing in Central America (see text box).

Case Study 2. Handwashing Initiative in Central America

Strategy: Commercialization.

Private sector component: Private suppliers (soap producers) and the media.

Intervention: The project acted as a catalyst between the public sector and the private sector. By partnering with *private suppliers* like soap producers and *the media*, the public sector can efficiently achieve health objectives. Private suppliers can benefit from the development of a new selling point for their products and from an enhanced image in the community

Description: Studies have shown that many households in Central America with a high incidence of diarrhea are using poor handwashing practices and that diarrhea and subsequent dehydration causes 25 percent of children's deaths in the region. To improve handwashing behavior and ultimately reduce children's deaths from diarrhea, the BASICS handwashing initiative was launched in 1996.

The terms of the partnership were stated in a formal agreement. The project task force, coordinated by the BASICS Project, was in charge of ensuring the integrity of the public health focus. Public health messages encouraged improved handwashing techniques and handwashing at critical times such as after defecating and before preparing meals. The soap manufacturers used their marketing skills to develop a creative strategy for advertising their products based on the public health messages developed by the task force. The media was involved in disseminating the public health messages to the population.

Non-financial incentives were used to involve the private sector. The project conducted baseline market research—beneficial to the soap producers’ marketing strategies—to analyze the handwashing behavior of the targeted population. Soap producers would also benefit from enhanced interest in their products and an improved image in the community.

Results: The project achieved its objectives of improving handwashing behavior. In Guatemala the number of children displaying intermediate or optimal handwashing behavior increased from 19 percent to 29 percent. This was in large part due to the involvement of the soap producers and their marketing channels. The incidence of child diarrhea decreased by 4.5% among children under five years of age .

Sources: Slater and Saade, 1996, Miller, 1997.

7. Training to Improve Quality of Care

Training private health care providers is among the most feasible activities that governments and donors can undertake to influence the providers' behavior. Training is a discrete activity, generally without recurrent funding commitments. Experience shows that a wide variety of training of private providers has in fact been carried out—the private sector components targeted for training include pharmacists, physicians, nursing aides, and traditional healers. Unfortunately, partially because most training efforts to date have been ad hoc rather than institutionalized, there is very little evidence of sustained impact for this type of training.

In many countries, the involvement of the private sector in training differs for pre-service training (medical and other professional training schools), in-service training, and continuing medical and nursing education. Most of the available literature emphasizes in-service training. Hudelson (1998) highlights several interventions undertaken to train private practitioners in the Integrated Management of Childhood Illnesses (IMCI). In Kenya, shopkeepers were trained in dispensing antimalarials and antipyretics, and providing treatment advice to customers for childhood illnesses. Training sessions for unlicensed drug retailers in Nepal and licensed drug retailers in Kenya, Indonesia, and the Philippines have been organized to improve drug-dispensing practices. All these experiences showed improvements in the behavior and practices of private practitioners after tailored training sessions.

Private pharmacists and their staff are a logical target for training, because of their strong influence on caregivers' behavior in many countries. Case Study 3 (see text box on the next page) provides details of a successful intervention to use the techniques of the pharmaceutical industry—training through detailing—to influence pharmacists' behavior.

In Nepal, retail drug outlets outnumber health posts and health centers by a ratio of four to one. In 1981, Nepal's Department of Drug Administration established a 45-hour course for drug retailers to improve the quality of services they provide. The course emphasized practical training and formal teaching on pharmacology, ethics, storage, and legal issues. The program proved to be feasible and popular, and had good geographic coverage, at an annual cost of $18 per retailer. Refresher courses were eventually needed, and dependence on donors to fund the training sessions was a concern (Kafle *et al.*, 1992).

The Indian Medical Association (IMA) developed a national ORT training program in the late 1980s to improve private physicians' management of childhood diarrhea. IMA physicians trained almost 22,000 physicians by 1988. The IMA successfully used its structure to promote the training program, publishing information on the program in its monthly newsletter. An entire issue of the Journal of the Indian Medical Association was devoted to diarrhea and its management. Knowledge and practice among trainees improved, and over 90 percent of participants recommended the trainings to others (Sobti, 1988)

Traditional healers have also been the target of training efforts. In rural areas of the Philippines—where more than half the villagers were found to seek the services of traditional healers before consulting the formal health care system—training of traditional healers (herbolarios) included lectures, discussions, demonstrations and practical case review. Results showed an increase in knowledge acquisition, but there was no evaluation of the impact on practices (Caragay, 1982). In Ghana, the Danfa project has been described as a success story for information provision to illiterate traditional healers. The project utilized verbal teaching of modern health techniques to these healers, while also educating villagers about improved traditional medical practices (Yeboah, 2000).

8. Advocacy

In the context of this paper, advocacy involves communicating with governments and private companies in order to convince them that promoting child health services is in their best interest and is the right thing to do. The USAID-supported TIPPS Project aimed to persuade private companies to provide family planning and MCH services to employees and their dependents. TIPPS presented data to corporate leaders in a range of countries, showing that these services could both save the companies money and improve the health of their workers. Overall, 140 companies agreed to add these services to their health package (JSA Healthcare, 1991).

Case Study 3. Improving Pharmacists' Treatment of Childhood Diarrhea

Strategy: Training—Detailing to Private Pharmacies.

Private sector component: Private pharmacies.

Intervention: A controlled field test of the WHO-CDD (Control of Diarrheal Diseases) *Guide for Improving Diarrhoeal Treatment Practices of Pharmacists and Licensed Drug Sellers* in Indonesia. The study evaluated the efficacy of face-to-face outreach to private pharmacy owners and staff in improving diarrhea case management for children.

Description: The Indonesian Ministry of Health (MOH) followed a four stage process: assessing knowledge and current actual diarrhea treatment processes, identifying underlying motivations and constraints to changing practices, designing a persuasive educational intervention through face-to-face encounters, and implementing the intervention. First, interviews were conducted with a sample of pharmacy owners, pharmacists, and counter attendants to assess current knowledge about diarrhea and its treatment. Next, "surrogate patients" were sent to these pharmacies to observe actual practices, posing as mothers of children with diarrhea and asking for advice. Six focus group discussions were then held with pharmacy workers to explore the factors underlying their observed behavior.

Based on the results of these information gathering activities, the MOH team developed printed educational materials to convey target messages about appropriate diarrhea management. The core of the educational intervention consisted of short, interactive face-to-face sessions between outreach educators, pharmacists and counter staff—a version of "academic detailing." These sessions were conducted by MOH personnel and had the sponsorship of the WHO and the National Pharmacists' Association.

Results: The study included 43 intervention pharmacies and 44 control pharmacies in Java. The "surrogate patients" visited each pharmacy one month before and after the training. The intervention was successful—from a baseline ORS sales rate of 40 percent in both groups, the intervention group increased its ORS sales by 34 percent after the training, compared to a 13 percent increase among controls. Intervention pharmacies also decreased their sales of antidiarrheal drugs by 29 percent after the training, compared to a 9 percent decrease among controls.

Keys to success: The in-depth information-gathering process allowed the MOH team to design effective and appropriate materials and strategies. One-on-one academic detailing, which has repeatedly proven effective in changing physicians' prescribing behaviors in industrialized nations, was shown to be feasible in the developing world context as well. The backing of respected national and international health organizations increased the credibility of the outreach educators. In addition, providing pharmacies with free posters and patient education materials extended the impact of the intervention. The surrogate patients were essential to an "unbiased" assessment of the intervention's impact.

Challenges: It is unclear how sustainable these improvements in diarrhea case management will be; a one-time intervention is unlikely to have a long-term impact, and follow-up strategies need to be developed. A variety of forces continue to motivate drug vendors to improperly prescribe anti-diarrheals or fail to prescribe ORS: the perception that ORS is "good first aid" but not strong enough treatment for diarrhea; aggressive advertising and product outreach by pharmaceutical companies; consumer preferences for specific anti-diarrheal brands; and the higher profit margin of anti-diarrheal drug sales.

Source: Ross-Degnan *et al.* (1996)

Goel *et al.* (1996) present a framework for analyzing the behavior of pharmacy staff in developing countries. The framework leads to four proposed types of interventions—including information alone, persuasion, incentives, and coercion. Advocacy involves the first three of these approaches, while the fourth, coercion, is more related to regulation. Each approach alone has strengths and weaknesses, and the most effective strategy will combine all four approaches.

9. Changing Behavior through Communication

The remaining two strategies—changing behavior through communication and promoting community involvement in financing—are directed at households rather than at private sector organizations (Figure 6). However, households themselves can be considered as a critical component of the private health sector—particularly since household expenditures on health care are a major source of health financing in

Figure 6. Strategies Targeting Households

Health Outcomes	Households	Private Health Sector Components	Government and Supporting Agencies—Strategies
Health and nutritional status; mortality	• Household behavior and risk factors • Household resources • Environment • Culture • Values	• Service providers: ▪ Formal sector ▪ Other for profit ▪ Employees ▪ NGOs ▪ PVOs ▪ Traditional healers • Pharmaceutical companies • Pharmacies • Drug vendors • Food producers • Shopkeepers • The media • Private suppliers • Health insurance	• Contracting • Regulation and setting standards • Financing support • Non-financial incentives • Coordinating services provision and financing • Commercialization • Training • Advocacy • Changing behavior through communication • Promoting community involvement in financing

many countries. Moreover, these two strategies directly influence how households use private sector health services.

Examples of behavior change efforts targeting households and related to child health care include:

- In 1995, the Cambodian Urban Health Care Association (CUHCA) was set up as a facilitator between private health care providers and their patients. CUHCA's goals were to guarantee good quality and fair pricing to patients and to provide training and logistical support to providers. The fact that consumers lack the requisite knowledge to make good choices in the market for health services was recognized early on as a fundamental problem. CUHCA now seeks to educate consumers (Stuer, 1998).
- In Bolivia, BASICS worked to reach households by helping to launch the "El Zambo Angolita" radio series for reinforcing integrated child health practices in the community. BASICS' work included building partnerships with radio stations, identifying local private sponsors, and identifying sustainable incentives for broadcasting the program (Contreras and Brun, 1998).
- In Guatemala, Honduras, El Salvador, and Costa Rica, the BASICS project worked to convince mass media organizations to mobilize their resources behind the expansion of a regional handwashing campaign (see Case Study 2, above). These efforts underline the close link between commercialization (in this case, of soap) and consumer education.
- In Peru, a health literacy campaign promoting family planning, immunization, and oral rehydration utilized a mass-communication approach, and relied heavily on private sector advertising agencies. The immunization campaign was highly successful, although the other programs were not (Hornik *et al.*, 1987).

10. Promoting Community Involvement in Financing

Community-level prepayment plans have recently been promoted, particularly in sub-Saharan Africa, as an alternative or complement to government financing of essential health services and as a means to encourage community involvement in health care management. The plans generally arise to protect households in the presence of user fees or other barriers to access to health care. In countries with relatively weak institutional structures, government-sponsored health insurance is not well suited for coverage of rural populations, unless funded by general tax revenues, because formal employment rates are low and income tends to be seasonal.

One difficulty in assessing the capacity of community prepayment plans to improve access to health care and contribute to financing is the diversity of the plans. Creese and Bennett (1997) reviewed 36 informal sector health insurance schemes. There are at least five categories of plans:

- Hospital-based facility schemes, which are managed by a hospital and generally cover catastrophic hospital costs.
- Community-based schemes focusing on primary health care and drugs.
- Cooperative schemes, which are linked to the labor market.
- Solidarity funds based on a common ethnic group.
- NGO plans.

Examples of these plans include:

- In Ghana, a hospital-based plan that targets farmers in a rural district. Membership in the plan provides 100 percent coverage of the costs of hospital admissions for referred patients as well as surgery and incapacitation of 15 days or more. Premium collection is annual, and corresponds to the time of the cocoa harvest. There are 23,000 members (Atim, 1999).
- In Cameroon, the Babouantou Association is an ethnically based group of urban workers and middle class professionals. Each of the 450 members contributes an annual premium; only five percent of dues owed are not paid. Beneficiaries receive a lump sum equivalent to $39 if they are hospitalized seven or more days (Atim, 1999).
- In Rwanda, pre-payment schemes (PPS) were recently introduced with assistance from the Partnerships for Health Reform (PHR) Project. PPS were set up in three pilot districts containing about one million people, with two control districts. The annual premium is equivalent to approximately $6.80 per family per year. Eight percent of the population in the three districts enrolled in the schemes. The beneficiaries had on average 1.2 to 1.6 consultations per year at health facilities, compared to 0.2 for non-members and control districts (Schneider and Schneidman, 2001).

Next Steps for Working with the Private Sector

1. Guidelines for Assessing the Potential of the Private Sector

The private sector clearly plays an important role in child health care in many lower and middle-income countries. This document has described a variety of interventions that governments and donors have undertaken in order to better harness the potential of the private sector to improve child health. Prescriptions as to which strategies will work in a given context are well beyond the scope of this paper. The logical next step is to establish guidelines to assess the potential for working with the private sector in a given country or context.

This document does not seek to provide a detailed assessment guide, but rather to present the directions that such a guide should take. A comprehensive assessment of the potential for working with the private sector to improve child health in a specific country would include:[5]

1. A compilation of national policies regulating the practice of formal and informal private practitioners—and information on the enforcement of these policies.
2. An evaluation of the extent of child mortality and morbidity resulting from different disease types, focusing on conditions that are most feasibly preventable through public health interventions and through collaboration with the private sector.
3. An understanding of health care seeking behavior. What are the relative roles of the various components of the private sector in household care-seeking behavior? What are the factors—including perceived quality, financial resources, and other factors—that influence households to use or not use private providers?
4. Identification of the types and distribution of formal and informal private providers.
5. Assessment of the quality of care provided by the private sector components, and its impact of child morbidity and mortality.
6. Identification of points of contact for private providers—including organizations and associations reaching formal and informal private providers.
7. An understanding of the factors influencing private providers—including their perceptions and sources of information.
8. Assessment of the capacity of the public sector to regulate and motivate the private sector components in question—including: pooling and payment capacity, information capacity, and financial resources.
9. Based on the above, identification of the private sector components in the country that have the greatest potential to affect child health outcomes and that can be reached through one or more of the strategies described in this document.
10. Identification of strategies to work with the selected private sector components.
11. Exploration of possibilities for collaboration with other organizations, including government agencies, multilateral and bilateral lending and donor organizations, professional associations, and NGOs.
12. Identification of the main local food, soap, and bednet producers—and their markets and incentives and disincentives to work with the public sector.
13. Assessment of the potential impact and sustainability of the strategies identified, including market analysis. The importance of sustainability is highlighted throughout this document. Many of the case studies reported here present results that appear to be successful in the short

5. Several authors have discussed the importance of assessments of the potential of the private sector for child health. This discussion includes elements from Tawfiq (2001) and Slater and Saade (1996).

or medium term, but for which results beyond that point are simply unknown. Other case studies document projects that have clearly proved to be unsustainable.

Assessment of sustainability should distinguish between different types. Initiatives with the private sector can fail in at least three major ways related to a lack of sustainability, or "non-sustainability". The first of these is "Structural" non-sustainability—an initiative to work with the private sector is (structurally) not sustainable because the cost of the initiative is greater than the corresponding public health benefits and neither the public nor private sector will continue to support the initiative. The second type can be described as "Ownership" non-sustainability—an initiative to work with private sector is not sustainable because government is not committed to the approach and will withdraw funding despite potential public health gains. The third type, "Capacity" non-sustainability might occur when an initiative is structurally sustainable (meriting public and public expenditure) and is supported by government officials, but is still non-sustainable due to a lack of technical, managerial, or administrative capacity.

The main steps in the assessment can be usefully portrayed in a grid format, indicating the identification of combinations of viable private sector components and feasible strategies to reach them (Figure 10). This type of grid can help to focus efforts and resources.

2. Documentation of Case Studies

There is currently limited experience with the use of the different strategies described in this document to improve private sector participation in child health at the country level. Existing experiences are generally limited to the use of one strategy at a time

Figure 7. Matching Strategies and Private Sector Components

	Strategies									
Components of Private Sector	**Contracting**	**Regulation and setting standards**	**Financing support**	**Non-financial incentives**	**Coordinating service provision and financing**	**Commercialization**	**Training**	**Advocacy**	**Educating consumers**	**Community involvement in financing**
Service providers:										
Formal sector										
Other for-profit										
Employers										
NGOs										
PVOs										
Traditional healers	**Fill in to indicate appropriateness and success of strategies.**									
Pharmaceutical companies										
Pharmacies										
Food producers										
Shopkeepers										
The media										
Private suppliers										
Health insurance										

and not in combination. There is a clear need to develop further case studies of these strategies in action, with clear documentation of their impact, cost, and implementation arrangements.

3. Documentation of Treatment Patterns

While it is clear that the private sector is an important source of care for child illnesses, there remains a lack of clear understanding of the level and patterns of private care in different countries. A large amount of data concerning private sector treatment for sick children has been generated through household surveys, but these data have been only partially analyzed. Among the available types of national-level household surveys that contain information on child health and care-seeking behavior are: the Living Standards Measurement Surveys (LSMS), the MECOVI surveys coordinated by the InterAmerican Development Bank, and the Demographic and Health Surveys (DHS). The lack of systematic analysis of these data to date represents a major gap in terms of lost potential information. The results of such analysis would increase understanding of the barriers to access to child health care and patterns of care-seeking behavior, and would assist in the design of interventions to improve access and to collaborate with the private sector.

4. Interventions

Following the development and implementation of an assessment tool, the next steps will be to work in a specific country to identify private sector components and strategies for a series of trial interventions—and then to systematically evaluate these interventions in order to be able to improve and replicate them in other settings.

References

Abdulla S, Schellenberg JA, Nathan R, Mukasa O, Marchant T, Smith T, Tanner M, Lengeler C. 2001. *Impact on Malaria Morbidity of a Programme Supplying Insecticide Treated Nets in Children Aged Under 2 years in Tanzania: Community Cross-sectional Study.* BMJ 322:270-273.

Atim, C. 1999. "Social Movements and Health Insurance: A Critical Evaluation of Voluntary, Non-Profit Insurance Schemes with Case Studies from Ghana and Cameroon." *Social Science and Medicine*, 48(7):881-896.

BASICS. 1999. *Pathways and Partnerships: BASICS Contributions to Child Survival.* Arlington, Va: Basic Support for Institutionalizing Child Survival [BASICS].

Bennett S, McPake B, Mills A, eds. 1997. *Private Health Providers in Developing Countries: Serving the Public Interest?* London: Zed Books.

Berman P and Rose L. 1994. *The Role of Private Providers in Maternal and Child Health and Family Planning Services in Developing Countries.* Boston, Massachusetts: Data for Decision Making Project, Department of Population and International Health, Harvard School of Public Health.

Bhat R. 1996. *Regulating the private health care sector: the case of the Indian Consumer Protection Act.* Health Policy Plan 11(3):265-79.

———. 1997. *Regulation of the Private Health Sector in India. In Private Health Sector Growth in Asia: Issues and Implications.* Edited by W. Newbrander. New York: John Wiley and Sons.

———. 1999. *Characteristics of Private Medical Practice in India: A Provider Perspective.* Health Policy Plan 14(1):26-37.

———. 2000. *Initiatives to Invite Private Capital Through Public-private Partnerships in Social Sectors: Some Experiences from the Health Sector.* Vikalpa. 25(3):37-48.

Bojalil R, Guiscafre H, Espinosa P, Martinez H, Palafox M, Romero G, and Gutierrez G. 1998. "The Quality of Private and Public Primary Health Care Management of Children with Diarrhea and Acute Respiratory Infections in Tlaxcala, Mexico." *Health Policy and Planning*, 13(3):323-331.

Brugha R. and Zwi AE. 1998. "Improving the Quality of Private Sector Delivery of Public Health Services: Challenges and Strategies." *Health Policy Plan* 13(2): 107-120.

Burkhalter BR. 1998. "Employer-based Maternal and Child Health Model in Malawi." In: *Community-Based Approaches to Child Health: BASICS Experience to Date*. Rasmuson M, Bashir N, Keith N, eds. Arlington, VA: Basic Support for Institutionalizing Child Survival [BASICS].

Buse, K and Walt G. 2000. "Global public-private partnerships: Part I—A New Development in Health." *Bulletin of the World Health Organization.* 78(4).

———. 2000. "Global public-private partnerships: Part II—What are the Health Issues for Global Governance." *Bulletin of the World Health Organization.* 78(5).

Caragay R. 1982. "Training of Indigenous Health Workers: A Philippine Experience." *World Health Forum*, 3(2):159-163.

Carovano K, Zucker D. 1991 [unpublished]. AIDSCOM: Brazil Implementation Plan. 13 p. (USAID Contract No. DPE-5972-Z-00-7070-00).

Chakraborty S. 1998. "Community Monitoring of Private Providers in India: Results from an Operations Research Study." In: *Community-based Approaches to Child Health: BASICS Experience To Date.* Rasmuson M, Bashir A, and Keith N, eds. Arlington, VA: BASICS.

Chakraborty S and Harding A. 2001. "Conducting a Private Health Sector Assessment (PHSA)." *The Private Health Sector Handbook—Chapter 2.* Washington, DC: The World Bank.

Chakraborty S, D'Souza S, and Northrup R. 2000. "Improving Private Practitioner Care of Sick Children: Testing New Approaches in Rural Bihar." *Health Policy and Planning.* 15(4):400-07.

Chaudhuri ER. 1990. "Universal Immunization in Urban Areas: Calcutta's Success Story." I*ndian Journal of Public Health.* 34(4):227-34.

Chowdhury AM, Karim F, Sarkar SK, Cash RA, Bhuiya A. 1997. "The Status of ORT (Oral Rehydration Therapy) in Bangladesh: How Widely is it Used?" *Health Policy Plan,* 12(1):58-66.

Chuc NT, Tomson G. 1999. " 'Doi moi' and Private Pharmacies: A Case Study on Dispensing and Financial Issues in Hanoi, Vietnam." *Eur J Clin Pharmacol 1999* June;55(4):325-32.

Chukudebelu W, Ikeme A, Okaro J, Egbuciem P, Onah B, Okeke V, Nwakoby B, Akpala O, Nwagbo D, Ikeagu A. 1997. "Involving the Private Sector in Improving Obstetric Care, Anambra State, Nigeria. The Enugu PMM Team." *Int J Gynaecol Obstet 59* Suppl 2:S107-12.

Claeson M, Griffin CC, Johnston TA, McLachlan M, Soucat AL, Wagstaff A, Yazbeck AS. 2001. *Poverty-Reduction and the Health Sector—The Health, Nutrition and Population Network's.* Chapter in the World Bank's Poverty Reduction Strategy Sourcebook.

Coll X and Beeharry G. 1999. *Health Sector Reform in Latin America: Lessons from Middle-Income Countries*. Washington, DC:The World Bank.

Contreras A, Brun L. 1998. "Promotional Strategy for the Re-launch of "El Zambo Angolita" Radio Series." Arlington, VA: BASICS. February:7-21.

Creese A and Bennett S. 1997. "Rural Risk Sharing Strategies." In Schieber, George (ed.) *Innovations in Health Care Financing.* World Bank Discussion Paper No. 365:163-182.

Criel B, De Vos P, Van Lerberghe W, Van der Stuyft P. 1996. "Community Financing or Cost Recovery?" *Tropical Medicine and International Health*. 1(3): 281-2.

Cuellar C, Newbrander W, and Price G. 2000. *Extending Access to Health Care through Public-Private Partnerships: The PROSALUD Experience*. Boston: Management Sciences for Health.

Deloitte Touche Tohmatsu International. 1997 (unpublished). *India: Mawana Sugar Works. Promoting Financial Investments and Transfers to Involve the Commercial Sector in Family Planning (PROFIT).*

DeRoeck D and Levin A. 1998. "Review of Financing of Immunization Programs in Developing and Transitional countries." *Special Initiatives Report No. 12.* Bethesda, Maryland: Partnerships for Health Reform Project, Abt Associates, Inc.

Desmet M, Chowdhury AQ, Islam MK. 1999. "The Potential for Social Mobilisation in Bangladesh: The Organisation and Functioning of Two Health Insurance Schemes." *Social Science and Medicine.* 48(7):925-38.

Ellis WW. 1998. "Private-public Sector Co-operation to Improve Pesticide Safety Standards in Developing Countries. *Med Lav 89 Suppl.* 2:S112-22.

Fabricant ST, Kamara CW, and Mills A. 1999. "Why the Poor Pay More: Household Curative Expenditures in Rural Sierra Leone." *International Journal of Health Planning and Management.* 14:179-99.

Ferraz-Tabor L. 1993. "Mobilizing the Private Sector: Indonesia." *Integration.* Dec; (38):34-8.

Ferraz-Tabor L, Jansen WH 2nd. 1991. *Forging new partnerships: PRITECH's Pakistan experience. Involving the commercial sector in ORS marketing.* Arlington, VA: Management Sciences for Health, Technologies for Primary Health Care [PRITECH].

Fiedler JL. 1996. "The Privatization of Health Care in Three Latin American Social Security Systems." *Health Policy Plan.* 11(4):406-17.

Fraser-Hurt N, Lyimo EO. 1998. "Insecticide-treated Nets and Treatment Service: A Trial Using Public and Private Sector Channels in Rural United Republic of Tanzania." *Bulletin of the World Health Organization.* 76(6):607-15.

Goel P, Ross-Degnan D, Berman P, Soumerai S. 1996. "Retail Pharmacies in Developing Countries: A Behavior and Intervention Framework." *Social Science and Medicine.* 42(8):1155-61.

Green A. 2000. "Reforming the Health Sector in Thailand: The Role of Policy Actors on the Policy Stage." *Int J Health Plann Mgmt.* 15:39-59.

Hongoro C and Kumaranayake L. 2000. "Do They Work? Regulating For-Profit Providers in Zimbabwe." *Health Policy Plan* 15(4):368-77.

Hornik R, McDowell J, Pareja R, and Romero J. 1987. *Communication for Health Literacy: Evaluation of the Peru Program 1984–1985.* Washington, D.C.: Academy for Educational Development.

Hudelson P. 1998. *Possible Roles for Non-government Health Providers in IMCI.* Geneva, Switzerland: WHO.

Huff-Rouselle M, Akuamoah-Boateng J. 1998. "The First Private Sector Health Insurance Company in Ghana." *Int J Health Plann Mgmt.* 13:165-175.

Ickx P. 1996. Central Asia Infectious Diseases Program, Simulated Purchase Survey, Rational Pharmaceutical Management, Kazakhstan. 1996.

Igun UA. 1994. “Reported and Actual Prescription of Oral Rehydration Therapy for Childhood Diarrheas by Retail Pharmacists in Nigeria.” *Social Sciences and Medicine.* 39(6):797-806.

JSA Healthcare. 1991. *Facilitating Corporate Investments in Family Planning and Maternal Child Health Services: The TIPPS Experience*. Columbia, MD.

Kafle KK, Gartoulla RP, Pradhan YM, Shrestha AD, Karkee SB, and Quick JD. 1992. “Drug Retailer Training: Experiences from Nepal. *Social Sciences and Medicine.* 35(8):1015-25.

Kenya PR, Gatiti S, Muthami LN, Agwanda R, Mwenesi HA, Katsivo MN, Omondi-Odhiambo, Surrow A, Juma R, Ellison RH, *et al.* 1990. “Oral Rehydration Therapy and Social Marketing in Rural Kenya.” *Social Science and Medicine.* 31(9):979-87.

Kirsch T, and Harvey M. 1994. “A Role for the Private Sector in Poliomyelitis Surveillance?” *World Health Forum.* 15:240-243.

Konde-Lule JK, Okello DO, Lubanga RN, and Arube-Wani J. 1998. “Legislatory Framework for Private Medical Practice in Uganda.” *East Afr Med J.* 75(9):544-8.

Krasovec K, and Shaw RP. 1999. *Reproductive Health and Health Sector Reform: Linking Outcomes to Action.* WBI course on Adapting to Change: Reproductive Health and Health Sector Reforms. Washington, DC: The World Bank.

Krasovec K, and Connor C. 1998. *Survey on Tax Treatment of Public Health Commodities*. Bethesda, MD: Partnerships for Health Reform.

Kumaranayake L, Mujinja P, Hongoro C, and Mpembeni R. 2000. “How Do Countries Regulate the Health Sector? Evidence from Tanzania and Zimbabwe.” *Health Policy Plan.* 15(4):357-67.

Langsten R, and Hill K. 1995. “Treatment of Childhood Diarrhea in Rural Egypt.” Social Science and Medicine. 40(7):989-1001.

La Rocca, A. 1995. “Indonesia: Innovations and Self-reliance.” In: *Population Manager. Volume 2: Managing Urban Reproductive Health Clinics*, Satia J, Liow ML *eds.* Kuala Lumpur, Malaysia, International Council on Management of Population Programmes [ICOMP], 15-33.

Lynch H. 1993. “ ‘I am a Healthy Indonesian Child.’ 1,000 Primary Schools in Jakarta Join in the School Health Program.” *INTEGRATION.* Dec;(38):10-3.

Managing Drug Supply, Second Edition, Management Sciences for Health in collaboration with WHO, 1997

Mantra IB, Davies J. 1989. “In Rural Indonesia Social Marketing of Oral Rehydration Salts—The Mothers’ Perspective.” *Hygie.* 8(4):26-31.

Manuel-Santana R. 1993. “Philippine Campaign Boosts Child Immunizations.” *FRONT LINES.* 9-10.

Marek T, Diallo I, Ndiaye B, and Rakotosalama J. 1999. “Successful Contracting of Prevention Services: Fighting Malnutrition in Senegal and Madagascar.” *Health Policy Plan.* 14(4):382-9.

McFarlane G, and Sammon A. 2000. “A Prepaid Healthcare Scheme in Rural Africa.” *Tropical Doctor.* July; 30(3):151-4.

McPake B, and Ngalande Banda E. 1994. “Contracting Out of Health Services in Developing Countries.” *Health Policy Plan.* 9(1): 25-30.

Mills A, Hongoro C, and Broomberg J. 1997. “Improving the Efficiency of District Hospitals: Is Contracting an Option?” *Trop Med Int Health.* 2(2):116-26.

Mintz P, LaForgia G, and Savedoff B, 2001 (draft). “Contracting for Health Services: Getting from Here to There—A Framework with Guidelines.” Washington, D.C. [The Interamerican Development Bank] IDB.

Mosley WH, and Chen L. 1984. “An Analytical Framework for the Study of Child Survival in Developing Countries.” *Population and Development Review* 10 (supplement): 25-45.

Muhuri PK, Anker M, and Bryce J. 1996. “Treatment Patterns for Childhood Diarrhoea: Evidence from Demographic and Health Surveys.” *Bulletin of the World Health Organization.* 74(2):135-46.

Muller O, Cham K, Jaffar S, and Greenwood B. 1997. “The Gambian National Impregnated Bednet Programme: Evaluation of the 1994 Cost Recovery Trial.” *Social Science and Medicine.* 44(12):1903-9.

Mulou N, Thomason J, and Edwards K. 1992. “The Rise of Private Practice: A Growing Disquiet with Public Services?” *P N G Med J.* Sep;35(3):171-8.

Murray J, Adeyi GN, Graeff J, Field R, Rasmuson M, Salgado R, and Sanghvi T. 1997. *Emphasis Behaviors in Maternal and Child Health Programs in Communities.* Arlington, VA: Basic Support for Institutionalizing Child Survival [BASICS].

Murray J, Mosazghi A, Kifleyesus B, and Orobaton N. 1998. *Rural Drug Vendors in Eritrea: A Study of Practices and Training Needs.* Arlington, VA: Basic Support for Institutionalizing Child Survival [BASICS].

National Institute of Health and Family Welfare (India). 1989. *Collaboration with Voluntary Organisations in Health, Family Welfare and Nutrition: An Overview of the Project on Private Voluntary Organisations for Health*. New Delhi: NIHFW.

Northrup R. 1997. "The Private Sector: Critical Partners in Improving Child Health and Survival." Child Survival BASICS. *BASICS Quarterly Technical Newsletter.* 4:1-9.

———. 1997. *Technical Support of Three Activities for Indonesia, Jakarta and Yogyakarta, October 29–November 9.* Arlington, VA: Partnership for Child Health Care, BASICS.

O'Neill CJ, and Saade C. 1996. *Integrated Plan for Marketing of ORS in Morocco, February 6-16, 1996.* Arlington, VA: Partnership for Child Health Care.

Orobaton N. 1997. *The Role of Rural Drug Vendors in Health Services in Eritrea: Discussion Paper.* Ministry of Health, Eritrea. Basic Support for Institutionalizing Child Survival [BASICS].

Palmer N. 2000. "The Use of Private-sector Contracts for Primary Health Care: Theory, Evidence and Lessons for Low-income and Middle-income Countries." *Bulletin of the World Health Organization.* 78(6): 821-29.

Pitaknetinan K, Tangcharoensathien V, Supachutikul A, Bennett S, and Mills A. 1999. "Profit, Payment and Pharmaceutical Practices: Perspectives from Hospitals in Bangkok." *Health Policy.* 46Mar;(3):179-94.

Population Services International [PSI]. 1994. *Saving Children's Lives in Bangladesh.* PSI Profile. Oct:1-2.

Preker AS, Baeza C, Jakab M, and Langenbrunner J 2000. *Resource Allocation and Purchasing (RAP) Arrangements that Benefit the Poor and Excluded Groups.* The World Bank/ILO/WHO RAP Project Concept Note. Washington, DC.

Raghu MB, Balasubramanian S, Balasubrahmanyam G, Indumathy, and Ramnath A. 1995. "Drug Therapy of Acute Diarrhoea in Children—Actual Practice and Recommendations." *Indian J Pediatr.* Jul-Aug;62(4): 433-7.

Rasmuson M, Bashir N, and Keith N, eds. 1998. *Community-based Approaches to Child Health: BASICS Experience to Date.* Arlington, VA: Basic Support for Institutionalizing Child Survival [BASICS].

Reyes H, *et al.* 1993. "Autopsia verbal en niños con infección respiratoria aguda y diarrea: análisis del proceso enfermedad-muerte." *Bol Med Hosp Infant Mex*, 50:7-17.

Ron A. 1999. "NGOs in Community Health Insurance Schemes: Examples from Guatemala and the Philippines." *Social Science and Medicine.* 48(7):939-950.

Rosen JE. 2000. *Contracting for Reproductive Health Care: A Guide.* World Bank, HNP/Population and Reproductive Health Thematic Group.

Rosenthal G. 2000. *State of the Practice: Public-NGO Partnerships for Quality Assurance.* LAC-HSR Health Sector Reform Initiative. Boston: Family Planning Management Development Project, Management Sciences for Health.

Ross-Degnan D, Soumerai SB, Goel PK, Bates J, Makhulo J, Dondi N, Sutoto, Adi D, Ferraz-Tabor L, Hogan R. 1996. "The Impact of Face-to-face Educational Outreach on Diarrhoea Treatment in Pharmacies." *Health Policy Plan.* 11(3):308-18.

Saade C. 1995. *The International Dialogue on Micronutrient Malnutrition: Forum on Food Fortification.* Ottawa, Canada. December 6-8. Arlington, VA: Partnership for Child Health Care.

———. 1998. *Public relations offensive for handwashing campaign in Central America: Guatemala, Honduras, El Salvador, and Costa Rica.* February 2-13. Arlington, VA: Basic Support for Institutionalizing Child Survival [BASICS].

Santoso B, Suryawati S, and Prawaitasari JE. 1996. "Small Group Intervention vs Formal Seminar for Improving Appropriate Drug Use." 42(8):1163-8. Erratum in: *Social Science and Medicine.* 43(1):I.

Saunders SG, Escoto C, Barahona F, Bonnano MR, Fiallos CE, Corrales G, Rosenbaum J, and Seidel R. 1993. "Public and Private Sector Collaboration for the Commercial Marketing of ORS in Honduras." In: *Notes from the Field in Communication for Child Survival.* Seidel RE, ed. Washington, D.C.: Academy for Educational Development [AED].

Schellenberg JR, Abdulla S, Minja H, Nathan R, Mukasa O, Marchant T, Mponda H, Kikumbih N, Lyimo E, Manchester T, Tanner M, and Lengeler C. 1999. “KINET: A Social Marketing Programme of Treated Nets and Net Treatment for Malaria Control in Tanzania, with Evaluation of Child Health and Long-term Survival.” *Trans R Soc Trop Med Hyg*. 93(3):225-31.

Schneider P, and Schneidman M. 2001. *New Prepayment Schemes for Health in Rwanda*. Washington, D.C.: The World Bank.

Sharma S, and Hotchkiss D. 2001. “Developing Financial Autonomy in Public Hospitals in India: Rajasthan's Model.” *Health Policy*. 55(1).

Sharma S. 2001. *The Private Sector and Child Health Care*. Chapel Hill, N.C.: Carolina Consulting Corporation and Washington, D.C.: The POLICY Project, The Futures Group International

Silimperi D. 1995. *The Urban Private Health Sector Inventory*. Nigeria. Basic Support for Institutionalizing Child Survival [BASICS].

Sinniah D, Rajeswari B, Harun F, Maniam CR. 1994. “Strategy for Child Immunization in Malaysian Plantations.” *World Health Forum*. 15(3):236-7.

Slack K, and Savedoff WD. 2000 (draft). *Public Purchaser—Private Provider Contracting for Health Services: Examples from Latin America and the Caribbean*. SDS Technical Paper, Washington, D.C.: Inter-American Development Bank.

Slater S, and Saade C. 1996. “Mobilizing the Commercial Sector for Public Health Objectives: A Practical Guide. Arlington, VA: Basic Support for Institutionalizing Child Survival [BASICS].

Smith L, Brugha R, and Zwi A. 2000 (draft). *Working with private sector providers for better health care: an introductory guide*. London: Options and DFID.

Sobti JC. 1988 [unpublished draft]. *Indian experience in training private practitioners in the appropriate management of diarrhoea*. Indian Medical Association.

Sriratanaban J, Supapong S, Kamolratanakul P, Tatiyakawee K, Srithamrongsawat S. 2000. “Situational Analysis of the Health Insurance Market and Related Educational Needs in the Era of Health Care Reform in Thailand.” *J Med Assoc Thai*. 83(12):1492-501.

Stenson B, Tomson G, and Syhakhang L. 1997. “Pharmaceutical Regulation in Context: The Case of Lao People's Democratic Republic.” *Health Policy Plan*. 12(4):329-40.

Stuer F. 1998. “Enhancing Health Programme Efficiency: a Cambodian Case Study.” *Health Policy Plan*. Sep;13(3):263-76.

Tawfik Y. 2001 (draft). *Utilizing the Potential of Formal and Informal Private Practitioners in Child Survival - Situation Analysis and Summary of Promising Interventions*. Washington, D.C.: The SARA Project, Academy for Educational Development.

Taylor RJ. 2000. “Contracting for Health Services.” *Private Participation in Health Handbook—Background Paper*. Washington, D.C.: The World Bank.

Thien A. 1994. “KAP of Mothers on Childhood ARI” *Southeast Journal of Tropical Medicine and Public Health*. September.

Tomson G, and Sterky G. 1986. “Self-prescribing by Way of Pharmacies in Three Asian Developing Countries.” *Lancet*. Sep 13;2(8507):620-2.

Uplekar MW. 2000. “Private Health Care” *Social Science and Medicine*. 51:897-904.

Van Der Stuyft E, and Sorensen D and SC. 1997. “Utilization Rates and Expenditure for Public and Private Curative Care Services in Semi-urban Guatemala.” *Annals of Tropical Medicine and Parasitology*. 91(2): 209.

Weerasuriya K. 1993. “Essential Drugs and Registration of Pharmaceuticals: The Sri Lankan Experience.” *Bulletin of the World Health Organization*. 71(2):229-35.

Winfrey W, Kanjilal B, Sharma S, and Hotchkiss D. 2000. “The Role of Private Sector in Reproductive and Child Health Service Delivery in Rajasthan.” In: *Financing Reproductive and Child Health Care in Rajasthan*. Indian Institute of Health Management Research and The Policy Project, The Futures Group International.

World Health Organization. 2001. *The Multi-Country Evaluation of IMCI Effectiveness, Cost and Impact (MCE) Progress Report: May 2000 – April 2001*. Department of Child and Adolescent Health and Development. WHO/FCH/CAH/01.05.

Yeboah T. 2000. “*Improving the Provision of Traditional Health Knowledge for Rural Communities in Ghana.*” Health Libr Rev. 17(4):203-8.

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Appendix 1. The Importance of the Private Sector in Child Health —Available Evidence

Region	Private Sector Component	Countries	Reference	Main Findings
Africa	Drug vendors	Eritrea	Orobaton, 1997	Drug purchasing data show that there were approximately 2.2 million contacts with private providers compared with about 1.8 million contacts with public facilities.
Africa	Private pharmacies, drug vendors	Senegal (Dakar)	Fassin, 1988	The total cost of drugs sold in an underprivileged suburb was 11 times the Ministry of Public Health expenditures on pharmaceuticals in the area.
Africa	Private providers	Uganda	1995 DHS	For childhood diarrhea and ARI, a total of 60% of caregivers seek care outside the home from informal private providers (24%), NGO clinics (18%) and government clinics (18%).
Africa	Private providers	Uganda	MOH, Uganda, unpublished study, 2000.	Study of 18,000 households showed that the sources of care for sick children outside the home are: public and NGO health facilities (17%), private clinics and pharmacies (41%); and shopkeepers (37%).
Africa	Private providers	Sierra Leone	Fabricant *et al.*, 1999	Most spending on curative care takes place in the private and NGO sectors. Even perfect user fee exemption systems in the government sector would have a very minimal effect because of the small contribution of these fees to household health expenditures.
Africa	Health insurance	Ghana	Huff-Rousselle, 1998	Nationwide insurance is the first company to provide private health insurance in Ghana. It has had difficulty developing a client base among large firms, who typically already have convenient health provision arrangements in place. Nationwide acts somewhat like an HMO. Covered services are specified and limited. Participating physicians have ownership in the company—and an incentive to control costs and promote quality.
Asia	NGOs	Indonesia (Jakarta)	LaRocca, 1995	The private voluntary organization Yayasan Kusuma Buana (YKB) has been working to strengthen private sector involvement in family planning (FP), maternal-child health (MCH), and community development since 1980. Among other activities, YKB has organized a system of six self-reliant FP/MCH clinics in urban areas to fill a service gap felt by lower-middle class women who could not afford private care and worked during the hours that government clinics were open.
Asia	NGOs	Indonesia (Jakarta)	Lynch, 1993	YKB launched a program to screen all school children for parasites and treat those infected. Parents had to pay Rp 1,000 per year for children to participate. Covers 250,000 students. The program was 72% self-sufficient in 1992.
Asia	Private providers	India	Bhat, 1997	Approximately 80 percent of registered doctors in India work in the private sector.

Appendix 1. The Importance of the Private Sector in Child Health —Available Evidence

Region	Private Sector Component	Countries	Reference	Main Findings
Asia	Private providers	India	Rohde, 1997	A nationwide study conducted in 1988 showed that, for children with diarrhea taken outside the home for treatment, 93% were treated by private providers—including unregistered village doctors—and only 7% by government facilities.
Asia	Private providers	India	Chakrabarty 1998, Northrup 1997, Rohde 1997.	More than 80% of households go to private health care providers for childhood illnesses. The private sector treats 93% of diarrhea cases and accounts for 65% to 70% of the ORS distributed.
Asia	Private providers	Nepal	Kafle, 1998.	A study of 900 households showed that the private sector (drug sellers and private providers) was the source of care for 65% of all diarrhea episodes and 60% of ARI illnesses.
Asia	Private providers	Myanmar	Thien Aung, 1994	Private providers were identified as the preferred health providers for acute respiratory infections in urban areas.
LAC	Drug vendors	Guatemala (rural area)	Delgado *et al.*, 1994	Women generally obtained advice from a drug seller or pharmacist before seeking professional medical help. The authors conclude that women turn to the private sector, which responds to their demands, rather than the inaccessible public sector that is less likely to prescribe the “potent” modern drugs they prefer.
LAC	Drug vendors	Guatemala (rural area)	Van Der Stuyft *et al.*, 1997	Drug vendors accounted for 38% of health care contacts by women and 26% by children, while private physicians accounted for 34% and 38%, respectively.
LAC	Private health clinics	Bolivia	Cuellar *et al.*, 2000	PROSALUD, an autonomous, nonprofit organization, manages a network of primary health care clinics for low- and middle-income people. These clinics provide free care to 10% of their patients.
LAC	Private providers	Bolivia, Guatemala, Paraguay	Berman and Rose, 1994	More than 50% of acute respiratory infections and diarrhea cases are treated in the private sector.
MENA, Africa	Private providers	Egypt, Sudan	Hudelson, 1998	Private physicians treat 41% of child ARI cases and 22% of child diarrhea cases in Egypt. In Sudan, the corresponding numbers are 18% and 10%.

Appendix 2. The Performance of the Private Sector—Available Evidence

Private Sector Component	Region	Countries	Reference	Main Findings
NGOs		General	Gilson *et al.*, 1997	Discusses increased reliance on NGOs for health care provision. Concerns include resource constraints, management inefficiencies, lack of clear distinctions between the government and NGO providers, and abuse of non-profit status. Policy development must reflect the strengths and weaknesses of NGOs in particular settings and should be built on NGO advantages over government in terms of resource mobilization, efficiency and/or quality. Policy development will always require a strong government presence in coordinating and regulating health care provision, and an NGO sector responsive to the policy goals of government.
Pharmacists	Africa	Nigeria (Borno State)	Igun, 1994	Retail pharmacists and drug sellers were most likely to prescribe drugs—especially antibiotics—for both watery and bloody diarrhea. Prescribing ORT was very uncommon.
Pharmacists	Asia	Vietnam (Hanoi)	Chuc and Tomson, 1999	Private pharmacies have been responsible for distributing most drugs since economic reforms in the late 1980s. A case study of two pharmacies found significant quality problems. Less than 1% of customers had prescriptions, and about 95% decided for themselves what drugs to buy.
Pharmacists	Asia	Bangladesh, Sri Lanka, Yemen	Tomson and Sterky, 1986	Study of advice given and drugs dispensed at 75 pharmacies for child diarrhea. Only 16 of the 75 pharmacies gave the appropriate advice—oral rehydration or consultation with a health worker. 19 of 25 pharmacies in Bangladesh, 16 of 25 in Sri Lanka, and 24 of 25 in Yemen dispensed drugs, with or without oral rehydration solution.
Pharmacists/ Drug vendors	Asia	Kazakhstan	Ickx, BASICS, 1996	A simulated purchase survey revealed that most drug sellers did not take an adequate case history nor investigate the severity of disease. ORS were recommended only in 13% of diarrhea cases.
Pharmacists/ Drug vendors	Africa	Nigeria	Igun, 1994	Most retail pharmacies and medicine shop operators interviewed say they would recommend ORT for diarrhea, yet very few of them actually prescribe any form of ORT for watery diarrhea.
Private hospitals	Asia	Thailand (Bangkok)	Pitaknetinan *et al.*, 1999	Compared drug management and prescribing practices in for-profit, non-profit, and government hospitals in Bangkok. Pressures to contain costs in private hospitals led to reliance on generic drugs and essential drugs, a positive finding. At the same time, the profit motive also influenced these hospitals to resort to undesirable practices like prescribing short courses of antibiotics.

Appendix 2. The Performance of the Private Sector—Available Evidence

Private Sector Component	Region	Countries	Reference	Main Findings
Private physicians	LAC	Mexico	Reyes *et al.*, 1997	Population-based case-control study looked at whether processes of primary care were determinants of ARI mortality. Inadequate referral, attention provided by more than one physician, and being attended by a private physician were significantly associated with ARI mortality in infants (odds ratio = 9.68). Conclusion: private physicians need training in case management.
Private physicians	LAC	Mexico (periurban)	Calva and Bojalil, 1996	Most antibiotics were prescribed by a physician, but they were often inappropriately prescribed—for instance, antibiotics were prescribed in 37% of the diarrheal episodes.
Private physicians/ pharmacists	Asia	India	Raghu 1995	In a study of 48 private providers and 56 pharmacists in India, 83% of doctors prescribed an antibiotic for the treatment of diarrhea. 56% of doctors and 80% of pharmacists prescribed/dispensed loperamide. Many pharmacists dispensed without a valid prescription from a doctor.
Private physicians/ pharmacists	MENA	Egypt (rural)	Langsten and Hill, 1995	A longitudinal household survey conducted in 1990-91 found that government clinics were more likely than private physicians or pharmacies to prescribe ORS. Children who were seen by private doctors or pharmacists were more likely to be given antibiotics and antidiarrheals.
Private providers—general	Asia	Papua New Guinea	Mulou *et al.*, 1992	In a survey of 325 patients attending 6 private clinics in Port Moresby, the most common reason cited for choosing private care was that it was faster than public sector care. Many also felt that private clinics had better doctors or gave better medicine.
Private providers—general	LAC	Mexico (Tlaxcala)	Bojalil *et al.*, 1998.	Private providers performed significantly worse than public ones in terms of advice, therapy, and drugs prescribed for both diarrhea and ARI.
Private providers—general		Various	Muhuri *et al.*, 1996	In a survey of 28 countries using DHS data, private providers were found to be a significant source of care for children with diarrhea. However, private providers were less likely to use ORS and more likely to prescribe unnecessary drugs than public providers.

Appendix 3a. Strategies to Work with the Private Sector for Child Health

Strategy	Private Sector Component	Countries	Reference	Description	Lessons and Recommendations
Advocacy	Employers	Various	JSA Healthcare, 1991	The TIPPS project aimed to persuade private companies to provide family planning and MCH services to employees and their dependents. TIPPS presented data to corporate leaders showing that such services could both save the companies money and improve the health of their workers. 140 companies agreed to add these services to their health packages.	"Corporations most likely to invest in these employees benefits were financially sound, had a relatively progressive view toward employee benefits, and a sizeable female labor force. Companies were more receptive to a package that included maternal-child health services rather than family planning alone."
Advocacy/ Educating consumers	Multiple	Thailand	Ellis, 1998	A pilot project aimed to improve storage and handling of pesticides to reduce the incidence of pesticide poisoning and environ-mental damage. Local language materials were created, basic training was provided to physicians and industry representatives, and information was distributed to importers, end users, teachers, and students. The project also lobbied for changes in government policies and regulations.	
Advocacy, Financing support, non-financing support	Pharmacies/ drug sellers	(theoretical framework)	Goel, Ross-Degnan, Berman and Soumerai, 1996	A framework for analyzing the behavior of pharmacy staff in developing countries. Components include pharmacy staffing and organizational patterns (availability and role of professional staff, sources of information on drugs, economic incentives, staff training, workload, perceived efficacy of a drug, pharmacy ownership, location, competition), client characteristics, physician behaviors, and regulatory factors.	Four proposed types of intervention include information alone, persuasion, incentives and coercion. Each type implies different levels of participation on the part of the pharmacist and policy implementer. Each alone has strengths and weaknesses, and the most effective strategy will combine all four approaches.
Commercialization	Pharmaceutical companies	Indonesia	Ferraz-Tabor, 1993	The PRITECH (Technologies for Primary Care) Project wanted to complement government efforts to reduce diarrheal deaths by increasing the availability of ORS on the Indonesian commercial market. PRITECH worked to convince commercial firms to invest in producing ORS, aiming to create self-sufficient production without donor support. PRITECH first conducted extensive market research, and used the data collected to convince the industry of the enormous untapped market potential.	Sales of ORS increased after just one year. It was essential for the government to be highly involved at first, and then to let industry take over. The author stresses the important role of the Indonesian Medical Association and opinion leaders in the medical community in the success of commercialization. The image of ORS needed improvement among mothers, who viewed it as an ineffective, low-tech intervention.

Appendix 3b. Strategies to Work with the Private Sector for Child Health *(cont'd)*

Strategy	Private Sector Component	Countries	Reference	Description	Lessons and Recommendations
Commer-cialization	Pharmaceutical companies	Morocco	O'Neill and Saade, 1996	BASICS consultants worked with private sector producers of ORS to help increase sales and use in rural areas. Some producers raised the concern that their product was not profitable because the MOH was flooding the market with free ORS packets.	The consultants urged the MOH to limit distribution of free ORS to areas not served by the private sector. Recommended that the MOH facilitate the registration process of a new version of ORS produced by primary supplier. Encouraged the MOH to permit sales of ORS outside of pharmacies. Also encouraged the MOH to allow sales of a higher-priced ORS packet in wealthier areas.
Commer-cialization	Pharmaceutical companies	Honduras	Saunders *et al.*, 1993	The Ministry of Health negotiated with private sector firms to produce and market ORS in the public interest.	The MOH had to study the market, assess needs for the product, determine the market potential of the product, and study the costs of infrastructure for the product. Steps for successful collaboration with the private sector are listed.
Commer-cialization	Pharmaceutical companies	Bolivia	Slater and Saade, 1996	Case study of establishing a part-nership with private sector to increase use of ORS. A task force of MOH and donor agency representatives was formed. Technical assistance was requested from marketing experts. Target companies were selected based on capacity criteria. A market research agency conducted a survey of consumer preferences and behaviors, and a marketing strategy was developed. Brand names and designs were created. The task force presented their findings to the selected companies and made the case for strong market potential for the product. The company agreed, and developed an advertising strategy. The product was then launched.	Companies sought to ensure that the product would be available in all pharmacies, actively recommended by retailers, and prescribed by physicians. They expanded the availability of ORS beyond pharmacies to small retail shops. Price sensitivity studies were used to appropriately price the product, though the final price was higher than recommended, in order to cover costs. The MOH promoted ORS through campaigns and health workers.
Commer-cialization	Pharmacies/ drug sellers	Pakistan	Ferraz-Tabor and Jansen, 1991	A PRITECH project successfully shifted the majority of distribution of ORS from the public to the private sector. The objectives and strategy for achieving the objectives are described as well as the implementation (criteria for selecting collaborating companies, the participating companies, and PRITECH's role in disseminating information, holding marketing workshops, conducting marketing research, and providing technical assistance, materials, and new product development).	While the private sector was responsible for production and distribution, the government was responsible for promoting ORS in government health facilities, as well as developing a National Diarrhea Treatment Policy and revising regulations that affected the marketing of ORS. The government also developed a national logo, messages for specific target audiences, and materials for pharmacies and shops. The project motivated private firms to participate by emphasizing profitability, company image, social responsibility, and product appeal.

Appendix 3c. Strategies to Work with the Private Sector for Child Health *(cont'd)*

Strategy	Private Sector Component	Countries	Reference	Description	Lessons and Recommendations
Commer-cialization	Pharmacies/drug sellers	Kenya	Kenya *et al.*, 1990	An ORT intervention campaign was implemented in a rural area of Western Kenya in 1986. The evaluation compared one area where flavoured ORS sachets were sold through private outlets and unflavoured sachets were distributed free through primary care facilities, to a control area where only unflavoured sachets were distributed free through primary care facilities. A mass communication campaign was implemented in the intervention area. After a year of implementation, the authors conclude that a combination of mass communication techniques and commercial distribution can increase the use of ORS.	It is essential that the message and ORS product design be carefully tailored to local population preferences and perceptions. The authors also concluded that the sale of ORS could not replace free ORS distribution through clinics.
Commer-cialization	Pharmacies/drug sellers	Indonesia	Mantra and Davies, 1989	A report on 2 interventions using social marketing techniques to increase access to and use of ORS for diarrhea; one relied only on public sector resources, the second on both commercial and public resources.	Supplementing the public-sector approach with distribution via the commercial sector clearly enhanced the effectiveness of the intervention. Giving mothers the choice of relying on the public sector or visiting a commercial outlet ensures greater access to ORS packets. However, special efforts still need to be made to reach rural mothers who lack access to both retail and clinical outlets.
Commer-cialization	Pharmacies/drug sellers	Bangladesh	PSI, 1994	Population Services International (PSI) has successfully established a social marketing program for ORS in Bangladesh. Sales revenues cover the cost of manufacturing and some operating expenses, while USAID supports marketing, training and education. The product is marketed by the PSI-affiliated Social Marketing Company (SMC), which promotes the product through pharmacies and other outlets at government-fixed prices. "The marketing effort is supported with consistent consumer advertising, trade promotion, and detailing to doctors and pharmacists."	More than 87 million sachets of ORS were sold between 1986-1993. The name "ORSaline" is now the generic term for ORS, and ORSaline commands about 75% of the commercial market. The article details lessons learned.
Commer-cialization	Private suppliers—bednet distribution	Tanzania	Fraser-Hurt and Lyimo, 1998	"The Rotary Net Initiative, implemented in Kilombero district, southern United Republic of Tanzania, explored different sales channels for the distribution of insecticide-treated nets (ITNs) and the insecticide treatment service in a rural area of very high malaria transmission." Five channels were utilized—public hospital pharmacies, public MCH clinics, "net committees," VHWs, and retail shops.	Each outlet was essential in increasing the availability of ITNs, but none had much success in encouraging net treatment. A "multiplier effect" was achieved by facilitating the import and sale of nets. The authors' experience" suggests that ITN activities may employ a mix of public and private outlets in order to assure wide and permanent availability of ITNs and treatment service."

Appendix 3d. Strategies to Work with the Private Sector for Child Health *(cont'd)*

Strategy	Private Sector Component	Countries	Reference	Description	Lessons and Recommendations
Commer-cialization	Private suppliers—bednet distribution	The Gambia	Muller *et al.*, 1997	The Gambia implemented a National Impregnated Bednet Programme in 1992. High rates of coverage were obtained when insecticide was given out free, but rates of insecticide treatment dropped precipitously when user fees were charged. Even with fees, use of impregnated bednets was higher in areas where the sale of permethrin emulsion by village health workers was supplemented by the sale of insecticide in individual packages through shops.	The authors concluded that the sale of insecticide through the private sector may increase bednet impregnation rates in African communities, but that the free distribution of insecticide through MCH services may be a more effective way of targeting young children.
Commer-cialization	Private suppliers—bednet distribution	Tanzania	Schellenberg *et al.*, 1999; Abdulla *et al.*, 2001	Ongoing study of a large-scale social marketing program of insecticide-treated bednets in two rural areas. Three local mosquito net manufacturers are participating, and a mix of public and private outlets are being utilized for sales. "Net agents" were identified and trained to sell the ITBNs, and local young people were appointed to implement net treatment.	During the first year, a total of 22,410 nets and 8,072 treatments were sold. After 18 months, a survey of 312 families with children aged under five years found that 46% of children were sleeping under treated nets. By the end of the second year of the marketing campaign, only 17% of children in the area were without a net. Commercial marketing has led manufacturers to lower prices and increase the choice of nets.
Commer-cialization	Private suppliers—child health products	Various	Slater and Saade, 1996	A guide for health professionals to develop cooperative relationships between the public and private sectors for addressing public health concerns. Describes steps for initial probe into potential for such a relationship, how to build the relationship, and roles for each partner.	The authors identify the following as possible areas for public-private partnerships: "Vitamin A supplements in separate units or in foods, iron supplements or iron-fortified foods, iodized salt or foods fortified with iodized salt, insecticide-treated bed nets, anti-malarial drugs and treatment, soap, oral rehydration solutions (ORS), disinfectants, antibiotics, timers, vaccines, and equipment for maintaining cold temperatures during transport or at a central location." Potential commercial partners might include: "manufacturers of food, pharmaceuticals, textiles, insecticides, soaps, chemicals, and equipment."
Commer-cialization	Private suppliers—soap	Guatemala, Honduras, El Salvador, and Costa Rica	Miller, 1997	In Central America, soap producers and public sector health and development organizations collaborated to promote handwashing as a means to prevent diarrhea, using a social marketing strategy.	Behavioral change reduced prevalence of diarrhea by up to 60 percent in selected groups. Advertising soap as a public health product resulted in a significant increase in sales for commercial soap producers.

Appendix 3e. Strategies to Work with the Private Sector for Child Health *(cont'd)*

Strategy	Private Sector Component	Countries	Reference	Description	Lessons and Recommendations
Commer-cialization	Private suppliers—soap	Indonesia	Slater and Saade, 1996	USAID promoted the use of a leading soap, Lifebuoy, as a handwashing and hygiene product, thereby increasing its market share significantly.	
Community involvement in financing	Community-based prepayment plans	Various	Criel *et al.*, 1996	(Editorial)	The authors raise the concern that community financing may be able to complement, but cannot replace government funding for the health sector. Relying on community financing may "offer the semblance of an alternative to the poor" but actually conceals the collapse of public sector responsibility. In many parts of Africa, there simply is not enough financial potential to support the costs of a basic package of health care, and substantial subsidizing will remain essential for many years.
Community involvement in financing	Community-based prepayment plans	Philippines Guatemala	Ron, 1999	The author reviewed the experience of two community-based prepayment plans in developing countries. The plan in Guatemala failed primarily for logistical and political reasons. The Philippines plan succeeded in providing affordable and accessible health care to low-income families in rural areas.	Keys to success in the Philippines: an existing cooperative organization provided an essential administrative structure and membership base for the Filipino plan. Providers were salaried, and a capitation system was established for hospital-based services, keeping expenditures under control. Concerns: need to take into consideration the specific characteristics of each community when designing such plans. May need to incorporate income-generating activities. There is a need for national coordinating policy, accreditation, technical guidance, and managerial support. Low-income families may not be able to afford to participate, and proliferation of plans may fragment the risk pool.
Community involvement in financing	NGO-based health insurance plans	Bangladesh	Desmet *et al.*, 1999	The author reviewed the two largest health insurance schemes in Bangladesh, both run by NGOs in rural areas (GK Health Insurance Scheme and Grameen Health Plan). Findings: subscribers are not participating in the management of the schemes.	Recommendations: NGOs should try to make management more community-based. Work to better protect poor households. Include hospital care in the coverage package. Introduce episode-based co-payments instead of itemised ones as means of simplifying administration.

Appendix 3f. Strategies to Work with the Private Sector for Child Health *(cont'd)*

Strategy	Private Sector Component	Countries	Reference	Description	Lessons and Recommendations
Contracting for curative care	NGOs/private providers	Cambodia	Smith *et al.*, 2000	The MOH piloted a program to contract essential health services to NGOs and for-profit firms in five districts. The MOH awarded the contracts through competitive tender. Two contracts granted total responsibility for the management and delivery of district health services to the awardee. Three other contracts granted management responsibilities to the awardee organization, but district health staff were to remain under MOH control ("contracted-in"). In all contracts, the MOH specified the delivery of a defined package of health services and level of service coverage. Targets were to be achieved within the four-year contract period.	"Although the contracts have not yet been completed, evidence from MOH monitoring systems suggests that contracted-out districts performed significantly better in terms of service coverage, as compared with contracted-in districts, a result likely due to more effective managerial control over staff. However, the quality and efficiency gains of the contracting approach have yet to be established. As reported by contractors, obstacles to these contracts include lack of supply of vital diagnostic and health care equipment."
Contracting for curative care	Private providers	(theoretical)	Palmer, 2000	Evaluation of the potential of contracting in developing countries. Notes that while contracting may ideally increase competition, efficiency, and transparency, in many countries there are insufficient providers to promote competition, transaction costs are extremely high, and government may not have adequate capacity to effectively manage contractual relationships.	Concludes that "relational contracting" may be more feasible and effective in the LMIC context. This implies that the trust which has developed over time takes precedence over specific stipulations in a contract. Integration and trusting long-term relationships may lead to more efficient outcomes, especially where there is little competition, writing a comprehensive contract is nearly impossible, transaction costs are high, government capacity is low, monitoring is imperfect, choice of provider is limited, and the partners are mutually
Contracting for curative care	Private providers—general	Peru	Fiedler, 1996	By the 1990s, almost 30% of IPSS beneficiaries had purchased additional private health insurance, because the quality of free public health services was so poor. In 1991, IPSS began the "minor surgery program" reimbursing participating private hospitals for minor surgeries. In 1992, IPSS set up the PAAD, a network of private primary care physicians, in Lima. Patients may select any PAAD-participating private physician, who then acts as a gatekeeper and can provide specified services. Physicians are reimbursed by IPSS at a flat rate per consultation.	Demand for private, duplicative insurance has decreased. Patients have greater choice of provider and much shorter delays in appointment time. The PAAD program has increased the number of service delivery sites and thus increased access to primary care. Consumer perceptions of the quality of IPSS have improved markedly.

Appendix 3g. Strategies to Work with the Private Sector for Child Health *(cont'd)*

Strategy	Private Sector Component	Countries	Reference	Description	Lessons and Recommendations
Contracting for curative care	Private providers—general	Nicaragua	Fiedler, 1996	INSS changed its role from being a direct provider of social security services to being the financier and administrator of health services. INSS now contracts with accredited health providers to provide care. The scheme is organized by employer, and workers vote on where they wish to receive care.	Acceptance and growth of the new program have been slow. There is a shortage of participating providers, due to the small private sector, the expense of becoming accredited, and the few guaranteed benefits of doing so. Private providers must take on an enormous amount of risk and some have already gone bankrupt. Some philosophical opposition among the populace to the privatization of health care. Lesson: overly rapid privatization may have significant drawbacks.
Contracting for curative care	Private providers—general	El Salvador	Fiedler, 1996	In response to criticism about long delays in obtaining needed care, and to improve coverage for young children, ISSS began to allow private physicians to provide specialty ambulatory care to ISSS-insured patients. Providers are reimbursed at a flat rate per consultation.	The program has been enormously popular with enrollees. Originally a temporary solution, the "privatization" program is now considered permanent. Whether the program is financially more efficient is still unclear. The program has taken advantage of large excess capacity in the private health sector. The "cautious, non-threatening" approach to reforms seemed to work well.
Contracting for curative care	Private providers—general	(theoretical)	McPake and Ngalande Banda, 1994	Evaluation of the potential of contracting in developing countries. Combining public finance with private provision allows resource allocation decisions to be made by the public sector, while encouraging private efficiencies in service provision. However, there may be limited competition or contestability in many countries. Competition may not promote efficiency if quality is reduced to lower prices. It may be impossible to design and monitor contracts effectively if government capacity is low or corruption is prevalent. Public finance may be insufficient.	Significant investments in human resources and information systems are needed to make contracting feasible in developing country contexts.
Contracting for curative care	Private providers—general	South Africa	Mills *et al.*, 1997	Costs and quality were compared at three private "contractor" hospitals and three government-run hospitals. The contractor hospitals were able to provide care at lower unit costs, with equivalent quality. However, the costs to the government were nearly as high as direct provision—the contractors reaped all efficiency gains.	MOHs in developing countries lack expertise in designing contracts and "driving a hard bargain." Need to develop this capacity before relying on contracting, to ensure that government (not just private sector) incurs the benefits of contracting. True competition may be impossible, especially in rural areas; therefore, the contribution of contracting may be primarily to increase clarity on objectives and performance expectations, rather than to lower costs.

Appendix 3h. Strategies to Work with the Private Sector for Child Health *(cont'd)*

Strategy	Private Sector Component	Countries	Reference	Description	Lessons and Recommendations
Contracting for curative care	Private providers—NGOs	Zimbabwe	Mills *et al.*, 1997	Costs and quality were compared at two government facilities and two rural mission hospitals receiving substantial government grant money. No formal contract existed between government and mission institutions; the informal relationship was based on goodwill. It was found that the two mission hospitals provided similar services to the government hospitals, but at much lower unit cost.	Informal contracting arrangements may work best in situations where there is a history of trust between the parties. Explicit contractual agreements might "damage the culture of missions that underlay their good level of performance."
Contracting for primary health care	NGOs	El Salvador	Rosenthal, 2000	The NGO FUSAL signed a three-year contract with the MOH assuming full responsibility for primary health services in the Municipality of San Julian, a difficult-to-reach, under-served rural area.	NGOs may be able to expand health services coverage to areas beyond the reach of the public sector.
Contracting for primary health care	NGOs—primary health care	Zambia	Rasmuson *et al.*, 1998	BASICS sponsors NGO Partnership Grants as a way to increase collaboration between the MOH and local NGOs in four rural districts. NGOs develop proposals for an essential health care package in the community.	Some public officials have been reluctant to work with NGOs, perceiving them as working in isolation and not prioritizing the most important populations/health risks. These relationships need maintenance and trust-building.
Contracting for primary health care	PVOs	Guatemala	Rosenthal, 2000	CARE operates a project in partnership with the MOH and Ministry of Social Welfare, in which it manages seven jurisdictions where health coverage is minimal and no formal service provision is operational.	NGOs may be able to expand health services coverage to areas beyond the reach of the public sector.
Contracting for primary health care	PVOs	India	National Institute of Health and Family Welfare, 1989	USAID funds the "Private Voluntary Organizations for Health" project in India. Organizations must apply for PVOH funding. Grants are targeted towards organizations emphasizing primary health care as opposed to curative medicine; innovation; a community participation component; replicability; sustainability; and complementing other services in the area.	
Contracting for primary health care / nutrition services	NGOs	Senegal	Marek *et al.*, 1999	The MOH delegates management of the community Nutrition Project to an NGO called Agetip. This NGO hires and provides training to local groups of young people living in target neighborhoods (poor, periurban areas). The young people are then responsible for running Community Nutrition Centers (CNCs), where they provide growth monitoring, nutrition education, referral to health services, some food supplementation, and improved access to water stand pipes. All workers are salaried.	The project has significantly decreased the prevalence of malnutrition among young children. It has expanded to 176 CNCs in 14 cities, and it is estimated that 79% of funds directly reach poor target neighborhoods. The government now views this type of contracting as a feasible way to expand coverage to underserved areas, allowing it to focus on other activities that cannot be provided by the private sector. However, around 91% of the project's funding comes from foreign donors, with 5% from the government and 4% from the communities, raising concerns about sustainability.

Appendix 3i. Strategies to Work with the Private Sector for Child Health *(cont'd)*

Strategy	Private Sector Component	Countries	Reference	Description	Lessons and Recommendations
Contracting for primary health care/nutrition services	NGOs	Madagascar	Marek *et al.*, 1999	The Prime Minister's office contracts with and oversees an NGO called Secaline to provide nutrition services in rural areas. Secaline staff train community nutrition workers (CNWs) from target villages. Secaline also contracts with local NGOs to supervise the CNWs, who receive payment in kind. The CNWs provide growth monitoring, nutrition education, referral to health services, some food supplementation, and income generating activities.	The project has significantly decreased the prevalence of malnutrition among young children. It has also expanded nationwide, though the current project is nearing its end. As in Senegal, dependence on donor funding is also a concern here. Competition and the bidding process ensure high performance by CNWs.
Coordinating financing	Private health insurance plans	Thailand	Sriratanaban *et al.*, 2000	A 1998 analysis of the insurance sector in Thailand, relying on stakeholder interviews and a "brainstorming" group session for data collection, indicated that the insurance sector was expanding, but that there were multiple concerns. "Public and private schemes overlapped, and were generally characterized by inadequate risk diversification, overutilization of services, lack of effective cost containment, inconsistent service quality, and poor understanding of health insurance principles."	Recommendations to the government: develop national policy on health insurance. Update insurance-related laws. Provide education and training on health insurance principles and health systems management to policy makers, system administrators, managers, providers and insurers.
Coordinating provision	Private general providers	India	Chaudhuri, 1990	The "Universal Immunization Program" aimed to immunize more than 85% of children in Calcutta against major diseases. An "Apex Coordination Committee" consisting of government, private sector representatives, UNICEF, and the voluntary sector collaborated to organize and implement the effort. Immunization targets were achieved 3 months earlier than planned.	The organizations pooled their cold chain equipment to increase the effectiveness of their outreach. Collaboration between public and private sectors was essential: private providers provided easy access to the general populace, while public sector coordinated logistics. NGOs went to slum areas in person to encourage immunization. Religious leaders encouraged their followers to immunize their children. Promotion also included radio, TV, billboard, poster, and newspaper advertising. One caveat to this type of success is the difficulty of sustaining coordination and collaboration on this scale.
Coordinating provision	Private general providers	Various	Kirsch and Harvey, 1994	The authors examine why private providers often do not participate in surveillance of diseases like polio, and emphasize the importance of the private sector in surveillance.	Strategies for increasing the role of the private sector in surveillance include: strengthening surveillance laboratories, assisting with transportation of specimens to labs, providing inducements to report new cases, establishing awards for private providers, making communication equipment available to providers, and developing simple reporting forms.

Appendix 3j. Strategies to Work with the Private Sector for Child Health *(cont'd)*

Strategy	Private Sector Component	Countries	Reference	Description	Lessons and Recommendations
Educating consumers	Households—mothers	Bangladesh	Chowdhury *et al.*, 1997	In the 1980s, BRAC, a Bangladeshi NGO, taught 12 million mothers how to prepare ORS from common household ingredients. Prepackaged ORS was subsequently distributed and promoted by the government. To assess the impact of these interventions, the authors conducted an evaluation of knowledge of ORS preparation, local availability, and use in 1993.	The authors found that over 70% of mothers knew how to prepare ORS correctly. Some of the young mothers had apparently learned the skill from their relatives, implying inter-generational transfer of knowledge. ORS was used for diarrhea in 60% of diarrhea cases. While prepackaged ORS is much more available in rural pharmacies, and is frequently recommended by drug sellers and rural doctors, physicians still lag behind in prescribing ORS for diarrhea.
Educating consumers	Private providers	Cambodia	Stuer, 1998	In 1995, the Cambodian Urban Health Care Association (CUHCA) was set up as facilitator between private health care providers and patients, guaranteeing good quality health care and fair pricing to patients and providing training and logistic support to providers. Providers were engaged on a fee-for-service basis and competition encouraged. CUHCA's objectives followed the same line of thought as the 1993 World Development Report, aiming at influencing the unregulated private health care market through competition mechanisms.	Soon after the start of the project the basic problem was recognized to be not the absence of effective government regulation but rather that consumers lack the requisite knowledge to make good choices in the market for health services. CUHCA had not adequately addressed the demand for health services. The original supply-side strategy of improving health services by increasing competition was a failure. In order to improve CUHCA's health program efficiency the association's objectives were subsequently redefined and its functioning reorganized. CUHCA now tries to educate consumers and provides good quality services so that consumers will be able to act on the basis of their newly acquired knowledge.
Educating consumers	Private sector media organizations	Bolivia	Contreras and Brun, 1998	BASICS worked to help relaunch the "El Zambo Angolita" radio series for reinforcing IMCI practices in the community. This involved building partnerships with radio stations, identifying local private sponsors, and identifying sustainable incentives for broadcasting the program.	
Educating consumers	Private sector media organizations	Peru	Hornik *et al.*, 1987	A health literacy campaign promoting family planning, immunization, and oral rehydration utilized a mass-communication approach and relied heavily on private sector advertising agencies. The immunization campaign was highly successful, though other programs were not.	
Educating consumers	Private sector media organizations	Guatemala, Honduras, El Salvador, and Costa Rica	Saade, 1998	In Guatemala, Honduras, El Salvador, and Costa Rica, the BASICS project worked to convince mass media organizations to mobilize their resources behind the expansion of a regional hand-washing campaign.	

Appendix 3k. Strategies to Work with the Private Sector for Child Health *(cont'd)*

Strategy	Private Sector Component	Countries	Reference	Description	Lessons and Recommendations
Educating consumers	Private sector media organizations	Indonesia	Krasovec, 1999	The government of Indonesia launched a "Blue Circle" campaign that aimed to improve the image and status of private doctors and trained midwives, as high-quality providers of family planning services.	After a 5-week campaign, the average weekly caseload increased by 28% for doctors and 36% for nurses. Helped to shift higher income clients to private providers.
Financing support—subsidies, tax breaks	Private hospitals	India (Rajasthan)	Winfrey *et al.*, 2000	The government of Rajasthan provides allotments of land at subsidized rates, sales tax relief on medical equipment, and eligibility for other fiscal benefits to private health institutions as a means of encouraging private sector growth. In exchange, medical institutions in specific categories are required to provide at least 10 percent of their beds free to poor patients referred by an authorized government officer. They are also required to provide outpatient services free for one hour in the morning and one hour in the evening to poor patients.	Subsidies can be an effective way to encourage the private sector to serve the poor.
Financing support—insurance	Private general providers and hospitals	South Korea	DeRoeck and Levin, 1998	The government of South Korea provides medical insurance for most of its population, and covers the cost of immunization services obtained through the private sector (most health facilities are private).	Public insurance can effectively influence the types of services provided in the private sector, and increase access to child health services through the private sector.
Financing support—subsidies	Employers	India	Deloitte Touche, 1997	PROFIT, an NGO, helped set up an in-house MCH clinic for workers and dependents at the Mawana Sugar Works in India.	
Financing support—subsidies	NGOs—clinics and hospitals	Malawi	Krasovec *et al.*, 1999	The government collaborates with the Christian Health Medical Association. It subsidizes about 15 percent of recurrent costs in mission facilities in exchange for collaboration in providing a range of family planning and IEC services.	
Financing support—subsidies	NGOs, private providers	India, Nigeria, Oman, Panama, and Zimbabwe	DeRoeck, 1998	These governments provide free vaccines to NGOs and private providers as an incentive to deliver immunization services.	
Financing support—subsidies	Private health clinics	Bolivia	Cuellar *et al.*, 2000	PROSALUD, an autonomous, nonprofit Bolivian organization, manages a network of self-financing primary health care clinics for low- and middle-income people. These clinics are located throughout Bolivia and offer affordable, high-quality services, supported by community participation. PROSALUD clinics provide free care to 10 percent of their patients, and their cost recovery is 70.9%.	The private sector may be able to extend high-quality services even to low-income people.

Appendix 3l. Strategies to Work with the Private Sector for Child Health *(cont'd)*

Strategy	Private Sector Component	Countries	Reference	Description	Lessons and Recommendations
Financing support—tax breaks	Pharmaceutical companies	Various	Krasovec *et al.*, 1999	A recent survey of the tax treatment of three public health commodities—vaccines, ORS and contraceptives—in 22 countries found that specific tax relief arrangements do exist and that vaccines receive the most favorable tax treatment. In almost all developing countries, government regulatory bodies give preferential tax and import treatment to "essential drugs."	This strategy could help rationalize drug utilization in low-income countries.
Financing support—tax breaks	Private health clinics	Pakistan	Bennett *et al.*, 1997	Pakistan has been successful in using tax incentives to convince private primary health care providers to set up operations in rural areas.	
Financing support—tax breaks	Private hospitals	Thailand	Green, 2000	The Board of Investment in Thailand helped encourage the growth of new private hospitals by providing substantial tax breaks.	The author argues that this support for private sector development has come at the expense of appropriate regulation and oversight by the Ministry of Public Health, which lacks political clout. Private hospitals now dominate the market in Bangkok and there are significant concerns about the quality of care and cream-skimming practices. There is a need for balance between the government's role as "promoter" and "regulator" of the private sector.
Non-financial incentives	Employers	Malawi	Burkhalter, 1998	39 tea estates in Malawi collaborated with Project HOPE to provide MCH services to their employees' families under a USAID child survival grant. Under the program, each estate hired a health promoter to provide MCH care to all families. The health promoters helped establish specialty clinics, build and maintain water and sewer systems, clean up residential compounds, and provide community education, immunizations, and other preventive measures. The tea estates continued to fund the program on their own following the end of the grant.	A BASICS survey showed remarkable improvement in health (well child visits, exclusive breastfeeding, water, and sanitation) as a result of this program. At present, there are 58 estates owned by 11 companies providing preventive care under this scheme to 55,000 workers and 270,000 family members.

Appendix 3m. Strategies to Work with the Private Sector for Child Health *(cont'd)*

Strategy	Private Sector Component	Countries	Reference	Description	Lessons and Recommendations
Non-financial incentives	Employers	Malaysia	Sinniah *et al.*, 1994	Two non-profit organizations negotiated with the United Planting Association (UPA) of Malaysia, the plantation industry group, to improve access to child health services. The UPA expressed frustration that the government expected it to take sole responsibility for the health care of its workers, for which it lacked resources and expertise. Through negotiations, the UPA agreed to provide free transport to government facilities so that children and pregnant woman could be immunized, and to keep track of immunization schedules. In turn, the government agreed to provide free immunizations, send mobile immunization teams to the plantations, and provide informational materials to plantations.	Corporations may be valuable partners in extending health coverage to working populations. The success of this plan relied upon the goodwill of the industry, but also demonstration of commitment on the part of the public sector. Working through the UPA was an efficient way to target 7% of the total Malaysian population.
Non-financial incentives	NGOs	Uruguay	Slack and Savedoff, 2000	Church-based NGOs, supported by donor funding, provide services for mentally retarded children. The NGOs are focused on providing high-quality care for as many children as possible; the government makes a contribution towards the costs of this care. The arrangement is designed to take advantage of each player's comparative advantage. The government's advantage is in bulk buying of drugs; the NGO's is in the staff's dedication to the cause and the expectation that high-quality service will be provided. Payments are often in kind: for example, the NGO might add ten children to its existing patient population in return for government provision of drugs for one hundred children.	The provider's risk is very limited, and the incentive for increased productivity weak, unless the public sector audits and holds the NGO accountable for fulfilling the terms of the arrangement.
Non-financial incentives	Private health clinics	India	Bhat, 2000	In 1997, the government of Delhi proposed a joint venture scheme under which the government would contribute land as part of the equity capital for a proposed health facility. In exchange for its contribution, the government expects the private sector to provide free care to a certain percentage of poor (about 30–40%) patients and to participate in government public health programs.	

Appendix 3n. Strategies to Work with the Private Sector for Child Health *(cont'd)*

Strategy	Private Sector Component	Countries	Reference	Description	Lessons and Recommendations
Regulation/ standards	NGOs	Dominican Republic	Rosenthal, 2000	INSALUD, a nodal organization for more than 100 NGOs in the Dominican Republic, participates in the National Commission for NGO Qualification and Accreditation. INSALUD collaborates with the State Secretariat of Public Health and Social Welfare in the development of systems that seek to ensure that services provided by NGOs receiving public funding comply with minimum requirements, standards, and norms.	Important to involve NGOs in the regulation process.
Regulation/ standards	NGOs	El Salvador	Rosenthal, 2000	The Ministry of Health in El Salvador contracted with ASAPROSAR to establish quality-of-care requirements (norms, protocols, and procedures) and assess compliance.	
Regulation / standards	NGOs	Bolivia	Rosenthal, 2000	CIES and PROCOSI have participated in and supported the development of protocols, norms, and procedures for the government.	
Regulation/ standards	NGOs	Mexico	Rosenthal, 2000	MEXFAM has participated in and supported the development of protocols, norms, and procedures for the government.	
Regulation/ standards	Pharmacies	Lao P.D.R.	Stenson *et al.*, 1997	The study investigated the focus of drug regulation in Lao PDR and the capacity of the Lao government to regulate drug provision. "…the main role of the government can no longer be as the main provider of drugs. Instead regulation has to become a major government function in order to influence the behaviour of the private actors in the direction of the government's goals."	An effort in 1992 to control the quantity of private pharmacies by restricting the opening of new pharmacies failed due to political pressures. It would apparently be feasible to increase the cost of professional licenses for drug providers. Licensing fees could be used both to raise revenue and to influence the geographic distribution of providers, and revenue could be used to strengthen the regulatory capacity of the government.
Regulation / standards	Pharmacies	Sri Lanka	Weerasuriya, 1993	Over 70% of pharmaceutical products registered by the private sector were listed on the essential drugs list, despite the fact that the list is intended to regulate the public sector.	The author concludes that the essential drugs concept influenced private sector registration of drugs.

Appendix 3o. Strategies to Work with the Private Sector for Child Health *(cont'd)*

Strategy	Private Sector Component	Countries	Reference	Description	Lessons and Recommendations
Regulation/ standards	Private general providers	India	Bhat, 1999	The author conducted a case study of 130 private doctors in Ahmedabad. It was found that financial pressures on private providers, due to increasing costs of location and high technology, are resulting in undesirable practices (fee-splitting practices, overprescription of drugs and diagnostics, inadequate sterilization and waste disposal, etc.). Awareness of the COPRA was high but awareness of other medical and drug legislation was very low.	Recommendations: regulations alone will not be effective. Need to reform payment methods to reduce demand-inducing behavior by physicians. Need to develop an effective continuing medical education program to reduce the frequency of negligence cases and the overprescription of drugs, and then link this to renewals of licenses. Strengthen licensing and registration mechanisms as a means of improving the geographic distribution of physicians. Use licensing mechanisms as a means to control importation of expensive high-tech equipment.
Regulation/ standards	Private general provider	(theoretical framework)	Brugha and Zwi, 1998	A paper by Brugha and Zwi "develops a model for identifying the influences on PPs, mainly private medical providers, in their management of conditions of public health significance." Factors determining private providers' behavior include unreliable sources of information, relationships between public and private sectors, whether patients pay direct charges, existence of laws and enforcement mechanisms, position of organized medical associations, and patient expectations.	"Interventions need to be inexpensive, practical, efficient, effective and sustainable over the medium to long term." Educational materials and workshops alone were found to be relatively ineffective. Academic detailing, practice visits, and patient-mediated interventions are usually effective, while use of local opinion leaders, feedback mechanisms, and reminders to providers have variable success in changing provider behaviors. Most effective: multifaceted strategies involving consumer education, community participation, and provider organizations.
Regulation/ standards	Private general providers	Uganda	Konde-Lule, 1998	A review of legislation regulating private providers in Uganda was conducted to determine how these laws affected the operations and development of private practice. Existing laws aimed to ensure the availability of affordable, efficacious drugs at all times, and to regulate licensing, supervision, discipline, and general control of medical professionals.	In contrast to other studies, these authors encouraged the government to reduce restrictions on private providers—by easing laws on drug imports, ending "the requirement for the professionals to renew their practising licenses and to register the premises annually at one central place in the country" and reducing "long periods of time mandated for acquiring experience before one can be permitted to practice privately."
Regulation/ standards	Private general providers	Philippines	Manuel-Santana, 1993	The Philippine Pediatric Society helped promote ORT as the preferred treatment for diarrhea. Reinforced the impact of government's social marketing program for ORS and commercial sector production.	Professional associations may be valuable partners in promoting healthy behaviors.

Appendix 3p. Strategies to Work with the Private Sector for Child Health *(cont'd)*

Strategy	Private Sector Component	Countries	Reference	Description	Lessons and Recommendations
Regulation/ standards	Private general providers, private hospitals and clinics	India	Bhat, 1996	Analysis of providers' opinions on the Consumer Protection Act (COPRA)—which established consumer councils to review cases—and its application to medical care. Most providers were aware of COPRA. Providers felt that COPRA would indeed reduce malpractice and negligent behavior, but also noted that it was imperfect and would raise costs, induce overprescription of drugs and lab services ("defensive medicine"), and negatively impact emergency care.	Since India's professional medical associations no longer are effective in regulating their members, consumer protection legislation is needed. However, legislation specific to the health sector would be preferable to this broad-based, general consumer protection law. There are few standards to support COPRA's consumer councils. Needed: an orientation program to the COPRA for doctors, better continuing education for doctors, oversight and publication of the fees charged by doctors, clear and peer-reviewed standards, and malpractice insurance.
Regulation/ standards	Private general providers, private hospitals and clinics	India	Bhat, 1997	The Consumer Protection Act, COPRA, came into effect in 1986 to protect consumer interests by establishing consumer councils. The purpose of the act was to promote and protect the rights of consumers, provide accurate information, protect consumers against unfair trade practices, and ensure that consumer interests receive due consideration in appropriate forums. However, experience so far indicates that COPRA has had limited effectiveness for changing provider behavior to improve quality standards.	
Regulation/ standards	Private general providers, private hospitals and clinics	Zimbabwe	Hongoro and Kumaranayake, 2000	Stakeholder interviews were used to explore the regulatory environment in the health sector and the effectiveness of existing regulations. There was limited knowledge of key legislation and regulations among both government workers and private providers. Respondents perceived that regulations were not being implemented or enforced effectively.	Findings: the regulatory commission is not independent, transparent, proactive, or well-informed, and it is too centralized. It needs more staff. Patients do not know their rights, and cannot advocate for themselves. There are few regulations to control prices charged by providers. Recommendations: laws need to be reviewed and updated. Professional associations are suggested as key players in enhancing the effectiveness of regulation of private providers. As well, "increasing consumer access to information and knowledge" would likely strengthen regulatory processes. Decentralized enforcement at the local level might also be more effective.

Appendix 3q. Strategies to Work with the Private Sector for Child Health *(cont'd)*

Strategy	Private Sector Component	Countries	Reference	Description	Lessons and Recommendations
Regulation/ standards	Private general providers, private hospitals and clinics	Tanzania	Kumaranayake *et al.*, 2000	Review of existing legislation and regulations affecting the health sector, and interviews with key informants. Private practice was legalized in 1991. Most regulations focus on licensing requirements for providers and facilities. Some regulation of physician salaries, prices charged in private practices, and importation/sale of drugs.	New regulations are needed to promote competitive practices and protect consumers. Regulations are also needed to govern new actors in the private sector, such as laboratories, health care organizations, and private health insurance. Since the private market is still relatively new in Tanzania, it is imperative to set up a regulatory structure soon—before stakeholders' interests become entrenched.
Regulation/ standards, financial and non-finacial incentives	Food producers	(theoretical framework)	Saade, 1995	Discussion of what the role of the private and public sectors should be in working to fortify foods.	The Forum on Food Fortification in Ottawa (1995) concluded that it is the private sector's responsibility to provide scientific research and development, conduct market research, develop appropriate products, and disseminate and market the products. In turn, it is the public sector's responsibility to assist in the development of standards, provide incentives, and reach out to industry.
Regulation/ standards	Private health clinics	India	Sharma *et al.*, 2001	Medicare Relief Societies (MRS) in Rajasthan, India are autonomous organizations that aim to complement and supplement existing service provision in public hospitals. The state encouraged the formation of these societies by relaxing restrictions on the collection, retention, and use of revenue by hospitals, thereby encouraging the use of alternative financing mechanisms, such as user-fee schemes and in-hospital pharmacies. Both the Ministry of Health and the Ministry of Family Welfare granted significant autonomy to the societies and provided seed money.	
Training	NGOs	Brazil	Carovano and Zucker, 1991 (unpublished)	AIDSCOM (a USAID project) worked to develop communication strategies for AIDS prevention. The project provided training to NGOs and private sector organizations on social marketing, materials development, research skills, communication strategies, and prevention activities for various groups.	This type of "train-the-trainer" intervention can magnify the results of training interventions.

Appendix 3r. Strategies to Work with the Private Sector for Child Health *(cont'd)*

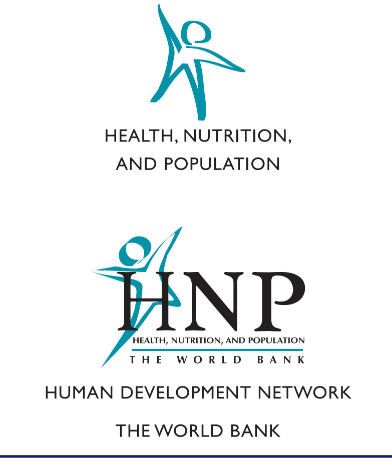
Strategy	Private Sector Component	Countries	Reference	Description	Lessons and Recommendations
Training	Pharmacies/drug sellers	Nepal	Kafle *et al.*, 1992	Retail drug outlets outnumber health posts and health centers by a ratio of 4:1, and private drug shops offer the only access to modern medicine for much of the population. Nepal's Department of Drug Administration established a 45-hour course for drug retailers in 1981 to improve the quality of services provided by these retailers. The course emphasized practical training and formal teaching on pharmacology, ethics, storage, and legal issues.	The program proved to be feasible and popular, and has had good geographic coverage, with an annual cost of $18 per retailer. Medical doctors were involved in reviewing teaching materials, and their political support was thus ensured. Teachers were qualified pharmacists who received special training and were monitored. Candidates were evaluated with written, oral, and practical exams. However, no formal evaluation has been conducted, and up to 50% of retailers still lack training. Refresher courses are needed. Donor dependence is a concern.
Training	Pharmacists and drug vendors	Various	Hudelson (1998)	Highlights several interventions undertaken to train private practitioners in integrated management of child health care. In Kenya, shopkeepers were trained in dispensing antimalarials (AMs) and antipyretics (APs), advising purchasers how to administer AMs and APs, and referring patients to a health facility when appropriate to improve home management of childhood fevers. Training sessions for unlicensed drug retailers in Nepal and licensed drug retailers in Kenya, Indonesia, and the Philippines were organized to improve practices regarding dispensing drugs and advising and referring consumers.	Providing training to traditional healers in South Africa and Sub-Saharan Africa highlighted the possibility of improving the quality of services provided by village doctors. All these experiences indicate remarkable improvements in the behavior and practices of private practitioners after undergoing tailored training sessions.
Training	Private general providers	India	Chakraborty, 1998; Chakraborty *et al.*, 2000	A study in Bihar tested the effectiveness of two methods for improving the quality of care provided by private providers to children—the "verbal case review" (a record of providers' case management practices as reported by mothers) and INFECTOM or "Information, Feedback, contracting, and Ongoing Monitoring." Providers received training on proper case management of ARI, diarrhea, and fever. "Contracting" implied obtaining commitment from providers to follow specific guidelines. For the "Feedback" and "Ongoing Monitoring," community health workers monitored 16 selected case management behaviors by interviewing mothers about the providers' practices at village women's organization meetings. The CHWs gave feedback from these "verbal case reviews" to providers.	Participants at the training sessions reported that they found them useful, but too short and not in-depth enough. Many mothers were unaware of quality of care issues, had great respect for their doctors, and often did not believe that doctors could be doing harmful things. Future efforts should investigate how community perceptions may affect the effectiveness of community-based monitoring. However, according to the authors, "results of the study show statistically significant improvements in private providers' history taking, examination and counselling practices for ARI, diarrhoea and fever."

Appendix 3s. Strategies to Work with the Private Sector for Child Health *(cont'd)*

Strategy	Private Sector Component	Countries	Reference	Description	Lessons and Recommendations
Training	Private general providers	India	Sobti, 1988 (unpubl.)	In 1987, the Indian Medical Association (IMA) developed a national ORT training program to improve private physicians' management of childhood diarrhea. About 170 trained IMA physicians conducted sessions of 20 participants each, training almost 22,000 physicians by 1988.	The IMA successfully used its structure to promote the training program, publishing information on the program in its monthly newsletter. An entire issue of the Journal of the Indian Medical Association was devoted to diarrhea. Knowledge and practice among trainees was improved, and over 90% of participants recommended the trainings to
Training	Private general providers and drug sellers	Indonesia	Santoso *et al.*, 1996	A controlled study of different methods for improving the appropriate use of drugs for diarrhea was carried out in six districts of Central Java. Intervention materials were developed based on the results of focus group discussions with local prescribers and consumers. Two intervention groups, one receiving a small-group face-to-face intervention and one a formal seminar, were compared to a control group of prescribers. Both interventions were given on a single occasion. Results were evaluated via pre- and post-surveys at the health centers where the prescribers worked.	Both interventions were equally effective in improving knowledge about appropriate management of diarrhea. The small group format intervention resulted in a greater reduction in the use of antimicrobials than the seminar format, though the formal seminar resulted in a greater reduction in the use of antidiarrheals. The smaller format was cheaper to implement per unit cost.
Training	Private providers	Nigeria	Chukudebelu *et al.*, 1997	Private providers were found to be preferred for obstetrical care by citizens of one region in Nigeria. Reasons for this preference included acceptance of flexible payment schedules, proximity, more reliable availability of a doctor, and the poor quality of government services. In 1992, 15 "health aides" from private facilities, with no formal midwifery training, were trained in the recognition and management of obstetric complications. One week of classroom instruction and two weeks of practical training in a hospital setting were provided.	Practical teaching methods, such as role-plays, were used heavily. Written tests, in-depth interviews, and monitoring were used to assess the intervention. Knowledge scores improved significantly, confidence improved, and supervisors reported significant improvements in case management, record-keeping, and patient interactions. Dialogue with the private sector can lead to improved treatment practices. The success of the intervention will depend on a sustained effort, however. Recommend not using teaching hospitals as training sites.
Training	Private providers—rural	India	Northrup, 1997	BASICs helped to design and implement an intervention to bring the case management practices of selected untrained private village providers in rural India into line with national standards for managing childhood illnesses.	

Appendix 3t. Strategies to Work with the Private Sector for Child Health *(cont'd)*

Strategy	Private Sector Component	Countries	Reference	Description	Lessons and Recommendations
Training	Traditional healers	Ghana	Yeboah, 2000	The Danfa project in Ghana has been described as a success story for information provision to illiterate traditional healers. The project utilized verbal teaching of modern health techniques to these healers, as well as educating villagers about improved traditional medical practices.	
Training	Traditional healers	Philippines (rural areas)	Caragay, 1982	Training of traditional healers (berbolarios) in rural areas—where more than half the villagers were found to seek the services of traditional healers first—included lectures, discussions, demonstrations and practical case review. Results show an increase in knowledge acquisition, but there was no evaluation of the impact on practices.	
Training—detailing	Pharmacies/ drug sellers	Indonesia	Ross-Degnan *et al.*, 1996.	A training guide was developed to enable the National Diarrhea Control Program to identify problems and their causes in pharmacies, using quantitative and qualitative research methods. The guide also facilitates the design, implementation, and evaluation of an educational intervention, which includes brief one-on-one meetings between diarrhea program educators and pharmacists/owners, followed by one small group training session with all counter attendants working in the pharmacies.	In an evaluation of the short-term effects of this intervention in Indonesian pharmacies, knowledge measures showed improvement; sales of ORS increased between 21-30%; sales of antidiarrheals decreased by 15-20%; and increases in discussion of dehydration were noted. The authors concluded that face-to-face training of pharmacists could significantly improve sales and communication practices.



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