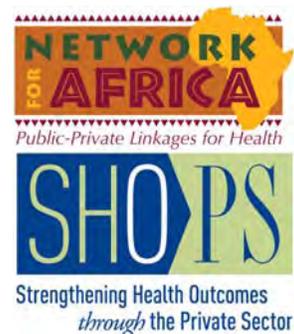




TECHNICAL EXCHANGE ON ENGAGING THE PRIVATE SECTOR TO STRENGTHEN HEALTH SYSTEMS AND ACHIEVE HIV/AIDS GOALS

November 2010

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BACKGROUND

Two global initiatives funded by the United States Agency for International Development (USAID) - Health Systems 20/20 and Strengthening Health Outcomes through the Private Sector (SHOPS) - joined efforts with the International Finance Corporation (IFC) Health in Africa Initiative (HiA) to convene a technical exchange for sub-Saharan African countries on facilitating public-private linkages for health systems strengthening. The technical exchange builds on the USAID-funded Network for Africa (N4A) initiative begun under the Private Sector Partnerships-One project (PSP-One) and continued under SHOPS.

The technical exchange in Mombasa continues a tradition of collaboration between USAID and the IFC to further engage the private sector in addressing health needs in Africa. In 2009 PSP-One and IFC jointly conducted a private health sector assessment in Kenya and continue to coordinate policy reforms in that country. Recently, SHOPS and IFC completed a three day workshop in September 2010, designed for West African policymakers and private sector champions on the role of PPPs in health.

WORKSHOP OBJECTIVES

The purpose of the technical exchange was to: i) share experiences within the region on building public-private partnerships which will contribute to health systems strengthening and improve overall health and HIV/AIDS outcomes; ii) identify key factors and lessons that contribute to effective private sector engagement and that can be applied to partnerships; iii) develop action plans that country teams can implement upon returning home; and iv) using the N4A platform, encourage communication and networking between the workshop participants.

PARTICIPANT PROFILES

Seven countries participated in the technical exchange, including Ghana, Kenya, Namibia, Uganda, Southern Sudan, Tanzania, and Zambia. Most country teams had two public and two private sector participants. The only exceptions were Kenya with more representation from the public sector and Southern Sudan with two private sector members only. In addition, donor organizations such as USAID, the World Bank Group and Italian Cooperation (ITC) sent staff to participate in the technical exchange. Table I provides an overview of workshop participants.

TABLE I: PARTICIPANT PROFILE

Sector	Public	#	Private	#	Donor	#
Type of organizations	MOH (Departments of Finance, Planning and PPP Unit)	6	For-Profit		World Bank	3
			Private providers	6	USAID	4
			Private provider associations	3	Italian Cooperation	1
			Employers providing services	2		5
			Employer associations	1		
	HIV/AIDS	7	NGO		USAID	
NGO associations			3	Implementing Partners		
			FBO		(organizing committee)	
			NGO associations	1		

WORKSHOP CONCEPTS

The technical exchange began with two presentations that helped set the stage for the three-day event. The first presentation provided an overview of **recent trends in private health sector growth and private sector financing and utilization of HIV/AIDS services in Africa**. The presentation concluded that:

- The private sector is already playing an important role in health care financing and provision across the continent;
- The private health sector is growing significantly and this growth is projected to continue;
- Imbalances in the private health sector's development -uneven distribution, variable quality, unethical practices, etc. - must be corrected;
- Private health sector resources remain largely underutilized; and
- Harnessing the potential of private sector resources requires changing public sector roles and fully exercising MOH leadership

The second presentation focused on public sector stewardship and described specific functions and tasks the MOH can assume to engage the private sector. This presentation also offered many of the key concepts used throughout the workshop.

First, there was a discussion on the meaning of stewardship (see Text Box 1). Good stewardship results in a favorable environment so that all actors in the health system make the greatest possible contribution. Stewardship does not mean command and control of all the stakeholders in the health sector, nor that the government maintains the dominant role in all health activities.

Second, the presentation illustrated the **diverse range and contribution of the private health sector to health system strengthening**. As Diagram 1 shows, there are many different private sector actors beyond private healthcare providers in each of the WHO health systems building blocks in a health sector. Participants observed that many of the same private health sector actors are present in multiple building blocks, signifying that working with private sector partners can help strengthen not only one building block but several simultaneously.

As some of the workshop participants noted, the diversity of private sector entities presents a challenge for the public sector because the private health sector is often fragmented and not “organized”. The breadth of private sector actors also presents an opportunity, offering a greater range of PPP possibilities that can strengthen the health system.

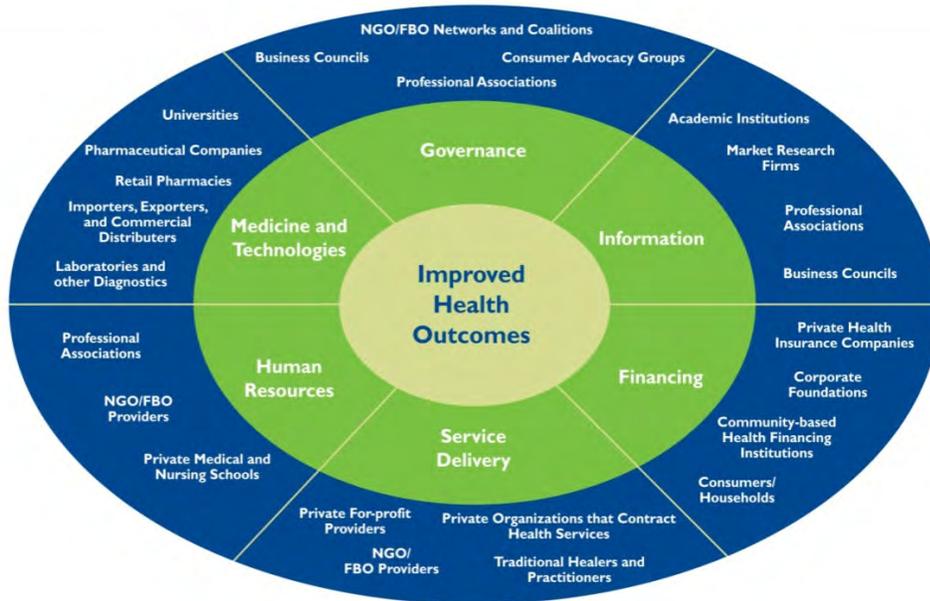
Text Box 1 Stewardship is...

... a government's fundamental responsibility to create a predictable and transparent health market by:

- Providing overall policy direction
- Defining clear roles for public and private sector stakeholders
- Developing and enforcing regulations and quality standards

DIAGRAM 1: PRIVATE SECTOR ACTORS IN A HEALTH SYSTEM

Private Sector Actors by WHO Health System Building Blocks



As Diagram 2 illustrates, there are **multiple tools and approaches to engage the private sector to strengthen the health system**: the mechanism depends on which elements of the health system are lacking. For example, demand side subsidies and vouchers incentivize private providers to deliver specific services at affordable price, thereby helping address both affordability and access to services. The range of tools illustrated in this diagram reveals there are many ways to engage the private sector above and beyond just PPPs, and underscores that most private sector interventions relate to more than one health system building block.

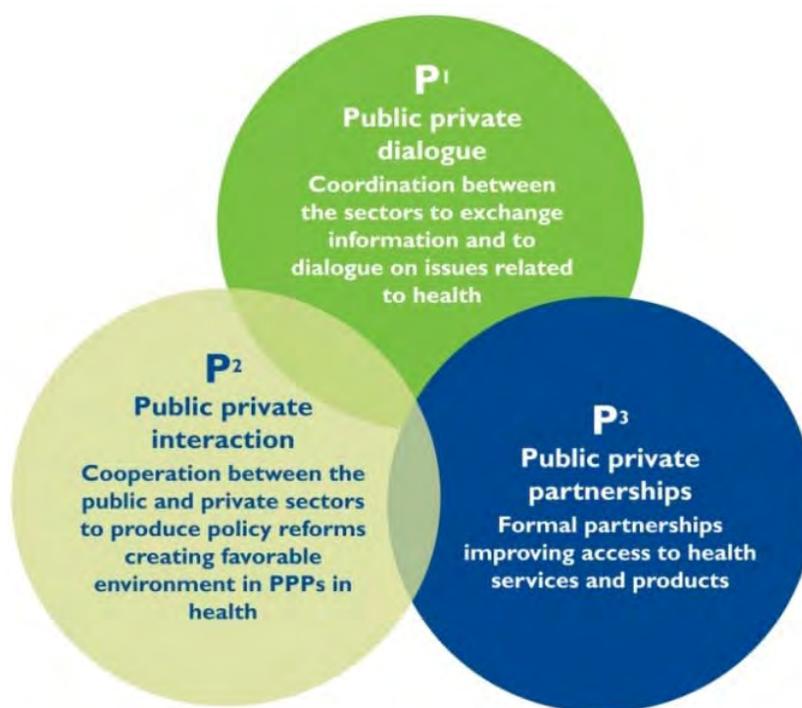
DIAGRAM 2: PRIVATE SECTOR STRATEGIES TO STRENGTHEN HEALTH SYSTEMS



Through the course of the three days, participant discussions confirmed that a wide variety of private sector actors are active in *all* the health systems building blocks in their respective countries, but that the public sector often overlooks their role and contribution. Some participants indicated that showing the range of actors and different strategies – as presented in these simple diagrams - can help the public sector think more strategically about the private sector and how to involve these actors.

Although public-private partnership (PPP) is a “hot” topic in development and donor circles, many workshop participants admitted there is much confusion about the term. Diagram 3 presents a new taxonomy **that captures the range of private sector engagement**, including but not limited to PPPs.

DIAGRAM 3: DIFFERENT LEVELS OF PRIVATE SECTOR ENGAGEMENT



There are three levels of private sector engagement:

P1 Public private dialogue is a process whereby government and the private sector groups exchange views on issues of common concern and interest in the health sector. In effect, the dialogue process gives the private sector “a seat at the table”, in policy and decision making discussions. As the country examples demonstrated (Ghana, Kenya, Tanzania and Uganda), frequent communication and regular meetings foster the relationships needed to overcome mistrust, misconceptions and suspicion between the sectors. The countries beginning to dialogue between public and private sectors - Namibia, S. Sudan and Zambia – commented on the positive results achieved through a more formal dialogue process/forum. **Countries with considerable experience in this area (Tanzania and Uganda) stressed that the need for dialogue never goes away and requires constant work between all sectors to maintain good communication.** Additionally, policy dialogue is even more critical as countries move towards more complicated and formal partnership arrangements under P3.

P2 Public private interaction moves beyond dialogue, and involves coordination between public and private sector on inputs, projects, and activities. Examples include joint supervision of public and private clinics in Tanzania; sharing of commodities and other health inputs to NGO services in Namibia; and sharing training resources and staff in Uganda. Also, the public and private sector begin to tackle harder issues *together* such as reforming policies, drafting new regulations, developing and annual planning processes. There is no formal arrangement or agreement at this stage but the public sector and private sector interact more frequently, resulting in better coordination and integration.

P3 Public private partnership: A PPP is the deepest level of engagement as it involves sharing risks and investments to achieve a common objective. At this stage, most partnerships are codified in a more formal agreement such as MOU, service agreement and/or contract. Such partnerships are operational and involve the delivery of health products and services. Many participants expressed interest in tools and/or handbooks that outline the steps for developing PPPs in health.

The workshop participants then used the “3 Ps” taxonomy in describing the types of private sector engagement in their countries.

Two countries – Zambia and Ghana – introduced a new phrase to describe the commercial, for-profit health sector that gained wide acceptance during the workshop: “self-sustaining” sector. They prefer this new term because it has helped defuse “profits” by stressing how revenues and profits are needed to stay in business. Along these same lines, a Kenyan participant said that the Kenyan government refers to the private sector as “profit sharing”, illustrating how taxes paid on profits help the government raise public revenues that finance key sectors, such as health.

EXPERIENCES FROM THE FIELD

The workshop was organized around several panels of country participants presenting and sharing their experiences. The following are highlights from these presentations and ensuing discussions.

Evidence provides objective content for honest dialogue between the sectors.

Kenya, Namibia and Ghana presented key findings and policy priorities from their private sector assessments (PSAs). All three stressed the importance of having data that objectively describes and quantifies the private sector to facilitate public-private discussions. Tanzania, on its own initiative, also conducted a PSA in 2005 and said the study was an “eye-opener” for the public sector and helped jump start the dialogue between public and private sectors. Two of the countries that do not have a PSA reflected how the assessments helped the countries with PSAs better focus the dialogue and prioritize needed policy actions



Namibia, Kenya and Ghana Public Sector Officials Presenting on their Private Sector Assessment Findings

In addition to PSAs, the workshop participants outlined other important analyses, such as: i) mapping all providers/facilities/services to identify gaps and duplications of infrastructure and services; ii) conducting costing studies in both sectors to compare cost-effectiveness of specific services; and iii) creating an inventory of partnerships (P² and P³) to better understand existing collaboration between the sectors.

Also, many countries shared their experience on how data “helped make the case” with industry and employers to increase their contribution towards healthcare. Namibia, Uganda, and Zambia shared their experiences on how they used data to convince industry to provide HIV/AIDS workplace programs, contribute to the cost of basic health care and purchase health insurance for their employees. Both Namibia and Zambia collected information on the costs of delivering HIV/AIDS services in private facilities and successfully used the data to encourage private health insurance schemes to include HIV/AIDS in their benefit packages.

Genuine dialogue is a necessary condition for successful partnerships between the public and private sectors.

Successful country dialogue processes (Kenya, Ghana, Tanzania and Uganda) share many of the same characteristics (See text boxes 2 and 3). Regular and consistent communication can initially help build

Text Box 2 - Lessons Learned in P¹

What does not work

- Mistrust and suspicion
- Complaints - the “blame game”
- Cherry picking private sector actors to work with

What works

- Communicating frequently, sitting together to discuss and share experience and expertise
- Accepting public sector as “owner” of policies and directives
- Inviting the whole private sector to participate in developing policies and programs
- Active participation by both sectors
- Sharing common vision and commit to providing quality healthcare for all

#

the trust needed to overcome skepticism and suspicion of the private sector. But dialogue is not sufficient. A “formal” forum is needed to ensure that communication is consistent and regular. Some countries have created new entities e.g. (Kenya) PPP-Health Kenya; (Ghana) Private Health Sector Alliance in Ghana (PHSAG) to facilitate dialogue while others have formalized their dialogue forum (Uganda, Tanzania) through regulations. A formal engagement mechanism also assures that the private sector is actively involved in policy and planning.

Text Box 3 - P¹ Values

- Commitment
- Change in mindset
- Positive attitudes
- Integrity
- Political will
- Willingness to learn from each other

In Ghana, Kenya, and Namibia, new PPP forums underscore the need for donor support and technical assistance enable partners to meet regularly and carry out joint activities. Donor assistance can also help the forums establish balanced dynamics between the sectors by agreeing on shared leadership and decision-making and building trust and confidence among sectors. Tanzania – the country with 10 years of experience in public-private dialogue reflected how dialogue is always needed no matter the stage of private sector engagement. Dialogue is even more critical as the partnerships become more complicated and sophisticated.

The private sector needs to “get its house in order” before it can partner with the public sector. These are common experiences in organizing the private sector, as demonstrated by Ghana, Kenya, and Tanzania. FBOs and NGOs are traditionally the first groups in the private sector to organize. These groups often form coalitions and/or umbrella organizations to represent their interests in dealing with the public sector. Gradually, commercial sector organizations (e.g. professional and trade associations) realize they too need to organize and form an alliance and /or coalition. Examples range from the recently formed PHSAG, which represents only the health sector, to the long-standing Kenya Private Sector Alliance (KEPSA) that has federations representing all the key sectors including health in the Kenyan economy. Eventually, commercial sector stakeholders join forces with traditional NGO and/or FBO umbrella organizations to create “power in numbers” that balance representation in discussions with the public sector. Organizing and nominating individuals and/or organizations to represent private sector interests at government meetings helps avoid government “cherry picking” of private sector individuals. The Tanzanian and Ghanaian private sector participants encouraged the private sector not to “wait for an invitation” from the public sector; instead suggesting that the private sector needs to take a lesson from the NGO sector and be proactive and persistent in pursuing the public sector.



Ugandan and Namibian participants comparing notes

A comprehensive policy framework, supported by political commitment, can help make PPPs an integral part of governing the health sector. Countries that have moved from the ad hoc and occasional partnership to more systematic and complex PPPs have both high-level political commitment *and* a comprehensive policy framework guiding PPPs. In many countries, private sector engagement is part of a wider national effort (Kenya, Ghana, Tanzania) and driven by the Office of the

Prime Minister or Ministry of Finance. In other countries, a MOH leader is a champion for working with the private sector.

A supportive policy framework includes: (1) acknowledgement of private sector in an overarching Health Policy/Law; (2) a PPP Law approved by Parliament; (3) MOH Policy/Strategy on PPPs in Health; (4) harmonized standards and guidelines that are applied equally across sectors; and (5) sufficient budget for MOH to enforce policies. In addition to putting these policies and laws into place, private sector participation in developing these policies and regulations can ensure fairness in how the rules are developed and enforced. Below is a preliminary list of the range of policies, law and regulations developed by workshop participant countries.

TABLE 2: PARTIAL LIST OF ESTABLISHED POLICIES IN SELECT COUNTRIES

Ghana	Policies/Laws/Regulations in place	Private Health Sector Policy – 2003 Medium Term Health Strategy that includes role for private health sector Private sector participate in develop of sector policies NHIS open to private sector providers with accreditation and subscription; reimbursement higher for private sector facilities compared to public
	In process of reforming	Ad hoc requests for duty waivers/tax relief on some medical equipment and supplies for private health facilities Strengthening PPP Steering Committee’s dialogue capacity
Kenya	Policies/Laws/Regulations in place	Vision 2030 identifies economic growth through private sector partnerships and health sector as priorities MOMS Strategic Plan (2008-2012) prioritizes PPP as strategy to address access MOMS created PPP Unit Generic PPP policy established by MOF
	In process of reforming	Updating Health Policy Framework, including acknowledgement of private sector role in health sector Streamlining and harmonizing 23 Health Acts. Key areas include updating scopes of practice and facility licensing Strengthening PPP-Health Kenya’s dialogue capacity Finalization of PPP Policy, Charter and Guidelines.
Uganda	In process of reforming	Private Sector Policy draft at Cabinet awaiting for approval Existing generic PPP policy at Cabinet awaiting approval
Tanzania	Policies/Laws/Regulations in place	MoHSW Health Sector Policy – 2007 - full participation of private sector -PPP cross-cutting throughout policy -appoints PPP Steering Committee Health Sector Strategic Plan – 2009 – involves full participation of private sector Developed Services Agreement – 2008 – permitting MoHSW to contract FBOs for key services; extended to commercial providers in 2010 PPP Act approved by Cabinet in 2010 MoHSW approves regulation that government will not build new public facility where private facility exists and can deliver same services MoHSW and private sector develop annual plans that identify roles and responsibilities MoHSW allocates budget to district health so they contract FBO/Commercial providers to deliver specific services
Zambia Zambia	Policies/Laws/Regulations in place	Public Private Partnership Policy of 2007 Public-Private Partnership Act, sponsored by MoF and National Planning and enacted by Parliament in 2009 -established PPP Unit, Council & Technical Committee -Defines projects for PPP and procurement process
	In process of reforming	2 partnerships in health sector in pipeline Center of Excellency Hospital, Lusaka Three diagnostic health facilities in Lusaka, Livingstone and the Copperbelt

There are several P3 level PPPs delivering HIV/AIDS prevention treatment in Africa. One of the key findings is the number and variety of PPPs. As illustrated by Table 3, most of the partnerships receive donor funds, but there are also several PPPs initiated by local partners. As the different panel presentations highlighted, several challenges remain to harnessing private sector capacity.

ARVs are the main cost driver in private sector services.

- Without access to subsidized and/or donated ARVs, private providers cannot decrease their fees.
- Many of the countries at the workshop have a program to accredit and make available ARVs to private providers: Kenya, Uganda, and Zambia.
- Even where MoH offers subsidized ARVs, stock-outs are a major problem. When this occurs, there is no MoH commitment to help private providers address stock-out, forcing private providers to purchase ARVs at retail prices.
- Private providers are seeking creative mechanisms to access lower priced ARVs: (i) partnerships with NGOs to access the drugs, (ii) donations from MoHs, (iii) exploring bulk purchasing at MOH prices.



Panel Participants from Zambia, Tanzania and Namibia Describing P³ Partnerships to Deliver HIV/AIDS Treatment

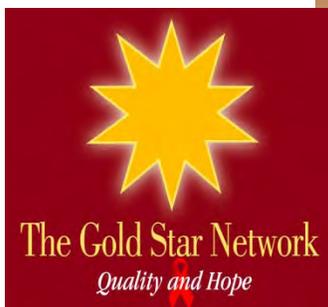
PHOTO GALLERY OF PPPs IN ZAMBIA, UGANDA AND NAMIBIA DELIVERING A RANGE OF HIV/AIDS SERVICES



First Quantum Minerals Mobile ARV units



The UGACOF clinic recently opened to an Ugandan community



Kenya's Gold Star Network



Bophelo! Mobile Clinic, Namibia

Quality and compliance with national standards of care are uneven

Quality in the private sector is still a major concern. There are several factors contributing to variable quality among private providers offering HIV/AIDS services:

- Private sector providers have limited knowledge of their potential role in addressing HIV/AIDS epidemic because the MoH has not involved them in the design and implementation of the National HIV/AIDS Strategy.
- Private providers have limited access to training and medical updates. Private providers' primary sources of information on the latest treatment regimes are Continuing Medical Education hours offered by pharmaceutical detailers and costly specialized training courses. If the public sector invites private sector providers to its training courses, the curriculum often does not respond to private providers' needs and schedule (e.g. evening or weekend hours, length of training, etc).
- Cost and quality of laboratory services are extremely variable, driving the overall costs of and compromising the quality of private health services.
- Private sector providers have limited contact with quality assurance processes. In the case of the public sector, MoHs do not have sufficient resources and staff to monitor private sector compliance with standards. Unless the private provider is associated with a network, franchise or insurance scheme, there are few quality assurance programs offered by professional associations.
- Kenya, Tanzania and Uganda are experimenting with partnership models to address quality in the private sector. In the case of Kenya and Uganda, USAID funded projects (Gold Star and HIPS, respectively) have set up comprehensive programs that offer clinical training, funds to renovate facilities and purchase needed equipment, and on-going supervision through multiple mechanisms (check-lists, job aides, guidelines). In Tanzania, APHFTHA performs similar quality functions. In both Uganda and Tanzania, HIPS and APHFTHA are working with the district level MoH staff to carry out these activities, building public sector capacity to monitor private sector quality.

There is currently a lack of incentives to attract private providers to deliver HIV/AIDS services

- Financial incentives – through vouchers, contracting, risk-pooling – are necessary conditions to motivate private providers to deliver health services at affordable prices.
- The Gold Star presentation clearly identified two challenges to expanding the private



Private Providers Receiving Training in Norplant insertion – HIPS Project in Uganda



Panel Participants from Namibia, Uganda and Tanzania Describing Provider Payment Mechanisms

sector role in HIV/AIDS: i) health coverage for workers is voluntary for employers and ii) HMOs and other medical insurance companies either do not include HIV/AIDS or have limited coverage. Both HIPS and Gold Star are exploring contracting and/or low-cost insurance schemes to address this barrier.

- Tanzania demonstrated that contracting can motivate the private sector to offer certain health services. In 2008, the MoHSW developed services agreements allowing the government to contract for key services (e.g. RH services, HIV/AIDS, children under five, elderly care). The government started with FBOs and later expanded its program to private providers in 2010. To date, 65 private providers offer HIV/AIDS care and treatment. In urban areas, more than 50% of RH services and 30% of HIV/AIDS services are reportedly delivered by private providers.
- Targeted regulations, such as Tanzania’s regulation prohibiting MOH construction of new sites where private (commercial, NGO, FBO) facilities exists, can also be used to encourage private investment to expand into underserved areas.

TABLE 3: OVERVIEW OF PRIVATE SECTOR ENGAGEMENT AMONG WORKSHOP PARTICIPANTS

Country example	Partners	Description
P¹ - Policy Dialogue		
GHANA – Private Health Sector Alliance in Ghana (PHSAG)	Wide membership of private sector orgs Private clinicians, health businesses, training institutions and FBO/NGO umbrella orgs	<ul style="list-style-type: none"> • Recently formed to organize private sector voice • Meets regularly • Starting to form direct relationship with public sector • With MOH help, starting to attend policy and planning meetings
KENYA- PPP – Health Kenya	Equal representation -MoH, MoF (5 persons) -KEPSA (4 persons) -FBO/NGO (4 persons)	<ul style="list-style-type: none"> • Signed a Charter outlining rule of the road • Functions as Board of Directors to advocate for PPPs • Established road map of key areas to be addressed thru policy reform • Meets regularly • Participate actively in policy forums, strategic planning
SOUTHERN SUDAN –dialogue	Ministry of Trade and Industry under SSBF and private sector	Nascent dialogue process between government and private sector Formed Working Group on financial sector
P² – Interaction and Coordination		
KENYA –policy reform	Public sector, private sector and donors MOH, WHO and PPP-HK	<ul style="list-style-type: none"> • Developed and agreed on healthcare financing strategy that includes different mechanisms – vouchers, contracting, mixed health insurance – remove economic barriers to healthcare • MOU with private universities on training health workers • MOU with FBO hospitals for provision of staff and commodities. • MOHS established Legal Reform Committee to drive update and modifications to policy framework
UGANDA– Policy reform and planning	MOH and private sector	<ul style="list-style-type: none"> • Public and private sector representatives finalizing PPP Policy which is ready for Cabinet approval • Promoting joint planning at district level • Revision of allocation criteria for subsidies and provision of drugs to private sector partners

Country example	Partners	Description
TANZANIA – policy framework	PPP Technical Working Group, CCM, PPP Steering Committee, HIV/AIDS Technical Working Group	<ul style="list-style-type: none"> Public and private sector representatives (CSCC, AFHFTA) put into place framework that defines, recognizes and fosters private sector contribution: i) National PPP Policy; ii) National PPP Act; iii) PPP Strategy and iv) new guidelines
NAMIBIA – Bophelo!	MoHsS Private companies Pharmaccess	<ul style="list-style-type: none"> MoHsS donates key inputs (e.g. vaccines, testing kits, medical equipment) to mobile units Private companies donate trucks and pays for services rendered to employees
NAMIBIA -	MoHsS and NABCOA	<ul style="list-style-type: none"> In Global Fund Round 2 and RCC, MoHsS and MoE second staff to private sector implementers including NABCOA
UGANDA – Kakira Sugar Works	Kakira Sugar work and MoH	<ul style="list-style-type: none"> Kakira Sugar clinic’s expanded services to include medical male circumcision, school HIV prevention programs and workplace based SME program MOH provided training, medical equipment & IEC
TANZANIA – coordination	MoHsS and Association of Private Health Facilitation of Tanzania (APHFTA)	<ul style="list-style-type: none"> MoHsS second staff to private sector facilities MoHsS and APHFTA conduct joint supportive supervision visits APHFTA and district-level MoHsS management develop joint plans and coordinate activities, resources MoHsS pledges NOT to build new facilities when private and/or FBO/NGO facility exists
	MoHsS and Christina Social Services Commission	<ul style="list-style-type: none"> MoHsS assists FBO health services by providing grants for staff, beds, drugs and supplies. Also MoHsS second staff in FBO facilities
ZAMBIA coordination through SWAP	Zambian government and civil society	<ul style="list-style-type: none"> Coordinate health services between public and not-for-profit facilities Offer clinical training to not-for-profit providers
P³ –Programmatic PPPs		
KENYA – Gold Star Franchise	NASCOP, Kenya Medical Association, PharmAccess, FHI	<ul style="list-style-type: none"> MoH/NASCOP makes available guidelines and standards; offers mentors and trainers; donates commodities (drugs, condoms, test kits) Gold Star/FHI certifies and accredits franchise providers; assures quality of network providers; promotes and markets network; offers management support
KENYA – National Aids Commission (NACC)	NACC and private manufacturers	<ul style="list-style-type: none"> NACC and local manufacturing companies exploring PPP to manufacture condoms and other latex-based medical products at affordable prices
NAMIBIA – Rosh Pinah	Rosh Pinah mining company and MoHsS	<ul style="list-style-type: none"> Proposed partnership will give public patients access to mine-operated medical facilities and basic diagnostic equipment (X-ray, ultrasound) not available at the nurse-staffed public clinic. Agreements are close to completion.
TANZANIA - Service Agreements Access to finance	MoHsS and private providers (thru APHFTA) APHFTA and commercial banks	<ul style="list-style-type: none"> MoHsS contracts-out with private and NGO/FBO providers to deliver PHC services APHFTA helps private providers respond to RFPs, strengthen business skills, upgrade clinical skills APHFTA offers low-interest loans to private sector providers to expand

Country example	Partners	Description
		services and improve quality
UGANDA – HIPS	Network of private providers and MOH, DHT	<ul style="list-style-type: none"> MoH supplies guidelines and standards; includes providers in training; donates commodities (drugs, condoms, test kits) HIPS certifies and accredits providers; assures quality of network providers in coordination with MOH; helps promote providers through community outreach activities (e.g. health fairs)
UGANDA – Niles Breweries	MOH, CSO and Niles Breweries	<ul style="list-style-type: none"> Niles Breweries partners with MOH and/or CSOs to deliver its work place programs (VCT and ART treatment) to employees and communities
ZAMBIA - Total Trust Hospital and NGOs	Private hospital and local NGOs Private to private partnership	<ul style="list-style-type: none"> To lower cost of private sector HIV/AIDS treatment, Trust Hospital entered into agreement with NGO to obtain subsidized ARVs NGO provides lower cost ARVs and test kits while Trust Hospital offers infrastructure, equipment, and competent staff Trust Hospital convinced private insurance to include HIV/AIDS treatment and care as benefit package resulting in 100 companies offering health insurance that now include HIV/AIDS benefits

As the country examples demonstrate, the range of private sector engagement also contributes to strengthening the health system. P¹ and P² help strengthen government capacity to govern and steward the health sector by including the diverse range of stakeholders in policy (Kenya, Tanzania, Uganda and Zambia), planning (Tanzania and Zambia) and dialogue (Ghana, Kenya and Tanzania). Greater coordination - P² – also helps address health system gaps such as lack of sufficient human resources (Kenya), and improving access to medicines and technology (Namibia, Kenya, Uganda and Tanzania). P³ helps address barriers to health services such as access and affordability (Kenya, Namibia, Tanzania, Uganda and Zambia).

CONTINUUM OF PRIVATE SECTOR ENGAGEMENT

The participating countries have varying levels of experience in working with the private sector. Although the countries are at different stages of private sector engagement, they all go through similar processes to create conditions for fostering private sector engagement. Based on country experiences that emerged from the presentations and discussions at the workshop, these factors can be organized into five areas:

1. Deliberate and formal dialogue process that is sustained no matter the stage of private sector engagement
2. Increasingly organized and structured representation of the not-for-profit and for-profits health sectors
3. Comprehensive policy framework that articulates high-level support for partnerships and defines what circumstances the public sector will partner with the private sector
4. Financial and other incentives (e.g. regulations that creates regulations and guidelines that apply equally to all sectors) that create favorable market conditions
5. Growing and dynamic private sector

Below is a classification of the participating countries according to level of and stage in private sector engagement (See Diagram 4). Table 3 offers a description of the status of the environmental factors and private sector trends in each stage. It is important to note that the factors outlined in this table are not based on empirical evidence but are derived from country participant discussions.

DIAGRAM 4: ILLUSTRATIVE COUNTRY PLACEMENT ON PRIVATE SECTOR ENGAGEMENT CONTINUUM

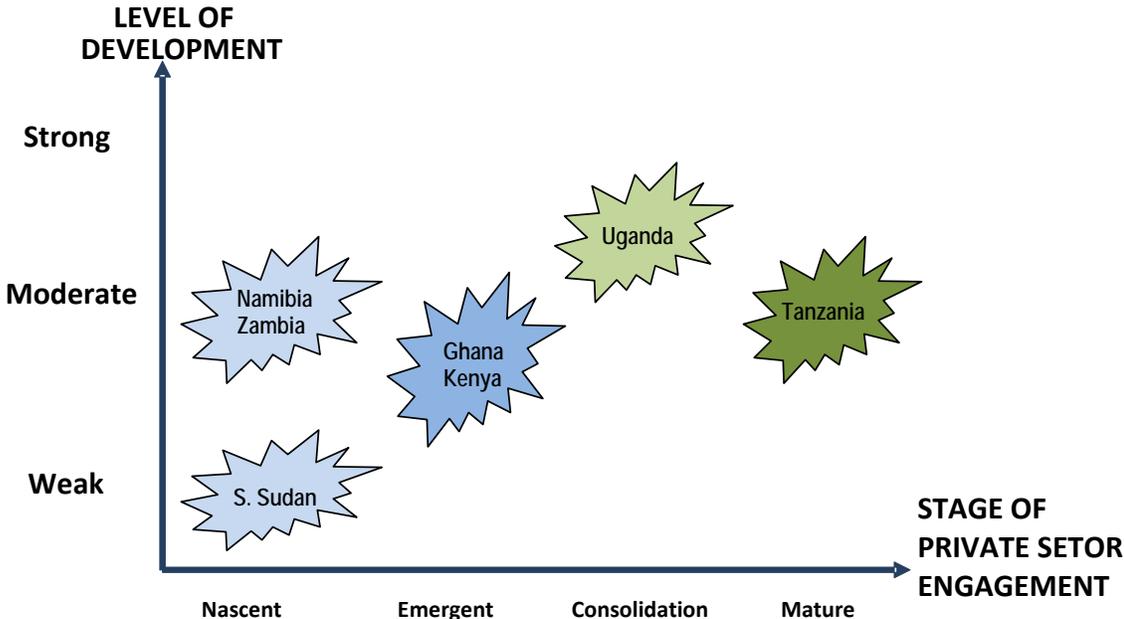


TABLE 4: STAGES OF PRIVATE SECTOR ENGAGEMENT

STAGES			
Nascent	Emergent	Consolidation	Mature
CRITERIA			
<p>Widespread mistrust and suspicion Public and private sector operate in separate spheres, with occasionally interaction Private sector begins to organize – FBOs /NGOs form umbrella organizations and private Some attempt to organize by creating alliances between provider associations</p>	<p>Misgivings on private sector linger but some openness among gov’t leadership Assessment on private sector activities conducted Private commercial sector attempts to organize by creating alliances between provider associations Gov’t “cherry picks” private sector representatives, inviting to occasional meeting</p>	<p>Carries out more in-depth and/or targeted analysis (e.g. facility mapping, market analysis, inventories of PPPs) Private sector creates “united voice”, moving beyond providers to other actors in health sector and joins forces with NGO/FBO organizations Gov’t forms more formal dialogue mechanism to engage all actors on somewhat regular basis</p>	<p>Consistent and frequent communication between sectors on wide range of health sector issues, ranging from policy and planning, to joint problem solving, to strategies Gov’t continues to collect data on private sector to inform policy and PPPs Based on dialogue and consensus, private sector regularly shares information with gov’t</p>
<p>Conflicting laws and regulations creating barriers to entry</p>	<p>Growing gov’t awareness of need to engage private sector MOH assigns staff to work with private sector</p>	<p>Through dialogue process and private sector engagement, gov’t drafts policy and regulatory framework supporting PPPs Gov’t grows internal capacity to work with private sector</p>	<p>Policy framework in place Gov’t consolidates its capacity to steward private sector engagement, authorizes staff and allocates budget to transact with private sector and monitors PPPs</p>
<p>Ad hoc cooperation between sectors – primarily NGOs and/or FBOs</p>	<p>FBOs /NGOs umbrella organizations pro-actively coordinate with and government on informal basis (e.g. public donates supplies, pays FBO/NGO and/or second MOH staff at FBO/NGO facilities Some FBOs /NGOs able to formalize coordination with MOH through MOUs Gov’t and commercial sectors begin to coordinate and share resources based on identified need and personal networks</p>	<p>Gov’t explores some form of public-private coordination with commercial sector based on strategic interests FBOs /NGOs manage to formalize MOH coordination through MOUs Gov’t contracts and pays FBOs/ NGOs for services Gov’t experiments with innovative financing (e.g. vouchers, risk-pooling) to address economic access to health</p>	<p>Gov’t assesses cost-benefits of PPPs Gov’t transacts FBO/NGOs for variety of activities (infrastructure development, management and staffing, service delivery, manufacturing commodities) Established risk-pooling and other financing strategies in place, creating financial incentives for private sector</p>
COUNTRY RANKING			
<p>Namibia Southern Sudan Zambia</p>	<p>Ghana Kenya</p>	<p>Uganda</p>	<p>Tanzania</p>

Namibia, S. Sudan and Zambia – Although these countries have very different private health sector markets they are classified as nascent because the public sector has limited interactions with the private sector. While there is a dynamic and sizable private sector in Namibia, the government still perceives it can “go it alone”. Recently, the Namibian government is beginning to realize that it may need to leverage private sector resources due to declining donor funding. In the case of S. Sudan, the public sector capacity is weak and therefore unable to interact with the private sector. Zambia has a PPP policy but lacks the political will to implement it. The private sector in Zambia is still small relative to other countries in the region.

Ghana and Kenya are at emergent stage. They have both recently conducted private sector assessments which have helped galvanize government support for working with the private sector, and identified priority areas for private sector contribution. The private sector groups– both for- and not-for-profit - have organized and meet regularly with the public sector to work on priority areas. The policy environment, however, still presents several obstacles to a greater private sector role including lack of political will, conflicting regulations, and MoH limitations. The two Kenyan MoHs have launched an initiative to update the Health Policy Act that will acknowledge private sector role in the Kenyan health system and harmonize the more than 20 existing Health Acts.

Uganda is consolidating its capacity to engage the private sector and becoming more systematic in its private sector partnerships. Uganda has a long history of working with the private health sector. Ten years ago the Italian Cooperation assisted the MOH to draft a PPP Policy which is now awaiting Cabinet approval. The Italian Cooperation provided technical assistance to develop MOH capacity to partner with the private sector through creating and training of PPP Unit staff. There are frequent interactions and strong coordination between sectors, with a growing number of P3 level PPPs.

Tanzania has a mature private sector approach. With over 10 years of experience, the Tanzanian stakeholder groups are well organized into umbrella organizations representing the NGO, FBO and commercial sectors. The MoHSW actively engages these groups in almost every aspect of its daily operations, such as policy development, strategic planning, annual planning, collaborative supervision of private facilities to and contracting private sector to deliver specific services. The respective roles and responsibilities for each sector are clearly defined and acknowledged. The MoHSW has developed internal capacity to engage the private sector and created the policies and procedures to contract the private sector.

DONOR SUPPORT

Although many of the PPPs presented at the workshop were initiated by local partners, international donors have played an important role in creating an enabling environment, providing technical assistance and contributing seed funding for partnerships. For example, GTZ, ITC, USAID and the World Bank have funded important analyses (e.g. private sector assessments, health system assessments, National Health Accounts, legal and regulatory reviews, costing studies, Demographic and Health Surveys) to help inform the policy process and private sector role. The same donors have also funded local institutions, helping build their capacity to assume their partnership roles. In addition, USAID, ITC and the World Bank provide technical assistance to PPP advisors/departments housed within Ministry of Health/Finance. GTZ has funded private sector entities, like NABCOA and APFHTA, to strengthen their representative roles. IFC has provided financing to governments to purchase bundled services (facility, staff, supplies, equipment), often from the private health sector. Workshop participants encouraged donors and foundations to think creatively about how to continue to support the different sectors – public, private and not-for-profit – to better work together in partnership.

Text Box 4 - Regional World Bank Project

World Bank has approved \$US 65 million to establish a regional network of laboratories – public and private – to diagnose and monitor TB and other communicable diseases. The project will:

- Support 25 satellite laboratories in cross border areas
- Provide referral services, and
- Strengthen public health lab capacity

Areas for PPPs include: strengthening existing partnerships with private clinical and support services and opening access to training, accreditation and information for the private sector

CROSS-CUTTING THEMES

There were two cross-cutting themes that emerged throughout the presentations:

- **Importance of including consumer voices:** Many participants stressed the need to involve community groups and consumer perspectives. Concrete ideas included: i) adding a consumer perspective into current initiatives to update policy frameworks and regulations; ii) understanding community needs to ensure private providers are responsive to their needs; iii) learning why consumers often prefer the private sector.
- **Scalability and sustainability:** Many of the PPPs presented during the workshop are small in size and/or do not have large-scale reach (geographic coverage and/or number of people). There was much discussion and agreement on the need to not only document the growing number of PPPs in HIV/AIDS, but to also explore strategies to take them to scale. Tanzania – through its systematic contracting of FBOs and now commercial providers, and Ghana – through its national health insurance scheme - offer promising approaches on how to take PPPs to scale.

In addition to going to scale, there were many discussions about sustainability. First, both public and private participants agreed that working with the private health sector is a key sustainability strategy, enabling governments to harness local resources, infrastructure and expertise. Second, many participants discussed ideas on how to leverage donor resources as investments to build systems and grow PPPs.

Also, the Tanzanian country action plan to create new health workers through private medical institutions prompted discussions on how to leverage donor funds. Originally, the country team proposed 2 million US dollars to produce needed mid-level health workers to cover the costs of training materials, books, desks, books, etc. Private sector participants suggested that instead of using the funds to buy “inputs,” donors could fund student tuition to attend these private institutions for a certain period of time. With this steady revenue stream, the private institutions could then go to a commercial bank and get a loan to purchase the same inputs. The leveraged donor funds would create a “win-win” for the students and private medical education institutions.

NEXT STEPS

The Mombasa Workshop participants expressed a commitment to not only apply some of the lessons learned at the workshop but to also stay in contact with each other to continue sharing experiences and expertise. Towards that end, the organizing committee has agreed to:

1. Draft and circulate a Workshop Report to all the participants for their comments.
2. Establish a mechanism using internet technology by which the participants can communicate with each other. The organizing committee will also use this site to post all the workshop materials, country action plans, and additional references.
3. Follow-up in three months (February, 2011) with each of the country teams to monitor progress on the country action plans
4. Identify specific opportunities for continued learning through south-to-south technical assistance and study tours.

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ANNEX TWO: AGENDA OVERVIEW

ENGAGING THE PRIVATE SECTOR TO STRENGTHEN HEALTH SYSTEMS AND ACHIEVE HIV/AIDS GOALS WORKSHOP OVERVIEW

Time	Tuesday – November 9	Time	Wednesday – November 10	Time	Thursday – November 11
8:30-9:00	Opening ceremony MOMS and MOPHS; World Bank Group; USAID MC Opening Ceremony: Khama Rogo	8:30-8:45	Welcome Review of day's agenda MC: John Osika	8:30-8:45	Welcome Review of day's agenda MC: Khama Rogo
9:00-9:15	Welcome, review of agenda and participant introductions MC: Barbara O'Hanlon	8:45–10:15	Module #5: Elements of successful private sector engagement: fostering dialogue (P1) Panel presentations and plenary Q&A Kenya – PPP Health Kenya (W. Okok) Ghana – Private Health Sector Alliance (L. Northey) Tanzania – Joint planning between APHFTA & MOH (S. Ogillo) Moderator: Barbara O'Hanlon	8:45–10:15	Module #8: Case Studies on how to ensure the quality of private sector HIV/AIDS services Uganda – HIPS Project (K. Dithan) Kenya – Gold Star (J. Adungosi) Presentation and Q&A in plenary Moderator: John Osika
9:30-10:15	Module #1: Why work with the private health sector? Trends in private sector financing and utilization of HIV/AIDS and other health services in Africa Presentation and Q&A in plenary Presenter: Khama Rogo				
10:15-10:30	Coffee Break	10:15-10:30	Coffee Break	10:15-10:30	Coffee Break
10:30-11:15	Module #2: Strengthening health systems by engaging the private sector: public sector stewardship role Presentation and Q&A in plenary Presenter: John Osika	10:30-12:00	Module #6: Private sector interactions leading to favorable market conditions (P2) Panel presentations and plenary Q&A Kenya – OBA scheme for FP (N. Gitonga) Uganda – SIMS scheme (S. Sentumbwe) Namibia – Vitality Medical Aid (I. De Beer) Tanzania –APHFTA (S. Ogillo) Moderator: Nelson Gitonga	10:30-12:00	Working Group Session #3: Preparing to “make the case” for PPPs Task #3: Summarize and prepare proposal of private sector engagement to pitch to panel of judges Facilitator: Barbara O'Hanlon
11:15 – 12:45	Module #3: Country perspectives: Key findings from private sector assessments in Ghana, Kenya, Namibia, and Uganda Panel presentation and plenary Q&A Ghana: (M. Martey) Kenya: (L. Kochola) Namibia: (J. Etuwat) Uganda: (TBD) Moderator: Nelson Gitonga				



ENGAGING THE PRIVATE SECTOR TO STRENGTHEN HEALTH SYSTEMS AND ACHIEVE HIV/AIDS GOALS WORKSHOP OVERVIEW

Time	Tuesday – November 9	Time	Wednesday –November 10	Time	Thursday – November 11
12:45-13:45	Lunch	12:00-13:00	Lunch	12:00-13:00	Lunch
13:45-14:45	Working Group Session #1 Bridging the divide between public and private sectors to partner on health systems strengthening and HIV/AIDS Each sector conducts self-assessment to identify challenges to partnering and effective solutions to address them Facilitator: Barbara O’Hanlon	13:00-14:30	Module #7: PPPs to deliver HIV/AIDS services and products (P3) Namibia- BOPHELO! (I. De Beer) Tanzania – CSSC (J. Balati) Zambia – FQM (G. Musanka) Zambia – Trust Hospital (M. Siwale) Moderator: Khama Rogo	13:00-14:45	Working Group Session #4 Pitching group PPP proposals to donors and MOH officials Task #4: Country groups deliver proposal to panel of judges Facilitator: Barbara O’Hanlon
14:45-15:00	Coffee Break	14:30-14:45	Coffee Break	14:45-15:00	Coffee Break
15:00- 15:45	Working Group Session #1 (Continued) Exchange of ideas and finding common ground Facilitator: Barbara O’Hanlon	14:45-16:45	Working Group Session #2 Identifying when to partner with the private sector and designing a PPP	15:15-16:30	Working Group Session #4 (Continued) Country groups deliver proposal to panel of judges
15:45-16:45	Module #4: Donor support of private sector engagement to strengthen health systems and meet HIV/AIDS objectives USAID, GTZ and IFC Presentation and Q&A in plenary Moderator: Khama Rogo	14:45-15:45	Task #1: Identify and agree on health system gaps in HIV/AIDS appropriate for private sector to address	16:30-16:45	Workshop evaluation Policy Toolkit Survey
		15:45-16:45	Task #2: Design the most feasible private sector approach to address the identified health system gaps Facilitator: Barbara O’Hanlon	16:30 – 17:00	Closing remarks MOMS, MOPHS, NAC MC: Khama Rogo
16:45-17:00	Wrap up day MC: Barbara O’Hanlon	16:45-17:00	Wrap up day MC: John Osika	17:00 -17:15	Workshop Closure



