

Africa Region Human Development  
Working Paper Series

# Trends and Opportunities in Public-private Partnerships to Improve Health Service Delivery in Africa

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# Acknowledgements

**F**inancial support from a Dutch Trust Fund, an Irish Trust Fund, and from USAID through the Sara Project was provided to carry out this study and is gratefully acknowledged.

The following people contributed greatly to this report as participants to the “Workshop on public-private partnership for health in Africa,” which took place June 28–29, 2004, in Nairobi, Kenya, with the intention to provide inputs to the first draft of the present paper, and the authors are most grateful to them:

*From the NGO sector:*

Philibert Kankye, Christian Health Association of Ghana (CCHAG), Ghana

Ibrahim Aliou Sall, Reseau Sante Sida Population/Conseil Appui Developement, Senegal

Magatte Wade, Agetip, Senegal

Peter Lochoro, Uganda Catholic Medical Bureau, Uganda

Michelle Folsam, Christy Hanson, PATH International

*From the private sector:*

Edwin Muinga, Sam Thenya, Kenya Association for Private Hospitals, Kenya

S. Ochiel, Kenya Medical Association, Kenya  
Jagi Gakunju, AAR, Kenya

Solomon Orero, KMET, Kenya

J. J. Wirima, Mwaiwathu, Private Hospital, Malawi

K. Jameson Makemele, SUKA Healthcare, South Africa

Jubi C. Nxumalo, SMM Healthcare, South Africa

P. Rugarabamu, HKMU Hubert Kariuki Memorial University, Tanzania

S. M. A. Hashim, Association of Private Hospitals in Tanzania

Harold Bisase, Uganda Private Medical Practitioners Association, Uganda

Nina Shalita, Sarah Nabembezi Uganda Private Midwives Association, Uganda

*From the public sector:*

James Nyikal, Director of Medical Services Nairobi, Ministry of Health, Kenya

Bande Karim, Hien Thadde, Zoungnanne Agathe, Ministry of Health, Burkina Faso

Cecilia Bentsi, Ministry of Health, Ghana

L. Ofosu, SPMDP, Ghana

Mame Cor Ndour, CAS/PNDS, Ministry of Health, Senegal

R. Eddie Mhlanga, University Kwa-Zulu Natal, South Africa

George Bagambisa, Ministry of Health, Uganda

The authors would also like to thank Kim Beer, Moncef Bouhafa, François Diop/Abt Associates, Mohsen Farza, Elisabeth Sommerfelt and the following colleagues from the World Bank: Eric de Roodenbeke, Gilles Dussault, April Harding, Kathy Khu, Benjamin Loevinsohn, Elsie Lauretta Maka, Oscar Picazo, Alexander Preker and Khama Rogo for their constructive comments and contributions.

**The findings, interpretations, and conclusions expressed in this paper are entirely those of the authors. They do not necessarily represent the**

**views of the World Bank Group, its Executive Directors, or the countries that they represent and should not be attributed to them.**

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# Foreword

**T**here is a growing awareness concerning the importance of the private sector in the provision of health services in sub-Saharan Africa. Private sector providers can range from traditional healers, informal drug vendors and private for-profit providers, to non-governmental organizations and community groups. Whether it is through an offer of lower cost, the provision of higher quality care, or a greater sensitivity to patients mistrustful of public institutions, private providers are often chosen by Africans of all socio-economic backgrounds in need of health care above government health services. This strong patronage, in combination with the expenditure of the private sector for health service provision, constitutes more than 50% of total health expenditures for many sub-Saharan African countries and shows that there may be more money flowing within the health sector than has been traditionally accounted for. As this paper illustrates, without greater cognizance as to the extent of private health services and the ability of African patients to choose them, any analysis and design of health systems will be incomplete.

It has been recently recognized in the World Development Report 2004 and the paper "Improving Health, Nutrition and Population Outcomes in sub-Saharan Africa: The Role of the World Bank", that when incorporated judiciously into national health plans, the private sector can be an efficient and effective complement to the existing public health services. Interventions such as national health insurance schemes, vouchers, tax exemptions, accreditation, franchising, contracting, and concessions are just a few of the possibilities for public-private partnerships in health. Although generally recently introduced and evaluated in various sub-Saharan African countries, there have been numerous successes and lessons learned upon which to build. There is much work to be done to improve progress toward attainment of the health-related MDGs, and it will thus be imperative to fully utilize all the means at our disposal.

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## List of Acronyms

AED	Academy for Educational Development	IT	Information Technology
BOO	Build-Own-Operate	MD	Medical Doctor
BOOT	Build-Own-Operate-Transfer	MDG	Millennium Development Goals
BOT	Build-Operate-Transfer	MHO	Mutual Health Insurance Organization
CBO	Community Based Organization	MOH	Ministry of Health
DHS	Demographic and Health Survey	NGO	Non-Governmental Organization
GIE	Groupement d'Intérêt Economique (legally formed entity of people who can be contracted for services)	OBA	Output-Based Aid
HIPC	Highly Indebted Poor Countries	OECD	Organization for Economic Cooperation and Development
HIV/AIDS	Human Immuno-Deficiency/ Acquired Immuno-Deficiency Syndrome	OOP	Out-of-pocket expenditures
IDA	International Development Association	PNFP	Private Not for profit
IFC	International Finance Corporation	PPP	Public-private partnerships for health services
ILO	International Labor Organization	SSA	Sub-Saharan Africa
		STD	Sexually Transmitted Disease
		USAID	United States Agency for International Development
		WHO	World Health Organization
		ZHAC	Zambia Health Accreditation Council

## Executive Summary

**T**he report, in its first part, destroys three common myths regarding the private health care sector in Africa:

- First, that the private sector is for the rich and the public sector for the poor. As demonstrated here, the poorer segments of the population do use the private sector extensively, and the public sector does substantially subsidize richer people who use its services.
- Second, that health is mainly financed by the public sector. In fact, the public sector finances less than half of total health expenditures. The rest is being financed from out-of-pocket, which goes primarily to buying services from the private sector. In most African countries, the private sector plays a more significant role than government, especially when compared to OECD countries where public financing provides the majority of resources.
- Third, that the private sector is not very developed in most African countries. In fact, in most countries the private sector provides a third or more of all health services.

Yet, in Africa most governments and aid organizations focus on public delivery of health services.

So, how to engage the private sector effectively? The second part of this report tries to answer with examples of some successful public-private partnerships (PPPs), using the broad definition of PPPs in health as any formal arrangement between government and a private entity established for the purpose of providing health services. The report also highlights some of the new trends in public-private partnerships and how to make use of opportunities which present themselves. Finally, it identifies what governments, the private sector, and the World Bank Group could do better.

It's clear today that unless one considers the health system in its entirety, the full spectrum of options for improving health outcomes will not be utilized. Considering the limitations on public health budgets and the reality of out-of-pocket spending flowing toward the private sector, it is time to bring the private sector into the fold as an ally in the struggle to provide higher quality services to a greater number of people. PPPs are a way to optimize the use of available resources.

It is expected that the information in this paper will be updated every two years or so, as more evaluation data become available and as more public-private partnerships are implemented.



# Why Focus on Public-private Partnerships in Africa?

**I**n this report, private sector providers are understood as any service providers who are not from the public sector. In particular, they include private for-profit providers, traditional healers, NGOs, community groups, and informal drug vendors. There are three myths regarding the private health sector in Africa:

- First, that the private sector is for the rich and the public sector for the poor. As demonstrated in this report, the poorer segments of the population do use the private sector extensively, and the public sector does substantially subsidize richer people who use its services.
- Second, that health is mainly financed by the public sector. In fact, the public sector finances less than half of total health expenditures. The rest is being financed from out-of-pocket, which goes primarily to buying services from the private sector. In most African countries, the private sector plays a more significant role than government, especially when compared to OECD countries, where public financing provides the majority of resources.
- Third, that the private sector is not very developed in most African countries. In fact, in

some countries the private sector provides half of all health services, and in most countries it provides about one third of services.

Yet, in Africa most governments and aid organizations focus on public delivery of health services.

## The Facts which Destroy the Myths

### a. Who uses the private sector and who uses the public sector?

Most people in Africa spend their health care money on private services, as Graph 1 shows for two countries. In addition, the rich seem to often benefit more from the public sector than the poor. This was shown in a benefit-incidence analysis undertaken in Guinea, where it was found that only 20% of those defined as poor benefit from MOH spending on health care, in comparison to 35% of those defined as rich. One of the main reasons public spending is pro-rich is that the rich mostly benefit from MOH spending on equipment-intensive hospitals and tertiary care facilities which cater to the urban elite. The Guinea data indicate that 40% of MOH spending on hospitals entirely benefits 20% of the rich,

while 40% of the poor benefit from only 14% of MOH spending on hospitals<sup>l</sup>.

Similarly, in Mauritania, benefit-incidence analysis showed that 40% of the richest people consume 72% of public subsidies given to hospitals, while the 20% poorest people only benefit from 2% of those subsidies. The situation is more equitable for subsidies to primary care, where 53% of public subsidies for primary care are consumed by the richest 40%, and 11% of public subsidies for primary care are consumed by the poorest 20%<sup>ll</sup>. This is not a situation unique to those two countries, and it can be found in many other African countries when such benefit-incidence analysis is undertaken.

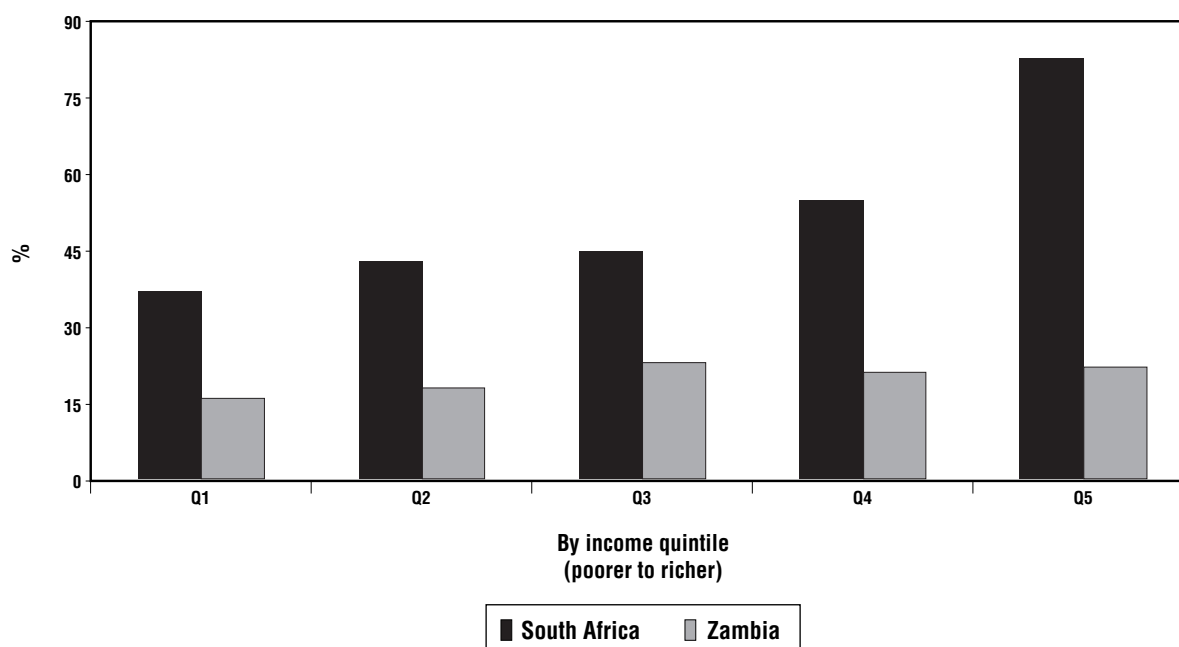
Graph 1 clearly shows that richer population groups disproportionately use private providers. However, more importantly, it shows that a large

proportion of the two poorest quintiles also use private providers, around 17% in Zambia and 40% in S. Africa.

## b. Who finances health in Africa?

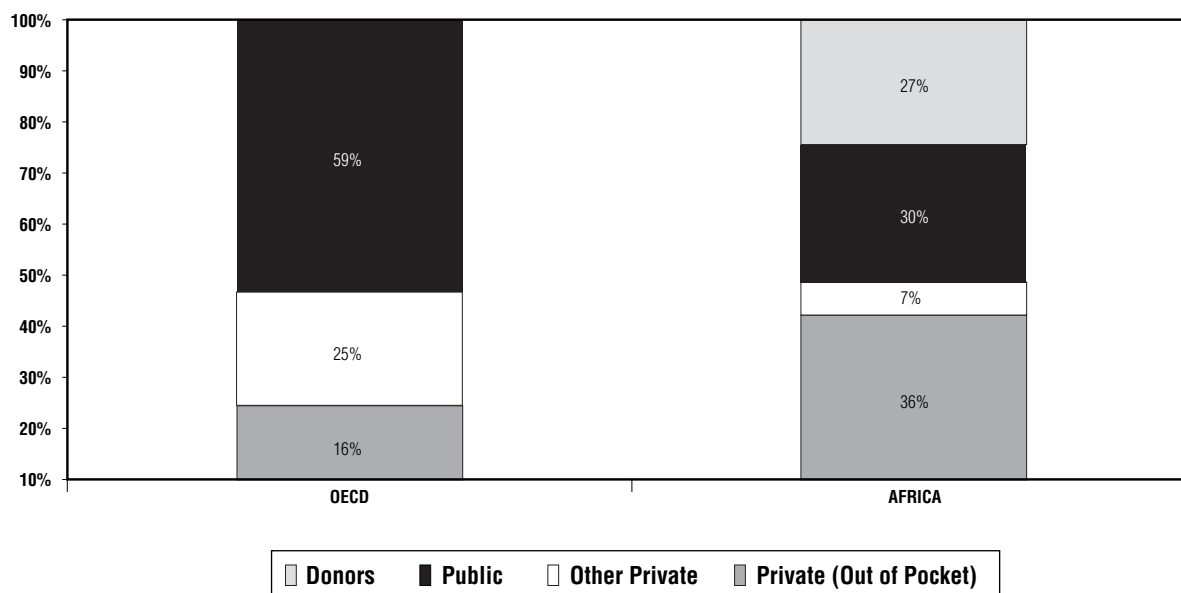
About half of health expenditures in Africa are private<sup>lll</sup> as Graph 2 shows. One should note that the Africa part of this graph is based on data from only 10 Eastern and Southern African countries. Data from other countries has not been analyzed. However, data from Guinea shows that donors contribute 47% of *public* expenditures on health. Since public expenditures constitute 9% of all health expenditures (Table 1), donors provide around 4% of *all* health expenditures, which is much lower than what we see in the graph for Eastern and Southern Africa. Graph 2 is thus a conservative

**Graph 1**  
**On use of private services for different symptoms**



**Source:** M. Makinen et al, "Inequalities in health care use and expenditures: empirical data from eight developing countries and countries in transition," Bulletin of the WHO, 78 (n.b., data was analyzed for only two African countries), 2000.

**Graph 2**  
Sources of total health expenditures in 24 OECD and 10 Eastern & Southern African countries



**Sources:** for OECD: World Health Organization. The World Health Report 2002, Annex 5: Selected National Health Accounts indicators for all Member States, estimates for 1995 to 2000. Geneva; and World Bank, 2002. World Development Indicators 2002. World Bank, Washington DC. For Africa: National Health Accounts in Eastern and Southern Africa: a comparative analysis, ESA NHA Country Teams, 2000, estimated for 1997–98.

estimate of private spending, which is probably higher in other African countries.

If one considers both private and public spending, it becomes obvious that there are lots of resources spent on health care, much more than the per capita minimum health service package cost of US\$13 per year, as Table 1 shows.

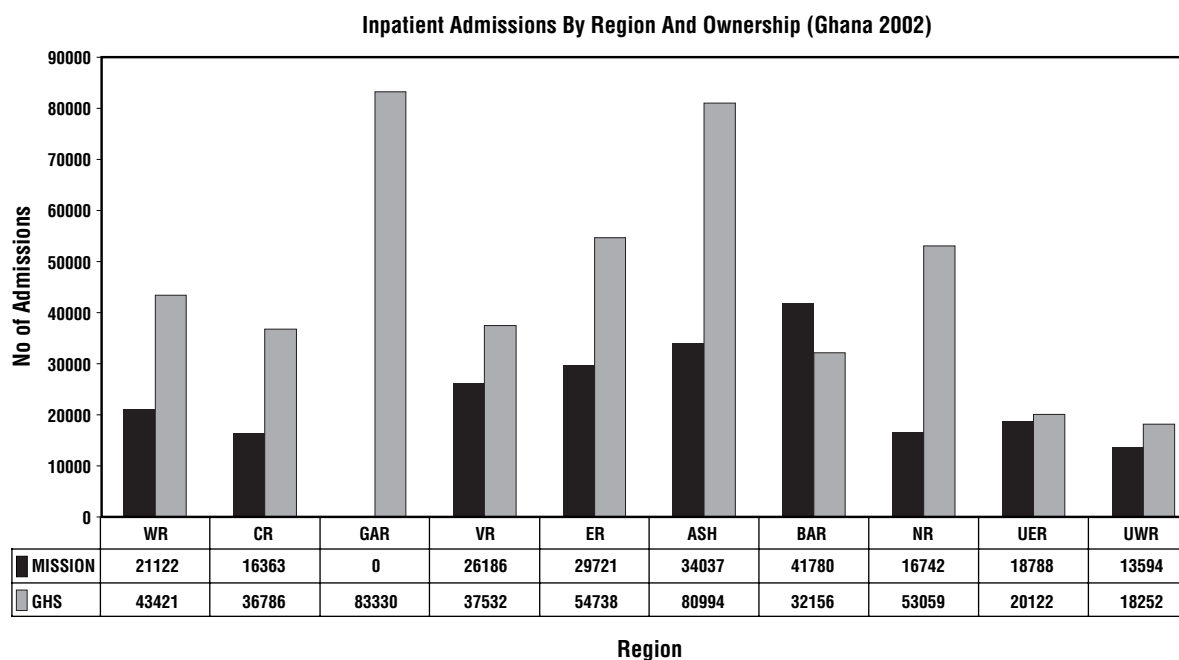
**Table 1**  
Yearly health expenditures per source, for three countries  
US\$/inhabitant (%)

Country	Government and Donors	Private (OOP)	Total
Mauritania <sup>IV</sup>	\$8 (26%)	\$23 (74%)	\$31
Guinea <sup>V</sup>	\$3 (9%)	\$31 (91%)	\$34
Burkina Faso <sup>VI</sup>	\$9 (43%)	\$12 (57%)	\$21

This shows there’s more money in the health sector than is usually thought, and there may be room for improving the efficiency of such expenditures, most of which are spent on private health care providers.

**c. How extensive is private sector coverage?**

Although there’s no systematic data available across all countries, evidence shows that a lot of the services in many African countries are provided by the private sector. For example, in Kenya the private sector delivers 49% of health services. Half of this is given by religious and NGO facilities and the other half by small- and medium-size commercial health enterprises<sup>VII</sup>. Another example is Ghana, where 37% of in-patient admissions (Accra excluded) are provided by missions (Graph 3). This varies by region as the graph shows.

**Graph 3****Coverage by the private not for profit hospital sector and by the public sector in Ghana, by region<sup>viii</sup>**

GHS = public network (Ghana Health Service); Mission network = CHAG (Christian Health Association of Ghana)

**Table 2****Tanzania: existing types of health services, 2000<sup>xi</sup>**

Facility	Government	Religious or Voluntary NGO	Private for profit
Specialized hospitals	6	2	0
Regional hospitals	17	0	0
District hospitals	55	13	0
Other hospitals	6	56	20
Health centers	505	48	16
Dispensaries	2652	612	663
Specialized clinics	75	4	22
Nursing homes	0	0	6
Laboratories	21	3	184
X-ray units	8	3	16

Finally, in Mauritania, the Ministry of Health looked at the contribution of the private sector to the immunization program and, based on this analysis, made some interesting recommendations (see Box 1).

Usually the private sector does not provide many of the services that the public sector offers. Often key public health services such as immunization and treatment for tuberculosis are not available at the private clinics, which refer those patients to the public sector, as was found in S. Africa<sup>x</sup>. The same study found that private clinics were used mainly for curative care. On the other hand, the public sector was often used for treatment of chronic conditions. A look at Tanzania's private sector (Table 2) shows that partnerships with the private sector to provide laboratory and X-ray services should be investigated.

#### d. What are the issues that need to be tackled to avoid “business as usual”?

- Despite all the evidence showing the significant amount of money being spent by populations on services from the private sector, most governments and aid organizations still focus quasi-exclusively on public delivery of health services. By doing so they did not account for a large portion of the available health expenditures and service providers. Only recently has the public health community started to think in terms of *health systems*, and not just in terms of ministries of health. With the arrival of HIV/AIDS, recognition grew that all potential service providers must be mobilized and harmonized to cope with the epidemic. Now, the concerns are more on deciding what services can best be provided, by whom, and how, so that public health goals are reached.
- Because the money spent on private providers by individual people is unpooled, it raises the issues of *efficiency and equity* when so much money from the poorest quintiles of the population is spent on the private sector.
- In addition, the *quality of services* by private providers could often be improved. For example, data from Uganda shows that only 19% of private health facilities correctly managed simple malaria, a mere 6% of them did so for simple diarrhea without blood, and 36% did so for pneumonia<sup>xii</sup>.
- Resources should follow the patient rather than the type of provider. This means that public *resource allocation* should be based on health service delivery rather than on the type of provider (public, NGO, for profit, informal). This encourages the development of an integrated health system with different actors rather than the continued pursuit of parallel systems<sup>xiii</sup>
- *Organizational adaptations* will be needed. Indeed, governments and aid organizations will have to make a special effort to work with different groups such as private sector associations; this will involve designing focal units to have an interface with the private sector, for example. In the same way, private providers will have to get organized so that they can be heard as one voice by their partners, since it is not possible for governments to deal with each individual, nor with each organization.
- Finally, governments should avoid developing two parallel types of care: one for the rich and one for the poor. It's important that those who pay, especially the poor, *be able to control the type of care they receive*, and that they be able to put pressure on the health care provider. This is not the case now in Africa for the majority of people who are poor. They are hostage to both the public sector, which often feeds on them through corrupt practices, and the private sector, which often requires extremely high payments. In both instances, high fees, whether formal or informal payments, put health services out of reach of many people. The availability of insurance programs, which could cover formal fees, is limited in Africa and subscription rates are low. The result is

**Box 1****Coverage by the private health sector in Mauritania**

A study done in the capital city<sup>IX</sup> showed that:

- The private sector provides at least 25% of consultations for infants and prenatal care, and 9% of deliveries.
- All private clinics vaccinate kids and women but very few collect the statistics since they mainly note the information on the patients' health card.
- The national immunization program has no statistics on activities done by the private sector.
- Only two of 15 private structures visited had an adequate refrigeration system but none had all the adequate tools to monitor the cold chain.
- Private structures buy their vaccines from private pharmacies in monodoses, which increases the cost to the patient.

The recommendations made in that study are relevant for any other type of PPP, namely:

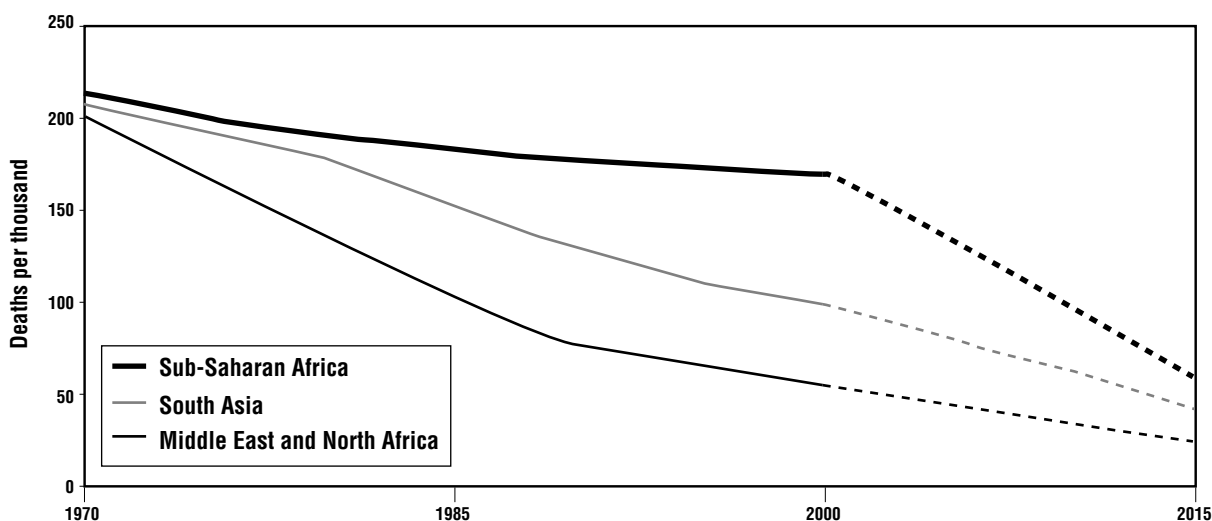
- *To the Ministry of Health:*
  - Ensure that a representative of the private medical association is included on the inter-agency coordination committee
  - Establish a temporary six-month collaboration committee with the main public and private actors who have something to do with pediatric/gynecology service delivery to see how such a mode of collaboration works.
- *To the partners:* ensure financial and technical support.
- *To the Extended Program of Immunization:*
  - Provide cold chain material to the private sector
  - Provide private structures with vaccines and management tools
  - Train private sector providers on immunizations
  - Assess the pilot PPP in the capital city after six months.
- *To the city's health officials:*
  - Monitor progress with the EPI structure
  - Sustain collaboration with the private sector while keeping in mind the specificities of the private providers.
- *To the private sector:*
  - Ensure that the associations of private doctors function well to provide an adequate interlocutor to government
  - Transmit monthly the data on EPI activities.

that both rich and poor patients can be at the financial mercy of both sectors, which do not always provide quality health services.

**e. Other reasons why can't we continue "business as usual"**

It will be difficult for Africa to come close to reaching the MDGs if it continues "business-as-usual" in the health care sector, as Graph 4

**Graph 4**  
**Reaching the MDGs in health: Trends in under-five mortality by region**



**Source:** World Development Indicators database (2003).

shows: the full line represents what is happening, and the dotted line what should happen to reach the MDGs.

Although it's important to continue to strengthen the capacity of MOHs, it's equally important to start paying attention to where people actually go for services and to ensure that their money, as well as public money, is used efficiently for quality care. Thus, lately, there has been more attention paid by development organizations such as the World Bank Group to exploring the role of the private sector in reaching public health goals.

The World Development Report 2004 state clearly that there is a need to consider different types of service delivery arrangements, depending on the country. Four out of the eight suggested service delivery arrangements involve contracting with the private sector.

The World Bank's Africa Strategy also acknowledges that Ministries of Health will not be able to reach public health goals unless they harness the potential of existing private sector providers<sup>XIV</sup>.

## Purpose and Scope of this Paper

Although there are no current large-scale partnerships between the public and the private sector for delivery of health care services in Africa, there are some successes as well as some trends. This paper outlines some of these successes and trends to provide lessons learned as of today.

It is hoped that this paper will help decision makers in governments, the private sector, and development organizations, build on the lessons learned to find a better way for public and private entities to work together to achieve public health goals and to empower consumers of health care services.

This paper also reinforces the role of the state as a regulator, policy setter, and strategic purchaser. It provides insights into the different types of policies and interventions a government can choose to influence the private sector to reach public health goals, examples of which are provided in Table 3:

**Table 3**  
**Types of policies and interventions available to Governments to influence the private sector**

<b>Type of policy a Government can use to influence the private sector</b>		<b>Available PPP interventions or schemes to be used by Government</b>
Demand side policies	Financing	<ul style="list-style-type: none"> <li>• National Health Insurance system</li> <li>• Community risk pooling schemes</li> <li>• Vouchers</li> </ul>
Supply side policies	Regulation	<ul style="list-style-type: none"> <li>• Tax exemptions</li> <li>• Accreditation</li> <li>• Licensing</li> </ul>
	Formal PPP	<ul style="list-style-type: none"> <li>• Franchising</li> <li>• Contracting</li> <li>• Leasing</li> <li>• Concessions</li> <li>• Divestitures</li> </ul>
	Facilitation	<ul style="list-style-type: none"> <li>• Give voice and information to the private sector</li> </ul>

**Source:** Author's own design.

## Who Delivers What Kind of Health Services in Africa?

### a. Where do people actually go for services?

The analysis of DHS data from 26 SSA countries with 42 data sets for different years (Annex 1) shows that almost half of the parents of a child who had diarrhea or a respiratory infection in the past two weeks didn't seek care. Another 28% brought the child to a public facility; and 22% took him to a private provider. However, an analysis by income level reveals a slightly different picture. There is no surprise or news in the fact that the wealthier groups use the private sector. What is news is that the poor also use the private sector extensively, since about half of the poorest who sought care brought their child to the private sector (Table 4). It also confirms that the public sector often subsidizes the rich since 52% of the people in the richest income quintile who sought care brought their child to a public facility.

In general, the poorest quintiles are somewhat less likely to seek care outside the home than the rich: about half of the poorest do, while about 60% of the richest do.

There are differences on where the poorest quintile goes to seek care. In some countries such as Ghana, the poor primarily go to private phar-

macies; in Burkina, Guinea, and Mozambique, the poor mainly use traditional healers; while in Niger the poor usually go to shops.

The richest quintile tends to make more use of pharmacies, doctors, and private facilities.

The rural population is much less likely to seek care outside home. When they do, they are more likely than the urban population to use the private sector in the form of traditional healers and shops. However, in some countries such as Benin, Comoros, Namibia, and Senegal, the rural population uses more public facilities than the urban population.

**Trends over time** for some typical countries where two sets of data were available:

- *In Malawi*, the use of the public sector diminished by about half between 1992 and 2000 (going from 33 to 16%); this is true of the rich as well as of the poor. At the same time, the use of the private sector went from 27% to 39% for the poorest quintile and from 31% to 49% for the richest quintile. This might indicate a dynamism of the private sector and a problem in the public sector.
- *In Benin*, between 1996 and 2001, *in Cameroon* between 1991 and 1998, and *in Ghana* between 1993 and 1998, the poor sought more care outside the home, favoring

**Table 4**  
**Use of private and public facilities among the poorest quintile when a child is sick**

Country and year of DHS	Among those who sought care outside the home, % who went to:				% seeking care outside home
	Private sector	Public sector	Other	Total	
Malawi 00	74%	24%	2%	100%	52.7
Mali 96	69%	24%	7%	100%	30.5
Uganda 95	69%	29%	3%	100%	73.6
Uganda 01	68%	27%	5%	100%	77.7
Ghana 93	65%	25%	10%	100%	57.7
Niger 98	59%	36%	5%	100%	35.4
Cameroon 91	55%	45%	0%	100%	24.6
Benin 96	53%	47%	0%	100%	37.3
Kenya 98	47%	47%	6%	100%	63.9
Malawi 92	46%	53%	0%	100%	58.8
Nigeria 90	46%	47%	7%	100%	50.9
Comoros 96	45%	47%	8%	100%	56.2
Madagascar 97	44%	56%	1%	100%	44.5
Cameroon 98	44%	52%	4%	100%	37.6
Benin 01	41%	55%	3%	100%	40.3
Guinea 99	38%	54%	8%	100%	44.4
Burkina 99	35%	59%	6%	100%	20.1
Mozambique 97	32%	63%	5%	100%	36.6
Tanzania 96	29%	68%	3%	100%	58.1
Zambia 96	24%	68%	8%	100%	64.0
CAR 95	19%	80%	1%	100%	27.7
S. Africa 98	14%	84%	2%	100%	64.5
Namibia 92	7%	90%	3%	100%	67.2
Gross Average:	45%	51%	4%	100%	48.9

**Note:** countries with more than 10% “other” were not included in the table.

**Source:** Sara Project, Academy for Educational Development, Washington, D.C., March 2004. Please see Annex 1.

public sector providers. The richest portion of the population in these countries favors private sector providers. Those trends are very good, as they indicate a move towards equity.

From the five countries where there are two sets of data with income quintiles details (Benin,

Cameroon, Ghana, Malawi, Uganda), except for Benin and Cameroon where the trends are very positive, the tendency is for people to seek less care outside the home. This can be explained by an increase in poverty, or a decrease in the perceived accessibility to health services (due to under-the-table payments for example), a decrease in the quality of care.

The data highlight an equity problem in health services availability, with the public sector being used by the rich more than by the poor in several countries. They also show that some countries have a problem of low utilization of public services in general: people are not seeking care anymore since they probably cannot afford it. In many countries, people sometimes have to pay up to 10 times the official rate to be taken care of in a public facility. Finally, the data show that the private sector is growing and is being used by all income groups.

### **b. Do people get good quality care in public and private sectors?**

There's room for improvement in both sectors. That is why it's so important for governments to adequately perform their role of regulator of the health system, including the private sector. However, there is a perception by many populations that private providers give service with better attention.

In South Africa a study of nine clinics showed that sexually transmitted infections had been diagnosed using the correct approach in 85% of the private clinics, compared with 68% in public clinics. In the private sector, 97% of patients had received treatment in line with the Department of Health's guidelines, compared to 80% in public clinics<sup>xv</sup>.

In Senegal, the national malaria program asked the U.S. Pharmacopeia Drug Quality and Information Program to provide an assessment of Senegal's antimalarial drug quality. This was done performing a random sampling of antimalarial drugs and testing them in the USA. It was found that 55% of the sampled sulfadoxine-pyrimethamine tablets contained less than the claimed amount; that drugs from the private sector failed more often than those from the informal market; and that the public sector had the least failings.

Tests on chloroquine found a similar pattern except that all the chloroquine that failed was

found to contain a higher dose than what was listed on the label<sup>xvi</sup>. Both under- and over-dosing can be very detrimental and point out a problem of drug quality surveillance by government. Finding ways to improve the procurement of good quality drugs by the private sector is one of many actions that were recommended. Another study by WHO provided similar results in other countries<sup>xvii</sup> (Graph 5), where the private sector, represented by vendors, shops, and pharmacies, did not provide better quality chloroquine tablets than the public sector.

In Uganda, a study undertaken in five districts and in the capital city showed that 81% of the simple malaria cases and 64% of pneumonia cases were not managed correctly by the 164 private health facilities treating those cases<sup>xviii</sup>. Kenya started to solve this problem when the Kenya Medical Research Institute worked with the MOH to train private drug retailers in a rural area in Kilifi district. About 500 shopkeepers were trained in 2–4 day workshops, with the result being an increase from 7 to 65% of children given the right dose of antimalarials<sup>xix</sup>.

People often have a better perception of the care provided by the private sector. For example in South Africa people liked the private sector because they were being treated promptly and with respect, which, with some exceptions, was not echoed in public clinics. The waiting time at the private clinics was 10–40 minutes, compared with 50 minutes to 3 hours in the public clinics<sup>xx</sup>.

### **c. Are private services more expensive than public services?**

Data show no conclusive evidence one way or the other; it depends on the facility and the country. There are great variations in both sectors. A comparison of the mean cost per visit between private and public care providers in South Africa and in Zimbabwe provided the results shown in Table 5, which did reveal some large difference in Zimbabwe, but no significant difference in South Africa.

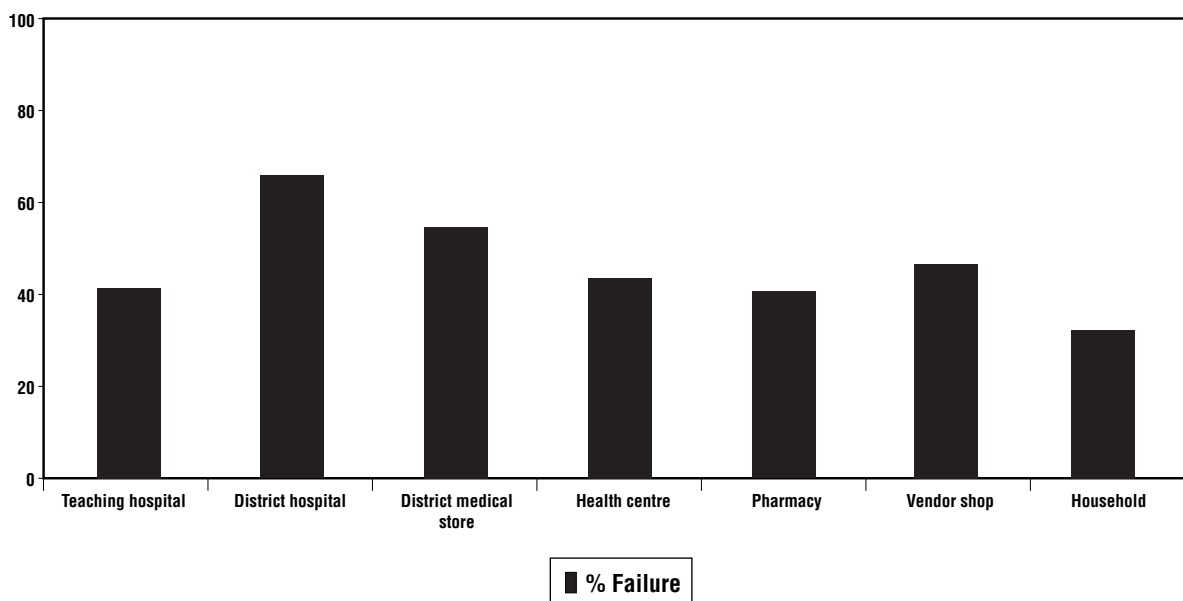
**Table 5**  
**Mean cost per visit to the public sector and to the private sector in two countries**

	Public Sector		Private Sector	
	Small clinics without full-time doctors	Large clinics with full-time doctors	Private clinics	Private general practices
South Africa <sup>1</sup> : Total cost/visit (in Rands)	33.20	65.78	42.14 (part of a chain of clinics)	89.44
Zimbabwe <sup>2</sup> : Outpatient consultation	US\$24–52 (depending on level of infrastructure)		US\$257	US\$125

<sup>1</sup>**Source:** Palmer Natasha et al, Bulletin of the WHO, 81 (4), 2003.

<sup>2</sup>**Source:** Mudyarabikwa Oliver, Madhina Denford, "An assessment of incentive setting for participation of private for-profit health care providers in Zimbabwe," PHR Small Applied Research No. 15, November 2000.

**Graph 5**  
**Percentage failure of chloroquine tablets content in 7 African countries, by source of distribution**



The private clinics in South Africa kept personnel costs low by using nurse practitioners as the main service providers. Drug costs were contained by using a basic company formulary, as well as by strict control of prescription practices via regular audit of dispensing patterns, using a

computer system. However, private clinics had higher external administrative costs, reflecting strong management support from their head of-fice.

However, in some countries, low official prices do not provide the real pictures. A probably

**Table 6**  
Ethiopia: costs in private and public clinics and hospitals, 1999–2000 (in Birr)

	NGO-managed clinics	Public-owned and managed clinics	Enterprise- owned hospitals	Private hospitals	Public hospitals
Recurrent cost per patient <i>treated</i>	9.78 (varied from 6 to 67)	12.55 (varied from 11 to 14)			
Recurrent cost per patient	42.03	38.35			
Recurrent cost per inpatient			2680	556	460

extreme example is in Guinea, where although most public infrastructures display a poster with the price list of services, the price paid by patients in the two main hospitals was 4.4 times the official price for outpatients, and 9.4 times for hospitalized patients. Out of those amounts, 53% went to buy drugs, 39% went under-the-table, 5% was for complementary exams, and only 3% went to the hospital register<sup>XXI</sup>.

The study did not investigate private structures, and cost comparisons are thus not available. However, considering that one of the major causes of those under-the-table payments was identified as the presence of 400 interns (“stagiaires”) and volunteers who are not paid, it is unlikely that this practice is found to the same extent in the private sector. It should also be noted that three-fourths of the 53% of the cost went for drugs purchased from the private sector, confirming that the public sector is a consumer of private sector drugs.

In Ethiopia (Table 6), the recurrent cost per patient is slightly lower in public clinics; however, the cost per *treated* patient is lower, on average, in NGO clinics. Large differences are observed among hospitals, and it appears that enterprise-owned hospitals could be more efficient<sup>XXII</sup>.

#### **d. Is the private sector draining the public sector of its human resources?**

It is interesting to note that the private-for-profit sector boomed during the latter part of the 20th

century, while a freeze on hiring was imposed on governments to contain their recurrent costs.

Today, mounting empirical evidence of poor public health service delivery is associated in part with lack of trained human resources. Ghana, for example, is suffering from a brain drain of medical and paramedical personnel to the West. Of the more than 2,000 physicians who were registered in Ghana in 1999, about 700 are engaged in the public sector while around 300 are in the private sector; the remainder are believed to work outside the country<sup>XXIII</sup>. A few other countries suffer from a similar problem. Other areas of the continent suffer from insufficient personnel to meet their needs. One example is Senegal, where there are 11,000 health workers, but there’s still a deficit of 3,500 agents<sup>XXIV</sup>. It’s unfortunate that personnel from the private-for-profit sector are not included in that count, especially considering Table 7, which shows that the private sector employs a lot of specialized personnel, and Government could use those resources.

A contentious issue is the competition for scarce human resources between the rapidly emerging private sector and the public sector. However, this could also be seen as an opportunity for better public-private partnerships, by:

- Increasing the number of medical and paramedical students who graduate from private training institutions. This was done in Senegal, where the number of paramedical graduates was doubled by contracting three

**Table 7**  
**Number of medical and paramedical personnel in the public and private sectors in Senegal in 2000<sup>xxv</sup>**

Sector	MDs		Dentists		Pharmacists		Nurses		Midwives	
	Public	Private	Public	Private	Public	Private	Public	Private	Public	Private
Number	358	354	53	84	66	306	1871	267	562	45

local private training institutions<sup>xxvi</sup>. Quality is standardized through the public service entrance test they take, which is the same for the public school graduates. In 1997, Tanzania saw the creation of the Hubert Kairuki Memorial University (*info@hkmua.ac.tz*), which trains medical professionals and nurses. Kenya has private training schools, but because of poor regulation, there's an uneven quality of graduates from those schools<sup>xxvii</sup>. There's a need to encourage the development of private training schools and ensure their accreditation or that they are up to standards.

- Including the private-for-profit sector in the health system to increase service coverage. This means private providers will be able to benefit from on-the-job training from the public sector, which is too rare an event today. For example, considering that in Uganda there is approximately one traditional healer per 100 people, while this ratio for medical doctors ranges from 1/10,000 in cities to 1/50,000 in rural communities<sup>xxviii</sup>, it makes sense to train those healers in certain medical practices. This also means that certain primary care services which are now mainly provided by the public sector—such as routine immunizations—be made available in the private sector.
- Contracting private providers to supply public services. Senegal is doing that by hiring nurses with a renewable contract for two years. Those contractors are paid better than their civil service counterparts (twice as much for medical doctors and about three times as much for nurses), but they fill positions in

remote areas where public employees have been unwilling to live and work. HIPC resources are used to pay them.

- Encouraging the development of good quality private providers, with centers of excellence, to retain as many professionals as possible in the country. Mali is developing a top laboratory with the help of the Bio-Merieux Foundation, which will become the reference laboratory and train other public or private labs throughout the country and possibly the whole sub-region. In Kenya, the Aga Khan Foundation hospital is one of the best in the world. These types of highly sophisticated providers can be used for training and they provide a quality standard in the country, while hiring local personnel who might have otherwise emigrated.
- Expanding and improving government contracting with private providers for public services, thereby improving the long-term opportunities of health professionals, while simultaneously expanding access to publicly funded services.

Africa is not alone in having a large proportion of its physicians in the private sector, as Table 8 shows:

**Table 8**  
**Percent of medical doctors who are private, by continent<sup>xxix</sup>**

Sub-Saharan Africa	Latin America and the Caribbean	Asia
46%	46%	60%

**Private practices by public servants:** In Africa, public employees often run the private sector. Indeed, although most governments have legislation to prevent public employees from practicing privately in public structures, this is commonly performed, sometimes to the detriment of the poor and of the public sector. For example, in Guinea, a study in the main two hospitals in the capital showed that 75% of patients paid more than the official tariff, and only 14% of what patients paid went back to the hospitals. Patients paid on average 10 times the official tariff. This was due in great part to the fact that interns are working full-time but are not paid by the government, so they pay themselves through informal fees from patients. One hospital employs 300 public servants, 75 contractors, and more than 400 interns. Those interns feel they work in place of public servants who are on the government's payroll, but who spend their time in their own private practice. The civil servants themselves sometimes also ask for extra payment from patients or simply refer them to their private practice<sup>xxx</sup>.

A study of dual public-private medical practice in China, Thailand, Peru, and Zimbabwe showed that doctors maintain their public sector jobs despite good income opportunities in private practice. Dual practice occurs even in settings where there are major regulatory restrictions, such as China. Rather than fighting this practice, there is a need to make the best use of it, namely to enforce clear guidelines and mechanisms that will prevent misuse of public sector resources and provide stable incomes, training opportunities, and sometimes other benefits such as a pension<sup>xxxI</sup>.

The decision of public health professionals to engage in private practice depends on several factors, one of which is how individuals are paid. Those paid a flat salary would have a greater incentive to undertake dual practice than those who are paid in an incentive system<sup>xxxII</sup>, which advocates for performance-based contracting.



## Experiences and Trends in Public-private Partnerships in Africa

**G**overnments can influence the private sector through different means, including:

- financing the private sector to make it more efficient or targeted (financial support for health insurance programs and demand-side promotion such as community health mutuals or vouchers)
- legislative/regulatory reforms resulting in enabling environments
- formal partnerships with the private sector to encourage the delivery of certain types of health services.

This section provides an overview of these means. Many of these practices have been successful; others lack evaluation data; several remain on a small scale; and numerous trends are encouraging. Ways to improve those practices and scale up the successful ones are also suggested.

### **a. Public financing of the private sector**

From colonial times until recently, governments financed the private sector mainly through grants to NGOs. User fees have also been used to

complement government contributions. Recently, some governments realized that they needed to find more efficient ways to finance health. Consequently, a national health insurance program is being tried in some countries like Ghana. Also, some governments are contributing to demand-driven programs that pool resources, such as community health mutuals, while other governments are trying targeted public subsidies through vouchers.

#### **i. Health Insurance**

Health insurance is not yet extensive in the sub-Saharan region, except in South Africa and the planned national health insurance program in Ghana. There are social health insurance programs in Kenya, Tanzania, and Mozambique that are usually mandatory for civil servants and sometimes offered to employees of large corporations on a voluntary basis. Medical aid societies exist in South Africa, Botswana, and Zimbabwe, which are usually organized along professional lines, for example, sickness funds.

#### **ii. Demand-driven community programs**

Community health insurance programs vary in ownership, management, benefit offerings, and

**Box 2****National Health Insurance Program in Ghana**

The introduction of a national health insurance program in Ghana has been proposed, following passage of the National Health Insurance Act of 2003. Previously, financing for health services came largely through public subsidies, foreign assistance, and user fees—mechanisms that were neither efficient nor always fiscally sustainable over time. The objective of the new health insurance program is to improve the way domestic resources for health are mobilized and obtain better value for scarce resources. Part of the financing burden of the program will be shifted to participants through a contributory health insurance premium.

The national health insurance program builds on the experience of the voluntary mutual health insurance organization (MHO) movement, which began in the early 1990s and grew to 159 organizations by 2002. These community-financing programs are spread across the country, and vary widely in design, membership, and management. Although a formal study of their impact has not been conducted, it is thought that the better-run MHOs have contributed significantly to improved access to health services and financial protection from the effects of ill health. The immediate goal of the national insurance reform is to eliminate the “cash and carry” system of co-payments in the public sector, and expand coverage by increasing the number of mutual health insurance organizations, their geographic outreach, and their membership.

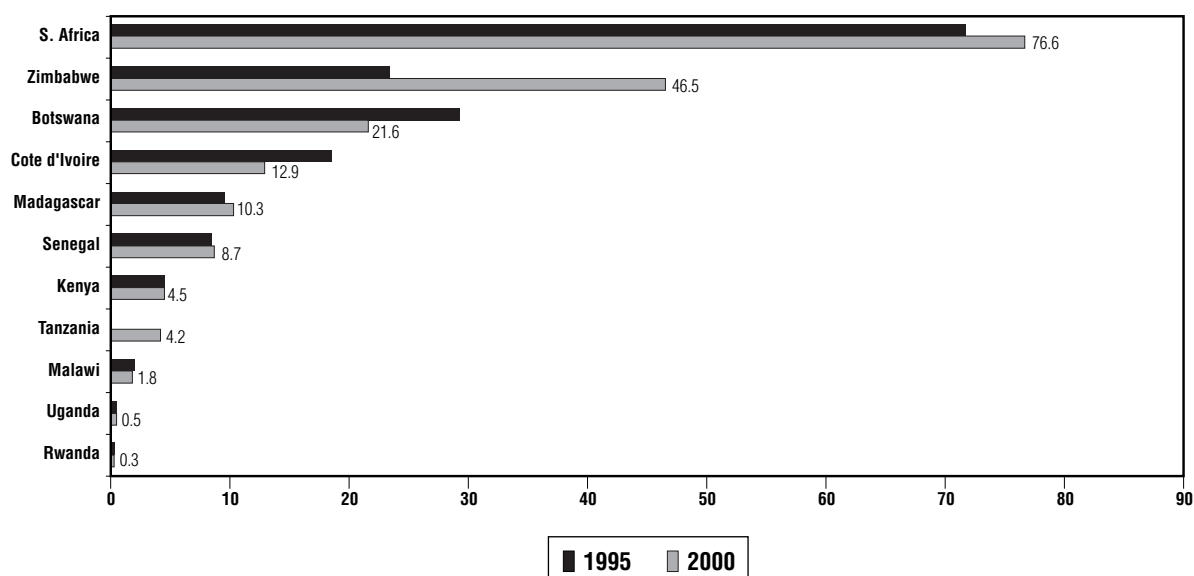
The National Health Insurance Act of 2003 establishes three types of health insurance organizations: district mutual health insurance programs, private commercial health insurance programs, and private mutual health insurance programs. Only the district insurance programs will be eligible for a subsidy for the indigent under the National Health Insurance Fund. The initial proposal is to expand insurance coverage to 30% of the population, while universal coverage is the long-term goal. Individuals would be obligated to obtain coverage from one of the programs, but would be free to opt out of the public system in favor of private insurance (and would not pay the public insurance premium). The insured would have a choice as to provider, using both public and private sector facilities, if they are accredited (the National Health Insurance Act specifies the scope of regulations governing the program, including accreditation of health care providers).

Competition among providers is anticipated in urban areas. The issue of subsidies currently provided to public facilities, which undermine the competitiveness of private providers, is one of a number of issues remaining for the government to address.

arrangements with providers, but they share common features that are a hallmark of health insurance: they involve prepayment and risk pooling. Graph 6 shows the extent of pre-paid plans in sub-Saharan Africa, with the Southern African countries leading the way, followed by French-speaking countries, and then by Eastern African countries.

Discontent with the quality, reliability and sustainability of publicly funded health services has instigated moves for establishing mutually beneficial financing arrangements devoted to health services. This is clearly the case with the “mutuelles” in West Africa, many of which originated from simple community drug-revolving funds, or complementary programs set up by

**Graph 6**  
**Prepaid Plans as % of Private Health Expenditures, 1995 and 2000**



**Source:** World Health Report 2002, World Health Organization.

**Table 9**  
**Evolution of the number of health mutuals in West Africa**

Country	Situation in 1997	Situation in 2003				Total
		Operational in 2003	Soon to be designed	Being designed	In difficulty	
Bénin	11	42	8	3	0	53
Burkina Faso	6	35	36	14	4	89
Cameroon	18	22	6	8	2	38
Côte d'Ivoire	0	36	1	0	3	40
Guinée	6	55	17	27	10	109
Mali	7	51	12	4	4	71
Mauritania	0	3	0	4	0	7
Niger	6	9	2	1	1	13
Senegal	19	79	30	18	9	136
Tchad	3	7	0	0	0	7
Togo	0	9	2	6	0	17
Total	76	348	114	85	33	580

**Source:** Inventaires Concertation des acteurs du développement des MS Afrique 1997, 2003.; [www.concertation.org](http://www.concertation.org)

civil servants who were not satisfied with coverage provided by the state. Their number has multiplied sixfold in 6 years.

Health insurance embodies the principles of public/private partnership, whether the health insurance program is mandatory, a private voluntary program for those in the formal sector, or a small community risk-pooling arrangement. Health insurance encourages purchasing from the managers of the fund (the risk pool), who are mandated by the members to accredit providers, negotiate payment terms, and monitor the quality and volume of services provided. The contractual arrangement between the health insurance fund and health facilities provides incentives for providers to perform better because there is a risk that their contracts or accreditation may not be renewed.

Health insurance is one of the best tools to empower the consumer of health care, especially when the program has emerged from the consumers themselves, such as in health mutuals.

Although the growth of health insurance in sub-Saharan Africa has been slow, except in West Africa (see Table 9), there is potential for further expansion and hence for more public-private partnerships. Given this potential, the World Bank is currently researching the impact of voluntary health insurance on financial protection and on access to health care<sup>xxxiii</sup>.

**Possible roles for the Bank and IFC.** The Bank should support such community risk-pooling programs. This support can be initiated by financing initial start-ups, evaluations, re-insurances, and supporting dispersed programs so they can form federations when they request it.

IFC has acquired a minority stake in the Africa Reinsurance Corporation (Africa Re), investing US\$10 million in Africa's largest domestic re-insurer. This new investment is a big part of the organization's strategy to support development of well-managed primary insurers in Africa. In addition, IFC is exploring opportuni-

ties to provide advisory assistance to governments and health insurers for improved contracting of health services, as it has done in other regions.

### iii. Vouchers

Voucher programs for delivering health services are a mechanism for subsidizing the provision of particular services to targeted groups through the use of a token (voucher) that can be redeemed to purchase all or part of a good or service. The general idea is that, under certain circumstances, providing demand-side subsidies will be more effective than using resources to provide supply-side subsidies<sup>xxxiv</sup>. Demand-side subsidies in general, and voucher programs in particular, have an advantage in creating an explicit link between the subsidy and the output, thus providing an incentive to increase the use of that output. The objective is to select specific health interventions that are cost-effective, directly target vulnerable groups, simplify administration (reducing the possibility of irregularities and false claims), and reduce provider-induced demand. Experience to date, however, has shown voucher programs to have higher transaction costs<sup>xxxv</sup>.

Voucher programs can be competitive or non-competitive. In a competitive voucher program, some form of competition exists among the providers of health services (for the business of the voucher holder) and thus creates a choice of provider for the voucher holder. In a non-competitive scheme, a designated service provider is charged with delivering services. A typical competitive voucher program works as follows:

- funds are transferred to a voucher agency
- the voucher agency produces the vouchers and distributes them to the target population (either by itself, or through a third-party organization)
- the recipient of the voucher presents it at the service provider of his or her choice in exchange for specified goods or services

- the service provider returns the voucher to the voucher agency (along with any required information)
- the voucher agency pays the provider an agreed-upon sum for each voucher returned
- the voucher agency reports program outputs and outcomes to the government or donor providing the subsidies<sup>xxxvi</sup>.

Data on competitive voucher programs for delivering health services is limited, in general, and particularly in Africa. Lessons from three programs in Africa—purchasing insecticide-treated nets in Tanzania, delivering emergency contraception in Zambia, and providing reproductive health services to young people in Kenya—are described in Annex 3. Some of the lessons learned are as follows:

- A substantial amount of time—often several years—is needed for people to understand and use the voucher program, even if a promotional campaign is in place. Multiple communication channels may be warranted. The targeted population must be made aware of the importance/use of the good/service and where to go to obtain it.
- Careful monitoring may be required, especially at the beginning of the program, so as to understand why targeted individuals are not making use of the program and how barriers can be addressed.
- A target group that is easy to identify and to reach—such as pregnant women—contributes to the success of the program.
- Rather than providing unfair competition to the private sector by subsidizing the provision of a good or service through public facilities, a voucher program can strengthen commercial providers while serving public health goals.
- In setting the value of the voucher, there is a trade-off between increasing its value (and thus providing greater benefit to the poorest, who may not be able to afford the service even with a lower-valued voucher) and mis-

use. Initially, it may be that the least poor are able to take advantage of vouchers, with the poorest participating only later in the life of the program.

- Minimizing misuse may be more difficult in larger, nationwide programs, as opposed to carefully controlled programs limited to a few districts.
- The use of third parties to distribute vouchers, particularly the social organizations around poor or disadvantaged groups or members of the groups themselves, may strengthen outreach. Particularly for services of a sensitive nature, such as sexual and reproductive health services, the point of contact—both in distributing the voucher and obtaining services—may be critical in ensuring comfort and confidentiality, and thus acceptance of the voucher program.
- In some cases, better results were obtained when the distributor of the voucher/provider of information was also equipped to deliver services.

Training of providers may be required to ensure quality of goods and services, and to ensure that providers are sensitive to and welcoming of voucher holders.

**Possible role for the Bank.** World Bank's credits and grants could be used to finance such programs, their evaluations, and what they need to go full-scale if the pilot is successful. Operations research could be financed by the Bank to find ways to minimize transaction costs.

## b. Regulating the private sector

Regulation, although a powerful tool, is not generally applied in a consistent manner across the continent, whether with the public or the private sector. In most African countries, basic legislation on private health practice is done through registration/licensure requirement. However, there are two major reasons why li-

**Box 3****Zambia's experience with accreditation to date\***

Zambia initiated its comprehensive health sector reform in the early 1990s. Reform was considered particularly urgent in the hospital sector, as nearly two thirds of the country's 79 hospitals were more than 30 years old, and more than half of government hospitals had sanitary systems characterized as poor or worse. With assistance from the USAID's Quality Assurance Project, the government launched the Zambia Hospital Accreditation Program in 1997 to accredit both public and private hospitals. Although there were other mechanisms to evaluate hospital performance, accreditation was chosen as it was considered to be a comprehensive and transparent program.

To design and implement the accreditation program, the Zambia Health Accreditation Council (ZHAC) was set up, which was comprised of 12 members representing government, professional organizations, and the public. ZHAC did not have independent funding or legal mandate, however, and the council members had full-time responsibilities elsewhere. ZHAC selected surveyors and trained them through formal training on accreditation principles and surveyor skills, as well as through a series of practice surveys over a 2-month period. Surveyors had full-time jobs elsewhere, and were to conduct surveys on an ad hoc basis and receive a nominal payment for their efforts.

Only one in five hospitals has completed the accreditation cycle. The question of long-term sustainability has been raised. With change in USAID funding, the program is now stalled.

In 2002, an internal examination of the program presented the following observations:

- Hospitals appreciated the educational nature of the accreditation process. However, hospital staff expressed the need for technical assistance in meeting accreditation standards. In addition, feedback to the hospitals took a long time, up to a year after completion of a survey.
- Although ZHAC's mandate is clearly defined, legislation to make it an independent and non-governmental organization did not go through. Without legal recognition and its own financial resources, ZHAC's capacity to carry out all tasks associated with regular survey and accreditation is limited. ZHAC staff perform their tasks on voluntary basis, and the level of participation has been waning due to lack of control over budget.
- While training of surveyors was effective, there has been high attrition of surveyors because of low compensation relative to the level of work demanded and opportunity cost.

\***Source:** Bukonda, Ngoyi et al, "Implementing a National Hospital Accreditation Program: the Zambian Experience," International Journal for Quality in Health Care, Volume 14, Supplement 1, 2002. Rooney, Anne, Paul van Ostenberg, "Licensure, Accreditation, and Certification: Approaches to Health Service Quality," Quality Assurance Project, 1999. Montagu, Dominic, "Accreditation and other external quality assessment systems for healthcare," DfID Health systems Resource Center, 2003.

censure (or other legislated regulatory mechanisms) has failed to guarantee quality:

- Weak enforcement of regulatory control, with limited funding. For example, in Malawi, the

Medical Council is supposed to make initial inspection of premises for anyone applying to open private practice, as well as performing periodic spot checks. In a survey of private practitioners, however, 73% of practitioner were found not to have any refrigerators, and they dispense a wide variety of drugs including those not on the approved list<sup>xxxvii</sup>.

- Unwillingness to enforce regulation against their own membership. For example, the Zimbabwean Medical Council has not publicized any case of malpractice for fear of damaging the reputation of the profession<sup>xxxviii</sup>.

Although many countries are trying to improve their regulations, some key gaps remain. For example, regulations in Tanzania and Zimbabwe (a) focus on individual inputs rather than health system organization; (b) aim to control entry and quality rather than quantity, price, or distribution, and (c) fail to address the market-level problems of anti-competitive practices and lack of patient rights<sup>xxxix</sup>. Similar problems were found in a study in South Africa, where it was noted that non-state providers tend to be more controlled rather than encouraged or supported by government<sup>xl</sup>.

Appropriate regulation of market practices is lacking in many places. For example, in Tanzania and Uganda, both of which have explicitly promoted PPP, most regulations focus on entry requirements for private providers, yet none explicitly aim to improve competitive practices. Tanzania has no explicit protection for the health consumer, and vertical integration is widespread, for example, self-referral of doctors—doctors owning private facilities such as laboratories where patients are sent, thereby limiting patient choice and often bypassing available public services.

A technical review in Tanzania in 2005 provided interesting observations about the regulatory framework in place in that country, which are summarized in Table 10 (ref. nbr. xiii).

Some alternatives to legislative regulation include:

- *Regulation by contract*, where there would be clear separation between service providers (private sector) and purchaser (government). The contract should contain agreement on the process to reduce the burden of “independent regulator” (more on this topic in the next chapter).

**Table 10**  
**Results of the Tanzania’s Technical Review 2005 regarding PPP regulations<sup>xiii</sup>**

<b>Positive aspects already in place</b>	<b>Aspects which need improvement</b>
Centralized systems for registration are in place	Sometimes system is cumbersome, time consuming Registration of public and private facilities does not take into account health services needs
A centralized inspection is in place	Not yet decentralized
A national quality framework was published in 2004	No comprehensive national quality assurance system in place No national standard for accreditation of health facilities
The Pharmacy Act was passed in 2002 and a Dispensing Manual was published	Regulation of pharmaceuticals is yet to be more effectively enforced
The Tanzanian Food and Drug Authority and the MOH have established a Drug Quality and Assurance Program	Relationship between government and the pharmaceutical sector is that of “regulator” and “regulated” and not partnership per se

- Existing and emerging *franchise programs* are performing a role of micro-accreditation agency to fill the gap, especially for those service providers who are not in the scope of formal regulation.
- *Provide financial incentives* such as access to subsidies, government loans, etc., depending on the accreditation status (conducted on voluntary basis) of the private practice. This is a viable option if sufficient capacity to monitor exists, and might be more applicable for middle-income countries.
- *Performance-based contracts* constitute a way to regulate the provider by requiring the provider to give monitoring data. This necessitates a good evaluation system, which can be contracted out; a variation is to pay against output only.
- Members of the private sector from Tanzania and from Kenya have suggested that a “*Loan Fund*” be put in place to provide low-interest loans to small-scale health providers, along with capacity building. In Kenya, the formal banking sector’s interest rates are above 24%, which makes it difficult for start-up operations to borrow. Such a fund would work closely with professional associations that would provide yearly certification for the quality of care delivered before renewing a licence. The Loan Fund would finance training, promotion, and establishment of practices in rural areas, and only those practices that have received their certification could graduate to a more substantial loan, for example. The idea of this Loan Fund goes much beyond, and has more potential, than what exists now on a small scale in Uganda or Kenya (see Box 4).

Medium-term alternatives are guided by what is achievable in the context of most African countries. In the long-term, regulatory frameworks and appropriate information systems for purpose of monitoring should be developed<sup>XLI</sup>.

## c. Formal public-private partnerships for service delivery

### i. Contracting the provision of health services

Three basic conditions need to be met to contract successfully<sup>XLII</sup>:

- minimum knowledge of the services to be contracted (in order to be able to define the content of the contract)
- capacity to manage contracts
- sufficient funding to cover the economic cost of the service at the projected level of demand<sup>1</sup>.

Contracting is one type of public-private partnership in which the public sector purchases specific services, be they clinical or non-clinical, from a private (for-profit or not-for-profit) provider.<sup>2</sup> The trend toward such partnerships is fed by growing evidence of the public sector’s failure to deliver high quality and essential services, including healthcare. Also, there is new thinking in public sector management that private sector mechanisms may help to improve efficiency, equity, and responsiveness to users<sup>XLIII</sup>. This type of partnership is now seen as complementing public sector provision in order to reach public health goals.

The theory is that replacing hierarchical management structures typical of public bureaucracies with contractual relationships between purchasers and providers—that is, separating purchaser and provide—will increase accountability and improve efficiency. Partnering with the private sector also has the potential to increase the volume and variety of services provided, and extend access, including remote areas.

<sup>1</sup> This last condition was added by the authors.

<sup>2</sup> Contracting may involve two public sector entities; however, such arrangements are not dealt with in this paper.

**Box 4****Examples of partnerships with professional associations<sup>x1</sup>**

In Uganda, the Market Day Midwives project, a joint effort between SOMARC (Social Marketing for Change) and the Uganda Private Midwives Association, set up midwives in community markets as a distribution system for family planning. SOMARC provided each midwife with a sales booth, training through Service Expansion and Technical Support, and a uniform, and sold products to midwives at wholesale prices (Futures Group International 1995).

Then, in January 2001, the Summa Foundation created a US\$175,000 revolving fund to provide microcredit to private healthcare providers (nurses, midwives, and doctors) to expand or improve their practices. Commercial Market Strategies Uganda provided training in business skills, marketing, and credit management alongside this, and has produced a business handbook for private health providers. The 3-year, USAID-funded project is expected to provide training and funds to 280 private healthcare providers ([www.cmsproject.com/country/africa/uganda.cfm?view=normal](http://www.cmsproject.com/country/africa/uganda.cfm?view=normal)).

In Kenya, Futures Group Europe initiated a small network of 38 private sector midwives to provide a range of reproductive healthcare advice and services. In addition to free contraceptive and vaccine supplies, the Ministry of Health supplied the midwives with free bed nets and malaria treatment, with the sale of the bed nets providing a revolving fund for the midwives ([www.fgeurpoe.com/site/mdmken.asp](http://www.fgeurpoe.com/site/mdmken.asp)).

Such projects seem to have potential, but are generally small scale; long-term sustainability, once donor project funding has ended, is uncertain. These types of pilots have tended to focus on the low-technology end of activity, on ambulatory care and normal delivery.

In Africa, contracting has been used successfully for primary care, training, ancillary services, and nutrition interventions. In addition, contracting has been successfully used in other regions for secondary and tertiary care, especially for specialized clinical interventions. Contracts are shaped by the nature of the service to be provided; the amount of risk that each party is willing to absorb; and the capacity of the public entity to create and administer contracts. Another consideration is the market for providers—whether there is sufficient private capacity to enable competitive bidding; whether providers are not-for-profit or for-profit, and thus respond differently to incentives; and whether the market is such that private provid-

ers would be inclined to partner with the public sector.

This chapter reports the characteristics of and lessons learned from the review of a number of contracting programs in Democratic Republic of Congo, Madagascar, Senegal, South Africa, and Zimbabwe (see details in Annex 4). The review is by no means an exhaustive account of contracting activity in Africa, but rather is meant to provide an overview of a larger strategy on public-private partnerships for the delivery of health services.

*Types of providers.* The review found that governments contracted with both for-profit providers, including institutions and individu-

als, and not-for-profit providers, predominantly secular non-governmental organizations (NGOs), community-based organizations (CBOs), and religious organizations. NGOs/CBOs and locally based individual contractors were found to be particularly effective with interventions that relied on closeness to and knowledge of communities, as well as long-term interactions requiring the changing of attitudes and behavior. This was the case with nutrition programs in Senegal and Madagascar, where community participation and ownership were key to the initiatives' success. Some countries still experience problems with the legal status of some private providers who need to have a status that allows them to enter into a legal agreement (see the section on Regulatory and Legal Framework below).

*Reasons for contracting.* In nearly all of the cases, governments' decisions to contract resulted from a need to reach underserved areas or to provide services for which the government had limited capacity, rather than an explicit policy to encourage private sector provision.

*Contract specifications.* Contracts were predominantly input-based, with both fee-for-service and lump-sum payment mechanisms. Contracts in many cases were poorly specified in terms of standards of quality, measures of performance, and sanctions for non-performance. This was the case of contracts with general practitioners in South Africa, where supervision of general practitioners was limited and sanctions were rarely, if ever, enforced. Practitioners were governed instead by professional ethics, ties to the community, and the goal of serving the public good.

*Tendering process.* Competitive bidding has been used in some contracting programs, although more often among NGOs than among for-profit providers. The contracts with for-profit providers were non-competitive,

negotiated agreements. In some cases, it was seen that there was not sufficient competition within the private sector to support a bidding process (and thus promote greater efficiency and cost reduction). The fact that private-for-profit providers supply counterpart funding is apparently an excuse for non-competitive bidding. Experience in other regions (and sectors) has shown that contracts for services are generally most efficient and may provide greater public benefits when tendered through a well-designed and carefully implemented competitive bidding process.

*Government capacity to contract.* The costs of formulating, negotiating, and administering a contract are high, and the sophistication needed to devise and administer a contract, especially for complex services, may be extremely high; in addition, capacity for such operations may be limited. Several of the cases reviewed revealed that the government did not have the capacity to effectively negotiate and enforce a contract. This resulted in the government attaining an unfavorable risk-sharing position with respect to the contractor, little monitoring of contractors or enforcement of sanctions, weak incentives to contractors, and few efficiency gains from contracting. In the case of a long-standing contract between a private hospital and the government of Zimbabwe, the government's lack of capacity to appropriately screen patients, as well as the fee-for-service nature of the contract led to excessive use and an enormous cost burden (70% of the provincial non-salary recurrent budget).

In some successful cases, NGOs are taking over part (or all) of the job of administering contracts, thus relieving the government of a role for which it is often not well equipped. The successful Community Nutrition Project in Senegal was administered by a delegated contract management agency (Agetip), which managed contracts for the government and monitored and implemented the project. In the DR Congo and the HIV/AIDS Disaster Response Project in

Burkina Faso, large, predominantly international NGOs were contracted by the government to subcontract many of the health interventions to smaller NGOs and individuals. This also encouraged small, often local, institutions to participate in health initiatives.

*Government information.* Governments often lack knowledge of the private sector and of costs of provision, weakening their bargaining position and reducing any efficiency gains from contracting. In the case of a contract between the South African government and a for-profit hospital company<sup>XLIV</sup>, the government's lack of knowledge about actual costs of provision and the extent of competition led to efficiency gains being captured by the company, not the government, in the form of higher profits.

Lack of management information systems that cover the size and mix of the private health sector, the regional distribution of private providers, the experience and qualification of practitioners, and the nature of private health infrastructure is a serious constraint. To build this capacity, some countries recently created PPP units in their MOHs to serve as an interface between government and the private sector, and to become specialized in dealing with the private sector; this is the case for Burkina Faso, Senegal, Uganda, and South Africa, among others.

A lot of work remains to be done to strengthen the capacity of both the public and private sector in contracting. WHO and the World Bank Institute have launched several courses on the subject in collaboration with local training institutions. IFC works directly with governments—advising and training ministries of health and health insurers on contracting and PPP projects through the design, tender, and implementation process.

*Regulatory and legal framework:* a major challenge for governments is establishing the legal and regulatory framework that protects the rights and responsibilities of all parties: government, patients, and providers (whether public

or private). Important elements of this framework include ensuring the legal status for contracting (both on the government and provider sides) and the design and implementation of contracting policies to minimize the uncertainty of any party to the contract. Some countries, including Ghana, have adopted such policies, while others, such as Senegal, are in the design process.

*Payment for services.* A critical concern of the private health providers is the rapidity and regularity of payment for services should be (Mills and Broomberg 1998). In several cases, government bureaucracy was such that payments were delayed for long periods, seriously handicapping the private provider. Reluctance of governments to cede control of services and funding to the private sector also resulted in delays. Using a delegated contract management agency has helped solve this problem, at least in the case of the Senegal Community Nutrition Project, and it's now being tried in other countries.

Despite some shortcomings, contracting of services has been quite successful in some instances. Contracting is a trend to encourage, and governments can be helped to become purchasers of services rather than direct providers. However, contracting must be done correctly, with strong regulatory and legal frameworks. Service contracts should contain detailed quality and service standards. Regular monitoring and adequate evaluation mechanisms are a must.

Another worldwide review of contracting, by the World Bank, looked at 10 well-documented experiences in Cambodia, Bangladesh, Bolivia, Guatemala, Haiti, India, Madagascar, Senegal, and Pakistan<sup>XLV</sup>. All 10 studies found that contracting was successful. Four cases with controlled or before-after groups had improvements in health indicators ranging from 9% to 26%. Six of the studies compared contractor performance to government provision of the same services, and all six found that the contractors were consistently more effective.

## ii. Leasing of equipment and facilities

Leasing can be used in two ways in the health sector: (i) *equipment leasing*, designed to fund necessary equipment to provide services; and (ii) *facility leasing*, used to provide new management to an existing healthcare facility. Equipment leasing has been widely used in other sectors as a cost-effective means to increase capacity, but has not been used often in the health sector in Africa. IFC has successfully developed leasing projects in other sectors and may extend these to the health sector. Leasing arrangements expand access to capital and services by funding equipment and transferring usage rights and responsibilities for ownership to the equipment operator, who may then provide services to both publicly funded and private-pay patients to generate income to cover the lease payments.

Providers (public and private) can also use leasing in a defined service area to pool their resources and meet requirements for medical equipment that would otherwise be unaffordable to individual health facilities. In Guinea, a CD4 counter was bought in 2004 by government and leased to a private laboratory that ensured its maintenance and tested HIV-positive patients. In South Africa, several public hospitals have leased surplus bed space (instead of closing them) to the private sector, which needed hospital beds but did not have the capital to invest in a stand-alone facility.

Lease arrangements give the private provider strong incentives to operate efficiently, because the provider's profitability depends on how much it can reduce costs while still meeting the quality standards specified in the contract<sup>XLVI</sup>.

## iii. Concessions

Concessions, widely used for physical infrastructure projects such as transport and utilities, are a common legal instrument used by governments to manage the private sector provision of public services. As concessions have become more common in Africa, their use has spread to the health

sector, primarily in South Africa. Under a contractual agreement, government defines the services to be provided, the standards at which the service will be provided, a pricing framework, and the length of time during which the concessionaire will provide the services. Experience has shown that the most successful concessions are output- rather than input-driven, leaving the provider to determine the most effective and efficient way of providing services within the confines of the contract.

Concessions require either management of public assets for a defined (usually long-term) period, or require new construction. The latter have several structures, the most common are BOT (Build-Operate-Transfer), BOO (Build-Own-Operate), and BOOT (Build-Own-Operate-Transfer). These models allow government to shift its role from investor in infrastructure, employer, and provider to a more concentrated role that defines policy and makes strategic purchases of services. Increasingly, governments are using these tools, with some adaptations, in the health sector to meet increased demand.

South Africa has developed the continent's most advanced hospital concessions as an extension of the Treasury Department's Public Private Partnership program (see Box 5). South Africa has followed the early concession model developed in the U.K. that provided only for support and technical services to be included in the concession. The U.K. has advanced their model, following the lead of many European and other countries, to include clinical services as part of concessions for health, a development that may be soon replicated in Africa.

The Pelonomi concession described in Box 5 includes an interesting feature that is being considered by governments in several other countries: the co-location of a private wing within an existing public facility. This arrangement benefits all parties. For the public facility, their employees and patients, there may be access to updated equipment, possible facility upgrades, and the potential for limited private

**Box 5****Examples of concession in South Africa**

The Inkosi Albert Luthuli Hospital in Kwazulu-Natal was designed to provide the region (one of the fastest growing in the world) with state-of-the-art tertiary care. The winning consortium, which included Siemens medical systems and equipment and a leading IT systems group, will provide full facility management, medical equipment provision and maintenance, and specified facility upgrades throughout the 15-year concession period. Government closed five aging hospitals in Durban neighborhoods to concentrate its resources on Albert Luthuli. Siemens has designated the hospital as a paperless facility and works there in cooperation with South Africa's public medical staff to pioneer IT solutions for healthcare management. It is estimated that this concession will save government 370 million Rands over the 15-year partnership.

A similar model was used by Treasury to attract investors to refurbish the Pelonomi hospital in Blomfontein. In this model, the Free State Government and South Africa's leading private healthcare provider, Netcare, entered an agreement for Netcare to refurbish and update the entire hospital facility. In addition to this capital investment, completed in 2004, Netcare will take over one wing of the hospital to provide services using their own staff and equipment to private pay patients.

Netcare will also share access, under strict contractual agreement, to some of the operating and other facilities with the public medical staff. All parties are able to achieve their objectives: government increases public access to affordable and updated services, and the private provider makes a cost-effective entry into the middle-income market that is developing in South Africa.

practice. A private wing may offer the private provider the potential to establish hospital-related services with only a portion of the capital investment that would otherwise be required.

In the early 1990s, the government of Benin gave the health center of Menontin in concession to a private religious association for 10 years. An evaluation is not yet available.

**Possible Bank and IFC roles.** IFC's Advisory Services department focuses on assisting governments to make efficient use of current spending for publicly funded health services. This is accomplished primarily through public-private partnership projects designed to tender for the private provision of these publicly funded services. IFC has successfully designed and implemented health PPP projects using various

forms of contracting—a private wing project and concessions in other regions—providing governments with the technical, regulatory, and legal framework required to process, monitor, and replicate these complex transactions.

IFC provides a team of transaction and technical specialists and, working with government, prepares the tender documents, including contracts for the provision of services along with details of staffing, service, equipment, quality standards, performance bonds, insurance requirements, penalties for nonperformance, and other specifications. Potential service providers are pre-qualified in preparation for the tender to ensure their strength, both clinical and financial. The relevant contracting agency (generally a ministry of health or health insurer) works alongside and is trained throughout the process

by IFC. At the conclusion of the tender process, government is provided with model documents for replication of the pilot projects.

#### iv. Divestitures

Divestiture is the selling of government assets to the private sector, forever. This has not happened in Africa, but the closest, described below, has been to transform a public entity into a private one; however, the assets remained government property, so what is described here is a mix of a concession and a divestiture.

The Central Medical Stores of several countries, namely in Cote d'Ivoire, Guinea, Mali and Niger, became autonomous as 'Etablissements Publics.' In Benin, Burkina Faso, Madagascar, and Cameroon, they were transformed into non-profit organizations with the state being present in their 'management board' and have been operating as such since the early 1990s. Success has been mixed.

**Possible Bank and IFC roles.** Those experiences need to be evaluated to see if there are any lessons to be learned, and the World Bank will soon finance such an evaluation. The question to answer is whether such arrangements have improved access to quality essential drugs by the poor.

#### v. Franchising

##### *Concept of franchising*

Franchising is a type of business model in which a firm (the franchiser) licenses independent businesses (franchisees) to operate under its brand name. In general, a firm chooses to franchise, rather than manage its outlets in different locations, when it wants to shift day-to-day management responsibilities to franchisees and expand its business network more rapidly. Franchising is not a new concept in Africa. For example, 20 franchise systems are estimated to

#### Box 6

##### **Divestiture in the pharmaceutical sector, the case of Guinea<sup>xlvii</sup>**

In Guinea, in 1994, the state-owned "Pharmacie Centrale de Guinée" became an autonomous body under the "Tutelle" of the MOH, with government representatives on its board, but with no other input from government. It operates as a business, and its staff is paid from its profits. Government uses it as any other private drug wholesaler, it bids along with other private sector entities. It has no privileges, paying the same taxes as any other private entity. It wins quite a few government bids because it buys in bulk with other similar agencies from the West African sub-region. It imports and distributes drugs to hospitals through a network of five depots distributed throughout the country. Both private or public health structures can buy from this wholesaler. Its turnover increased from US\$1.5 million in 2001, to three times this amount in 2002, and increased again in 2003. However, it faces the following problems, which endanger its sustainability:

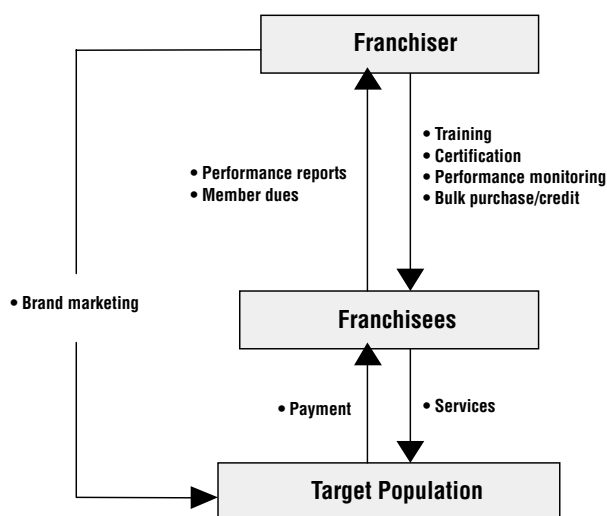
- although its profit on drugs was 17% in 2002, it decreased to 5% in 2003 due to the devaluation of the Guinean franc, coupled with long delays in payment by its main client, the government.
- the contract it signed with government is not adequate and does not protect the "Pharmacie Centrale de Guinée": there's no legal recourse mentioned, payments are made 100% after the drugs have been delivered, there's no limit for delays in payments by the client.

be operating in Cote d'Ivoire, mainly in fast food, automotive rentals and hotels, while approximately 478 franchises are operating in South Africa, 82% of which are of domestic origin.

The franchising approach has been used in the African health sector in the past decade. A review revealed that more than a dozen countries have launched a type of franchise in health (See Annex 2 for a description of five franchises). While there are some variations, under a typical franchising structure in the health sector, the franchiser sets performance criteria, trains franchisees, monitors their performance, and markets the brand name to target population. Franchisees are accountable to the franchiser to provide services at specified level, and may pay member dues (Diagram 1).

**Franchising in Africa.** In preparing this paper, the team conducted a desk-review of existing franchising programs in Africa (see Annex 2) and made the following observations. These observations are meant to provide a snapshot of the current situation. They are formed based on existing articles and franchisers' Websites and not on the result of a rigorous evaluation. In

**Diagram 1**  
**A typical structure of franchising in health**



addition, the clinic chains—such as those rapidly developing in South Africa—were not included in the case study, as they are often owned centrally and do not fall under the definition of franchise given above<sup>3</sup>.

- Successful franchising requires standardization of services that enables relatively straightforward training and monitoring. This is especially important when the capacity of potential franchisees is limited. Most franchises started out by providing services that are goods-intensive and relatively easy to standardize, such as essential drug provision (e.g. CFW in Kenya) and family planning (e.g., K-MET, TOP Reseau).

However, franchising is being applied in other areas of services, especially to address the HIV/AIDS crisis in the region (e.g., New Start). Some existing networks originally established for more “traditionally franchisable” services have ventured out to include HIV/AIDS in their services as well. (e.g., KMET, CFW).

- The franchisers tap into existing resources to expand service coverage, whether they are general practitioners, nurses, or community-based health workers.
- The franchisers are not-for profit organizations. PSI, which is running a majority of franchises in Africa, is building on its experience in social marketing to expand its franchising network.
- The cost of running franchises can be high for the franchiser, and some franchisers, such as K-MET, rely substantially on the work of volunteers. *Franchisees* may become self-sustainable—for example, 80% of the CFW

<sup>3</sup> For more information on clinic chains in South Africa, see Palmer, Natasha et al, “A new face for private providers in developing countries: what implications for public health?”, *Bulletin of the World Health Organization*, 81(4) pp292–297, 2003.

franchisees operate in a self-sustainable manner. However, franchiser's sustainability remains to be tested. Among the cases reviewed, only one franchiser (CFW) has estimated the scale of operation that allows it to become self-sustainable.

- Successful franchises seem to offer franchisees proprietary gain from the franchise. Anecdotal evidence shows that joining TOP Reseau resulted in higher use of clinics for some doctors, and the founder of the CFW network concludes that it was key to the network's success to date.
- Successful franchises combine supply-side and demand-side interventions. On supply-side interventions, all programs provide quality control to service providers. On demand-side, franchises conduct an aggressive mass media campaign, and at least one (TOP Reseau) mobilizes demand through the work of peer educators who lead education sessions in the community.
- Unlike other types of PPPs, such as service contracts and management contracts, most of the franchises have limited partnership with the public sector. Most partnerships, if any, come in the form of donation of free commodities from the government (e.g., K-MET) or contribution from international donors.

#### Possible Bank and IFC roles

- As mentioned previously, cost effectiveness and sustainability of franchises has not yet been vigorously studied, especially as compared to other modes of service delivery. The World Bank may finance operational research into the cost effectiveness of a franchise program.
- Franchising has potential to deliver services to the poor, as it mobilizes existing health practitioners who are located close to the poor. As such, government may have interest in forming partnerships with franchises, and tap into their network to deliver subsidies to

the poor. Such partnerships have yet to be formed, however. The World Bank may play a role in helping governments establish a framework for partnership. This may include:

- Establishing a policy environment that acknowledges the role of private practitioners, including informal service providers
- Establishing standards to ensure the quality of services, and to clarify qualification required to offer certain kind of services. They may include licensing and accreditation
- Clarifying procedures to select private partners and establishing transparent mechanisms to transfer funds
- Aligning private incentives to policy goals.
- Many franchises focus on providing primary health care. While government may provide more cost-effective services by establishing partnerships with such franchises, potential cost savings and benefits of such partnerships will be minimal without a strong referral linkage that allows for comprehensive coverage of health care. The Bank may play a role in assisting a government establish effective referral networks.
- IFC can play an important catalytic role, as it did with the SHEF project franchise in Kenya (described in Annex 2). IFC worked with the founder on the business concept, provided access to funds, business training and advice, and other start-up resources as the franchise concept was refined, grew, and spread to the current network of 64 providers.

#### d. Facilitation

In this type of intervention, government make sure the private sector is represented in policy forums and that it can access information on how to contribute to public health goals as well as obtain the necessary financing. This report

gives several examples of the private sector being represented in policy bodies. This trend needs to be strengthened, as it is not common. In addition, unless the forums concerned are efficient, there's an opportunity cost to attend such meetings, which the private-for-profit sector usually considers. The private sector will also have to fight to gain a place at the policy table, as not all governments will offer it.

## **e. Shifts in paradigm, trends and opportunities to grasp**

### **i. Public-public performance-based contracting**

Lately, following the decentralization trend in most of Africa, some governments are starting to contract public entities, in the same way they'd contract private providers. Formal contracts—used when dealing with the private sector—are replaced by “Memoranda of Understanding” when dealing with two public entities, but the same principles as in a public-private contract apply. This trend is an attempt to increase efficiency, transparency, motivation, and successful outcomes in the public sector.

The trend is to sign “performance-based contracts,” as was tried by Burkina Faso with some degree of success (see Box 7). This represents a shift in paradigm in the sense that those agreements give incentives for the service provider to reach, or even go beyond, the stated objectives. Such developments might help in making public-private partnerships contracts more acceptable.

The reason why such formal agreements seem to be well received might be because they help ensure that rewards are based on objective criteria. This is not the perception most civil servants have in a non-performance-based contracting environment, where rewards are often perceived as due to solidarity networks, ethnic ties, and other factors.

The problem will be to ensure that these agreements and eventual bonuses are really enforced and applied.

### **ii. Decentralization**

Most African countries have initiated a decentralization process, but few have gone beyond deconcentration. However, this decentralization trend is an opportunity to increase public-private partnerships. Most communes, or other decentralized entities, know better than anybody else who are the best service providers in their area. Decentralized entities could monitor their performance more easily than the central government would, and they are more accountable. However, local officials have not yet fully accepted the PPP concept. In Tanzania, for example, the 2005 Technical Review of PPPs noted that strategic health planning at the district level does not yet properly accommodate PPPs. There's thus a need to train decentralized public servants as well as elected officials, such as mayors and their teams, in PPP concepts.

### **iii. Private sector human resources**

Some argue that—considering the lack of human resources in the public sector—it would be counterproductive to encourage the private sector, as this might constitute another channel of brain drain from the public sector. A counterargument is that the private sector already exists, and we just want to make it more efficient and improve its quality. An additional argument is that the nature of the provider, whether public or private, is not as important as the outcomes, as measured by MDGs and other agreed targets for public health and human development.

The concern should be how to encourage employees to serve healthcare consumers better; how to stop the brain-drain outside of the continent by providing better opportunities throughout the entire health sector in Africa; and how to ensure that the existing private sector human resources contribute to public goals. Sev-

**Box 7****The Burkina Faso experience with public-public contracting<sup>XLVIII</sup>**

There appears to have been growth in some output indicators during the period of the program (e.g., immunization coverage), while others remained static (e.g., assisted deliveries and use of curative care services). However, methodological limitations make it difficult to link the program to either of these phenomena. Some evidence suggests that deficiencies in the health system's delivery structure may also have influenced performance during this period.

Greater attention needs to be paid to incorporating a systematic research evaluation component into programs of this kind. Research is necessary to examine the effect of institutional capacity and delivery structure variables on a variety of health system performance outputs that are linked to individual/household behavior change and ultimately to improved health status outcomes. Scientific evidence that performance-based management programs in the public sector can contribute to improved health system performance is urgently needed.

The foremost challenge for the immediate future is whether this model—implemented with Bank financing—can be replicated by governments with the support of a bilateral donor. It is essential that the legal framework within which the program was implemented—in particular, a waiver to the existing law of finance—be re-evaluated. Procedures and requirements will also need to be simplified. Priorities, as articulated in the performance indicators, will need to be re-examined to ensure compatibility with the new health sector development plan.

A better balance must be achieved between financial and technical performance auditing. Increased engagement of technical managers of vertical disease-control programs at central level also must be obtained. To achieve better efficiencies, greater decentralization of program oversight and management responsibilities should be considered. Support to health facility-community management committees came late in the program and should therefore become a primary focus of attention.

Many questions remain. Can greater coherency be achieved in internal and external assistance to sub-national levels, so that managers can exercise greater autonomy and control over the resources required to achieve their priority outputs? Institutional capacity is necessary but not sufficient in itself to achieve improved health system performance. There are a considerable number of delivery structure problems; can they be adequately addressed?

An important lesson learned from this first experience is that decentralized management programs are likely to achieve only partial success without concurrent policy reforms and capacity building at central level in a wide range of systems, such as planning, budgeting, and health information. Those lessons can also be applied to public-private partnerships.

eral solutions are outlined below, each based on two principles: motivation of personnel and increased accountability.

Ways to increase motivation:

- Help public employees (those who already work in the private sector for themselves anyway) set up their business by giving them

management training, franchisee training, and encouraging franchisers to set up business in drug retail or selected health service delivery

- Facilitate access to credit for private providers who want to work in certain underserved areas
- Provide training opportunities to private sector providers

- Work on the basis of performance-based contracts, be it with the private or the public sector, and stimulate competition by making results known.

Ways to increase accountability:

- Encourage medical graduates to set up their private practice in rural areas as country doctors. Mali has done this and their 80 country doctors are providing quality services to their communities
- Hire people who come from, or live in one area, to work in that area
- Support demand-based programs where local communities want to work with health providers and will sign contracts with them (community health mutuals, community health centers, for example).

Zimbabwe allows public-sector doctors to run their own private clinics after hours, and this constitutes a large proportion of the private provision. More than 50% of doctors work in the

private sector. An assessment identified government incentives to encourage private-for-profit providers to participate in health care provision. Monetary incentives range from tax credits to full tax exemptions for some services, such as health financing by Medical Aid Societies. Non-monetary incentives, such as training, were more inclined to ensure quality of care. Contracting out of some public services was the most unexploited incentive, and was therefore recommended as a way forward to creating efficiency at public facilities with minimal cost to the government<sup>XLIX</sup>.

#### iv. Private Internet communication technology helps service delivery

Private telecommunication firms could help set up or partly subsidize communication technology, which would improve health care delivery (see Box 8). In addition, phone technology could be used as vouchers, which would eliminate the high administrative costs of vouchers and limit leakage.

### Box 8

#### Examples of the use of private sector Internet technology to improve health service delivery in Kenya and South Africa

In Kenya, “Afriafya” was set up in 2000 as a consortium of seven partner agencies, all NGOs, and financed by the Rockefeller Foundation. It helped to set up computer communication equipment and train health personnel in seven dispensaries and it targeted AIDS. After 18 months of implementation in one of the districts, the information-coverage of reporting rose from 49% to 92%<sup>L</sup>. Improved reporting provides adequate and timely feedback to the service providers and is vital to better planning.

A South African NGO, ‘Cell Life,’ financed by the Vodacom Foundation and in partnership with the University of Cape Town and Cape Technikon, another training institution, provides help to 500 HIV-positive patients. The strategy is as follows: “Severe limits to resources mean that the flow of information between doctors, hospitals, and patients has always been a challenge in rural South Africa. The extent of this challenge is illustrated by the fact that there are only 18 telephone lines per 1,000 people in some parts of the country. However, cellular networks cover more than 90% of South Africa, and with a third of all South Africans currently using cellular phones, this information gap can be closed.

*(continued on next page)*

**Box 8** *(continued)*

As an example, when an HIV-positive person is at a level suitable for treatment, the individual is interviewed for acceptance into an ARV treatment program. Once in the program, the person is assigned to a therapeutic counselor. Typically, counselors handle from 15 to 20 HIV-positive people. They are trained to gather vital information about these people, using a cellular phone equipped with sophisticated application software developed by Cell-Life engineers. The cellular phone provides a menu-based, real-time system to capture treatment relevant patient data, such as symptoms, drug adherence, and socio-economic factors. This information is logged immediately and directly to a central database. Efficient and user-friendly, this technology eliminates the need for cumbersome paperwork and provides a solution to logging accurate data about AIDS patients on a large scale, with minimum cost, maximum efficiency, and significantly less human error.” (*www.cel-life.org*).

**v. Globalization of public-private partnerships for health service delivery**

These days health care delivery cannot be limited to just national frontiers. Africa is developing centers of excellence that can serve populations of the entire continent, and beyond. A couple of examples were given previously for Mali and Kenya (see Para. II.d.).

Another example is South Africa, where a private service provider, Netcare, sells services to England for ambulatory eye care clinics. Netcare personnel go to England a few months at a time and return enriched by the experience. Thus, human resources and technical plateau problems should start to be analyzed on a regional and global basis, no longer solely on a national one.

## Private sector and Governments' challenges and possible responses

### a. Private sector challenges

**P** rivate providers in Africa face a range of challenging circumstances—lack of infrastructure, limited access to supplies and equipment, loans at very high interest rates, and other elements that can drive up the cost of services. Still, many recognize that they can cost-effectively serve a larger market, including the poor, if they can develop a reliable paying market at a variety of service levels. In order to reach this viability, private providers require reliable purchasers at rates that cover costs. This response from the private sector must be met with an equally committed effort from government.

A number of important challenges to the private sector were identified by the mostly private-sector participants in the Kenya PPP workshop organized by the authors in June 2004. The challenges included:

- The need for the private sector to *get organized* so that a government does not have a multitude of partners to deal with. An example is the way NGOs got organized and are now regrouped in many countries under one to three umbrella organizations. Such organization allows government to quickly

reach the whole network of NGOs. Although many professional associations exist, they are still too fragmented and numerous. For example, there are associations of private clinics, of midwives, of medical doctors, of nurses, etc., which all need to come together under some sort of umbrella representation. This will allow them to (i) have a stronger voice in the dialogue with government and donors; (ii) be organized to receive funds; and (iii) find ways to avoid delayed payments to private providers for reimbursements by government.

- *Gain a place at the policy table* so that the private sector is represented, informed, and can take advantage of opportunities that present themselves. This can be done through business coalitions or professional chambers. Some governments have already taken actions to improve partnership with the private sector. For example, in Burkina Faso a permanent committee was created in 2001 by the Ministry of Health with the private sector. In 2002, a sub-directorate for Private Health Care was created, and now there are private sector representatives on the monitoring committee of the National Health Program.
- Professional associations could also claim *the role of peer reviewers* to ensure quality of care

in the private sector. Such peer reviews are usually quite effective, and a periodic external evaluation could be set up by Government to ensure sustained results. Those “semi-accreditation” bodies could be contracted by government to maintain the quality of care based on government standards.

- Once the private sector gets organized, gains its place at the policy table, and receives funds, it will have to be careful not to become too dependent on government subsidies. In most African countries such *subsidies cannot always be expected to continue*.
- *Pooling of procurement for drugs and supplies* is done by some private entities such as religious associations. This example should be followed by the for-profit sector so as to be able to obtain less expensive drugs.

## b. African Governments’ challenges

The government has two main types of tools that it must use together to ensure that poor people have access to adequate health care:

- *Empowering tools* give the consumer the power to decide where to seek care and to require quality care. Today, poor people tend to avoid the public sector because of the way they are treated and because they have to pay a high price for unsure outcomes. Health insurance, health mutuals, performance-based contracts, and vouchers are all demand-side tools that can help the poor increase its choices. In addition, giving a place at the negotiation table to private providers as well as to consumer groups is another way to empower civil society. This can only be done by working with private-sector or consumer associations, federations, or coalitions.
- *Supply tools* must be put in place by government to ensure it does not act as a predator on the poor, such as it is happening now when corruption prevents the poor from benefiting from public services. Paying its own public

labor force adequately is a *sine qua non*. Government can also encourage private providers to work for poor communities as has been done in Mali, with community control. Government should also enforce regulations so that the private sector provides a minimum standard of health services, like the South African accreditation system. Public-private partnerships are a way to improve standards in the private sector, to cross-subsidize in order to give more money to the poor, and to liberate the public sector from serving the rich so it is available to the poor.

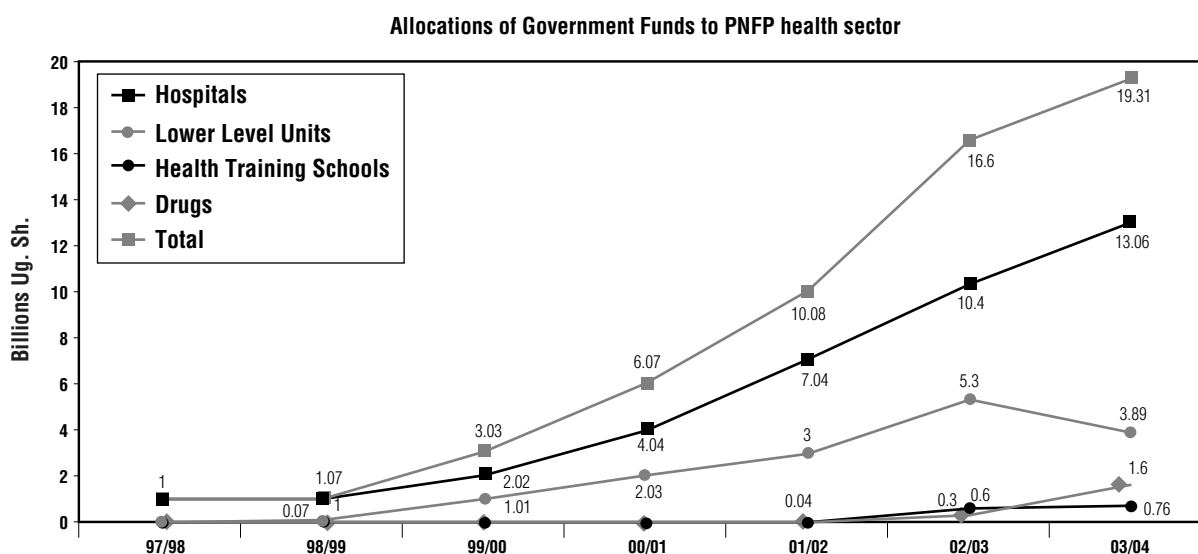
One of the most notable supply tools tried in recent years in Africa and elsewhere is Output-Based Aid (OBA). OBA is a way of allocating public resources, such that government contracts an entity to deliver services and ties payment to the services actually delivered. This has the potential to address issues related to ineffective targeting and lack of accountability.

OBA forces government to specify outputs clearly, which is not always the case with input-based approaches. Second, by tying disbursement of public funds to specific outputs, OBA provides a clear framework for accountability and strong incentives for efficiency. Third, the link between disbursement and outputs also means that it provides incentives for innovation. Finally, under OBA, government screens service providers who are qualified to offer specific services. By tying qualification of providers to eligibility to receive public funding, OBA provides an incentive for service providers to raise their standards of services. The German KfW has started to implement OBA programs in Kenya and Uganda.

Other supply tools include:

- Making it easier for private providers to obtain their licenses. For example, in Ethiopia the private providers obtain their licenses only from regional health bureaus. This is perceived by them to be overly centralized, and most believe it should be delegated to the

**Graph 7**  
Uganda's government financing to NGOs



**Source:** presentation by Dr. George Bagambisa, Coordinator of the PPP Unit, MOH, Uganda, on "PPP in Health: Uganda's Progress," PPP Workshop organized by the World Bank, Nairobi, Kenya, June 2004.

zonal level. License renewal is also bureaucratic and often takes a long time<sup>LI</sup>.

- Helping training institutions provide courses on PPP to public and private professionals.
- Finally, financing the private sector through different PPP programs. Already, quite a few countries have been financing the private sector with subsidies, but very often without asking for results (Graph 7). It is time for this to change.

Lessons from existing experiences<sup>LII</sup> highlight elements that policy makers need to think about when considering public-private partnerships:

1. *Political commitment*, which is needed for any new way of doing things. It will help make the new mechanisms more acceptable to practitioners, particularly by explaining that such partnerships do not necessarily mean privatization or disengagement by the state;

2. Recognize *there is an array of public-private partnerships programs* the government can use, depending on what responsibilities and risks it would like to delegate to the private sector;
3. Accept that the partnership is not a one-time affair, but is *a relationship that needs to be nurtured from the inception to the termination of the partnership*. This requires sustained effort;
4. Do not underestimate difficulties, and *make sure that the state uses all possibilities to help it manage these partnerships*. For example, using delegated contract management agencies to manage the multitude of contracts;
5. The *need for public-private partnerships policies* to provide the proper environment;
6. The role of the state in *investing in training, regulation, capacity building, monitoring, and mediation*;
7. The need for *quantitative evaluations* to ensure that more lessons are learned as soon as

possible. It is important that third-party evaluation be organized to assure objectivity.

These elements reinforce the government's stewardship role, which is essential to successful PPPs. To help governments carry out their

role as steward, this report outlines an array of policies governments can use to work with the private service providers, depending on their goals. These policies are summarized in Table 11, which also spells out some elements for improvement based on what exists now in Africa.

**Table 11**  
**How each policy and intervention can be used to reach public health goals, and examples on how to improve on what exists**

<b>Reason for PPP</b>	<b>What government wants to do</b>	<b>Type of policy most used</b>	<b>What governments usually need to improve</b>
a. To increase coverage by using existing providers	Motivate private providers to serve the poor through targeted financing	Formal PPP Financing	<ul style="list-style-type: none"> <li>• use OBA for formal PPP</li> <li>• give faster feedback on issues raised by private sector</li> <li>• provide more information and communicate better with private sector (open more communication channels; institutionalize dialogue between govt. and private providers)</li> </ul>
b. To increase coverage where govt. is not present	Motivate private providers to move to those places	Financing Regulation Facilitation Formal PPP	<ul style="list-style-type: none"> <li>• pay contracts faster</li> <li>• improve health referral system</li> <li>• ensure contracts are well designed</li> </ul>
c. To increase coverage by providing services that govt. is not providing	Motivate private providers to provide new services	Financing Regulation Facilitation Formal PPP	<ul style="list-style-type: none"> <li>• facilitate registration</li> <li>• let private managers manage</li> </ul>
d. To improve service quality of private providers	Motivate private providers to apply the standards	Regulation Facilitation	<ul style="list-style-type: none"> <li>• improve supervision or inspection by MOH</li> <li>• allow more private representation</li> </ul>

**Source:** Author's own design.

## The World Bank's and IFC's challenges and possible responses

### a. Portfolio review of what the World Bank is doing on PPPs in Africa

**T**he study team reviewed 40 health projects in the Africa region approved between Fiscal Year 1995 and Fiscal Year 2003 to determine the nature and extent of private sector involvement. The results showed that:

- 23% of projects from 1994 to 1998 had high private sector involvement, compared with 57% of projects approved between 1999 and 2003
- In 13 out of 40 projects (33%), no mention was made of the private sector
- In 19% of projects, the private sector—NGOs or community-based organizations (CBOs)—was expected to help finance project activities. The amount of co-financing expected from NGOs and communities ranged from 5–25%. No project specified co-financing from private actors other than NGOs or CBOs
- The for-profit private sector played a role in 40% of projects reviewed, with physicians, pharmacies, and clinics each involved in 22% of projects. “Industry” actors, including pro-

ducers/distributors of bed nets, contraceptives, food, pharmaceuticals, and oral rehydration solution were involved in 31% of projects

- Health services from the private sector included primary care (34%), STD/HIV prevention and treatment (26%), hospital services (20%), reproductive health care (14%), nutrition services (14%), and maternal and child health care (11%)
- In one-fifth of projects, the private sector played a role in financial protection by establishing rural or community health funds
- Partnerships were implemented mainly through service contracts (66%), management contracts (33%); there was no leasing, divestiture, or franchising
- 43% of projects involved some form of training for private sector actors
- Regulation was used to engage the private sector in 29% of projects.

#### Notable Successes

- High involvement of NGOs and communities in successful nutrition projects
- Community-run projects—additional examples of success in reproductive health.

### Challenges identified

- Government resistance
- Contract delays plagued many of the projects
- Lack of private sector expertise among Bank's task team leaders
- Lack of engagement of informal private health sector.

### What's needed in the Bank to more effectively engage the private sector

- Further information on the size and scope of the private health sector in countries
- Additional support from private-sector experts, and better-trained task team leaders in terms of PPP
- Institutional commitment by the Bank's management to work with the private sector

Another review of Bank projects from 1993 to 2002 throughout the world looked at private-

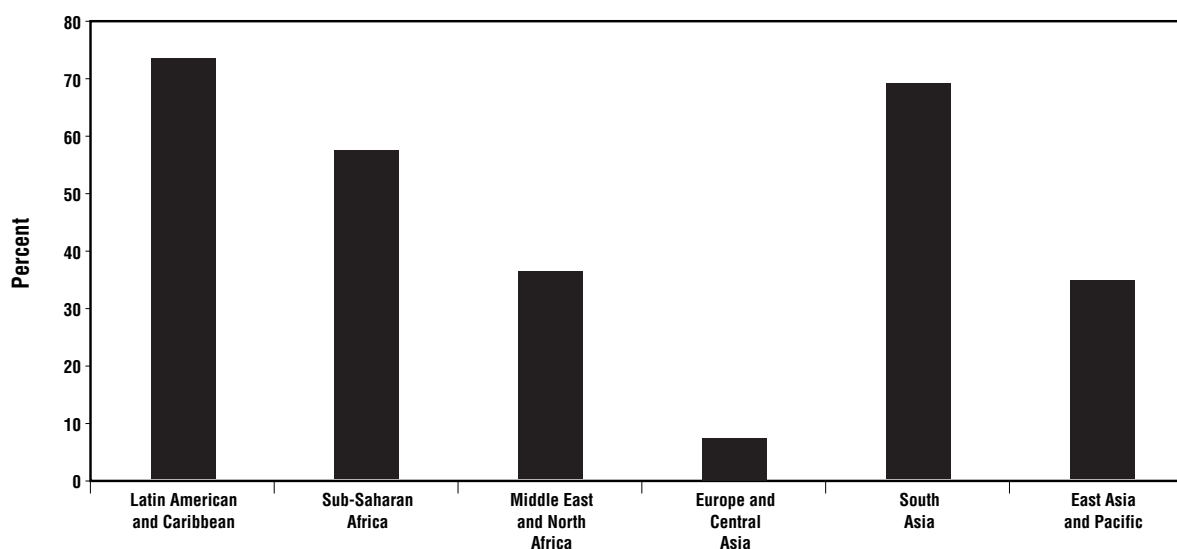
sector participation specifically in child health<sup>LIII</sup>, and its results were similar to the review described above. It revealed that about half of the reviewed projects engaged the private sector to improve child health outcomes (see Graph 9), however, sub-Saharan Africa was one of the regions with comparatively high private sector involvement (Graph 8).

### b. What IFC is doing in PPPs

IFC has a long and successful history of advising and implementing successful PPPs in Africa for infrastructure and related sectors. Based on this experience and the needs in the social sectors, as expressed by government, IFC is seeking opportunities for PPPs in health. To date, IFC has provided technical and financial support for one PPP project in health: the SHEF project (summarized in Annex 2) for a franchise of drug shops across rural Kenya. To increase the vol-

### Graph 8

**Proportion of the total number of projects financed by the World Bank with child health components that involved the private sector, by Region**



**Source:** Henrik Axelsson, Flavia Bustreo, April Harding, "Private sector participation in child health," HNP discussion paper, World Bank, May 2003.

ume and scope of projects, IFC has in early 2005 dedicated increased staff and resources to discovering and developing PPP opportunities in Africa. Such opportunities will include both stand-alone IFC and joint Bank-IFC projects.

### **c. The World Bank's challenges to contribute to PPPs**

#### **What to do Internally**

In light of the Africa Region Portfolio Review and the trends noted in this report, if the Bank is to be successful in helping its country clients to work well with the private sector, there's a need for the Bank to:

- Simplify its procedures to facilitate access to and use of IDA and IFC resources by small health service providers
- Help document and evaluate existing experiences and share them across continents
- Build on successes. The Bank has been successful in working with communities for prevention services, such as nutrition. It has not, however, been able to expand much on those successes until now.
- Train its staff on PPP, or ensure that there's personnel who can assist country teams to work on this issue by providing focal persons with enough time to work in this area. Such persons should establish a PPP network to ensure that the best consultants are made available to the country teams when needed. For this, the Bank should work with other institutions such as WHO (for policy development), with ILO (for mutuals), and with private entities (for franchising and concessions).
- Establish direct communication channels with the private sector. Having PPP focal persons

in World Bank offices could help implement this suggestion.

- Start considering health-service providers, based on the public health functions that need to be performed rather than on ownership. This means developing budget allocation guidelines, which explicitly include the private sector.
- Conduct systematic assessments of the private sector's potential to contribute to program's objectives and monitor the private sector's involvement.
- Raise the importance of PPP in higher policy forums such as those on Poverty Reduction Programs' and Credits' matrix discussions.
- Set up a PPP fund to complement the Bank's operating budget and thus ensure that this issue will not be bypassed.

#### **What to do Together with the Bank's Clients**

Based on the trends identified in this report and the comparative advantages of other institutions, it is recommended that the Bank:

- Provide training to its clients through the World Bank Institute ([www.worldbank.org/wbi](http://www.worldbank.org/wbi)). This has started, but is only a beginning. There's also the need to develop the capacity in African institutes to implement such training.
- Monitor, evaluate, and disseminate the results of lessons learned.
- Help clients develop partnership mechanisms such as contracting, concessions, and franchising.
- Study and reinforce health mutuals, which are a promising venue.
- Finance training and capacity-building in PPPs within countries.



## Conclusion

**L**everaging the private sector can be an important component in an overall poverty-reduction strategy. Data provided here did not offer any surprises or news in the fact that the wealthier use the private sector. What is news is that *the poor also use the private sector extensively*.

Some of the myths about the private sector were destroyed, many challenges identified, and some practical recommendations were provided to the private and public sectors, as well as to the World Bank and the IFC.

It is important to note that the authors do not see public-private partnerships as a panacea, but just as one of the ways to improve health systems.

One of the major contributions of this report is that it emphasizes the need to consider the health system in its entirety. Planning, financing, regulating, and formal PPPs all need to be set up based on the packages of public health functions that a government wants to deliver to different population groups, which must involve all service providers in the country.



## Annex 1: Where Do People Go for Services?

**Care-Seeking For Young Children  
with Recent Illness, Diarrhea, and/or  
Respiratory Infection in the Two Weeks  
before the Interview**

namely Mali 2001 (with 21% “other”), Rwanda 2000 (12% “other”), and Senegal 1997 (11% “other”)

**Analysis of Data from Demographic  
and Health Surveys**

*By the Sara Project, Academy for Educational  
Development, Washington, D.C., March 2004*

Countries with more than 10% “other source of care” were eliminated from the analysis,

### **Benin 1996**

<b>Source of Care</b>	<b>Rural (%)</b>	<b>Urban (%)</b>	<b>Total (%)</b>
No care sought outside the home	64.19	55.81	61.68
Shop	8.90	5.65	7.93
Traditional healer	4.77	4.56	4.70
Private pharmacy	0.00	1.86	0.56
Private doctor	0.56	1.82	0.93
Private health facility	3.26	10.01	5.28
Public health facility	17.56	18.15	17.74
Other	0.77	2.14	1.18
Total (n)	932	399	1,331

**% of people using different sources of care by quintile of wealth index**

<b>Source of Care</b>	<b>Lowest</b>	<b>Second</b>	<b>Middle</b>	<b>Fourth</b>	<b>Highest</b>	<b>Total</b>
No care sought outside the home	62.69	63.07	63.36	65.00	48.85	61.68
Shop	9.01	9.30	11.38	4.28	2.55	7.9
Traditional healer	6.62	6.41	3.38	4.68	0.00	4.70
Private pharmacy	0.38	0.00	0.00	1.01	2.30	0.56
Private doctor	0.30	0.00	0.26	2.41	2.92	0.93
Private health facility	3.66	2.38	2.71	4.97	19.18	5.28
Public health facility	17.35	17.10	17.96	14.89	23.73	17.74
Other	0.00	1.73	0.97	2.75	0.46	1.18
Total (n)	322	310	288	249	161	1,331

**Benin 2001**

<b>Source of Care</b>	<b>Rural (%)</b>	<b>Urban (%)</b>	<b>Total (%)</b>
No care sought outside the home	58.16	53.65	56.77
Shop	8.53	7.16	8.11
Traditional healer	1.80	1.38	1.67
Private pharmacy	0.48	3.66	1.46
Private doctor	1.74	2.23	1.89
Private health facility	5.10	11.35	7.03
Public health facility	21.82	17.60	20.52
Other	2.37	2.97	2.56
Total (n)	1,052	469	1,521

**% of people using different sources of care by quintile of wealth index**

<b>Source of Care</b>	<b>Lowest</b>	<b>Second</b>	<b>Middle</b>	<b>Fourth</b>	<b>Highest</b>	<b>Total</b>
No care sought outside the home	59.66	56.76	54.61	55.76	56.59	56.77
Shop	8.48	10.66	11.96	7.24	0.44	8.11
Traditional healer	3.00	2.18	0.97	1.62	0.00	1.67
Private pharmacy	0.34	0.34	0.94	0.65	6.26	1.46
Private doctor	1.34	1.56	2.09	1.32	3.57	1.89
Private health facility	3.58	6.06	5.80	6.93	14.99	7.03
Public health facility	22.29	20.08	19.84	23.94	15.07	20.52
Other	1.31	2.35	3.78	2.54	3.08	2.56
Total (n)	352	314	308	304	242	1,521

**Burkina Faso 1992–1993**

Source of Care	Rural (%)	Urban (%)	Total (%)
No care sought outside the home	79.12	66.36	77.35
Traditional healer	5.03	2.62	4.69
Private pharmacy	0.07	0.15	0.08
Private doctor	0.00	1.03	0.14
Private health facility	0.56	2.23	0.79
Public health facility	14.94	27.32	16.66
Other	0.28	0.29	0.28
Total (n)	2,006	322	2,328

Quintile data was not included in the survey.

**Burkina Faso 1998–1999**

Source of Care	Rural (%)	Urban (%)	Total (%)
No care sought outside the home	73.46	46.34	70.64
Traditional healer	7.11	3.58	6.74
Private pharmacy	0.34	0.87	0.39
Private doctor	0.12	1.96	0.31
Private health facility	0.34	1.90	0.50
Public health facility	16.73	43.25	19.49
Other	1.91	2.10	1.93
Total (n)	1,976	230	2,206

**% of people using different sources of care by quintile of wealth index**

Source of Care	Lowest	Second	Middle	Fourth	Highest	Total
No care sought outside the home	79.92	69.05	76.35	72.92	51.13	70.64
Traditional healer	6.42	10.72	6.98	5.69	2.61	6.74
Private pharmacy	0.00	0.23	0.64	0.18	1.20	0.39
Private doctor	0.23	0.23	0.00	0.00	1.25	0.31
Private health facility	0.46	0.68	0.36	0.18	0.84	0.50
Public health facility	11.82	16.11	14.17	19.30	40.77	19.49
Other	1.15	2.98	1.50	1.73	2.21	1.93
Total (n)	509	515	368	454	361	2,206

**Cameroon 1991**

Source of Care	Rural (%)	Urban (%)	Total (%)
No care sought outside the home	66.10	54.95	61.61
Traditional healer	3.53	1.85	2.86
Private pharmacy	0.88	5.65	2.80
Private doctor	0.71	0.11	0.47
Private health facility	9.67	9.52	9.61
Public health facility	18.75	26.52	21.88
Other	0.35	1.40	0.78
Total (n)	742	500	1,242

**% of people using different sources of care by quintile of wealth index**

Source of Care	Lowest	Second	Middle	Fourth	Highest	Total
No care sought outside the home	75.40	69.72	64.17	53.54	49.83	61.61
Traditional healer	5.22	3.80	3.78	1.97	0.42	2.86
Private pharmacy	0.00	0.46	1.63	5.70	5.14	2.80
Private doctor	0.69	0.00	0.62	0.94	0.19	0.47
Private health facility	7.56	8.48	6.59	12.54	11.55	9.61
Public health facility	11.13	17.53	23.22	24.59	30.08	21.88
Other	0.00	0.00	0.00	0.72	2.77	0.78
Total (n)	191	285	212	279	275	1242

**Cameroon 1998**

Source of Care	Rural (%)	Urban (%)	Total (%)
No care sought outside the home	56.78	48.80	54.56
Shop	6.22	4.82	5.83
Traditional healer	5.42	3.35	4.85
Private pharmacy	2.23	6.15	3.32
Private doctor	0.96	1.12	1.00
Private health facility	7.34	12.22	8.69
Public health facility	19.30	22.33	20.14
Other	1.75	1.22	1.61
Total (n)	800	308	1,108

**% of people using different sources of care by quintile of wealth index**

<b>Source of Care</b>	<b>Lowest</b>	<b>Second</b>	<b>Middle</b>	<b>Fourth</b>	<b>Highest</b>	<b>Total</b>
No care sought outside the home	62.43	61.39	55.01	44.07	47.73	54.56
Shop	3.97	7.97	6.35	6.64	4.12	5.83
Traditional healer	5.96	7.22	4.04	3.73	2.67	4.85
Private pharmacy	0.00	1.14	2.35	7.46	6.66	3.32
Private doctor	1.99	0.00	0.40	0.55	2.17	1.00
Private health facility	4.47	7.97	9.25	12.19	10.46	8.69
Public health facility	19.70	12.60	20.25	24.06	25.05	20.14
Other	1.49	1.71	2.35	1.30	1.13	1.61
Total (n)	257	224	217	233	176	1,108

**Central African Republic 1994–1995**

<b>Source of Care</b>	<b>Rural (%)</b>	<b>Urban (%)</b>	<b>Total (%)</b>
No care sought outside the home	71.82	55.02	64.65
Shop	0.51	0.19	0.37
Traditional healer	0.64	0.27	0.48
Private pharmacy	0.30	0.68	0.46
Private doctor	0.19	0.29	0.23
Private health facility	4.26	5.10	4.62
Public health facility	22.17	38.47	29.13
Other	0.10	0.00	0.06
Total (n)	988	735	1,723

**% of people using different sources of care by quintile of wealth index**

<b>Source of Care</b>	<b>Lowest</b>	<b>Second</b>	<b>Middle</b>	<b>Fourth</b>	<b>Highest</b>	<b>Total</b>
No care sought outside the home	72.28	73.89	62.08	63.26	52.03	64.65
Shop	0.74	0.49	0.00	0.57	0.00	0.37
Traditional healer	1.51	0.89	0.00	0.00	0.00	0.48
Private pharmacy	0.28	0.59	0.26	0.00	1.19	0.46
Private doctor	0.27	0.29	0.00	0.00	0.60	0.23
Private health facility	2.41	4.61	2.73	6.69	6.21	4.62
Public health facility	22.23	19.25	34.94	29.48	39.97	26.13
Other	0.28	0.00	0.00	0.00	0.00	0.06
Total (n)	351	332	303	385	352	1,723

**Chad 1996–1997**

Source of Care	Rural (%)	Urban (%)	Total (%)
No care sought outside the home	77.15	61.68	73.69
Shop	2.97	1.62	2.67
Traditional healer	1.76	0.21	1.41
Private pharmacy	0.00	2.99	0.67
Private health facility	9.13	5.49	8.31
Public health facility	5.54	25.62	10.04
Other	3.45	2.39	3.21
Total (n)	1,910	551	2,460

**% of people using different sources of care by quintile of wealth index**

Source of Care	Lowest	Second	Middle	Fourth	Highest	Total
No care sought outside the home	89.05	78.28	73.93	68.90	59.60	73.69
Shop	1.20	1.78	6.12	3.26	1.71	2.67
Traditional healer	0.30	1.68	0.99	2.55	1.15	1.41
Private pharmacy	0.00	0.00	0.00	0.00	3.32	0.67
Private health facility	4.35	9.87	10.24	10.29	6.18	8.31
Public health facility	2.09	6.49	4.09	10.67	25.33	10.04
Other	3.01	1.89	4.63	4.32	2.72	3.21
Total (n)	430	615	390	530	496	2,460

**Comoros 1996**

Source of Care	Rural (%)	Urban (%)	Total (%)
No care sought outside the home	37.79	31.82	36.28
Shop	4.88	2.27	4.22
Traditional healer	12.08	12.88	12.28
Private pharmacy	4.37	15.91	7.29
Private doctor	1.80	5.30	2.69
Private health facility	1.03	4.55	1.92
Public health facility	32.65	21.97	29.94
Other	5.40	5.30	5.37
Total (n)	389	132	521

**% of people using different sources of care by quintile of wealth index**

<b>Source of Care</b>	<b>Lowest</b>	<b>Second</b>	<b>Middle</b>	<b>Fourth</b>	<b>Highest</b>	<b>Total</b>
No care sought outside the home	43.85	28.44	38.46	35.42	32.93	36.28
Shop	5.38	8.26	1.92	3.13	1.22	4.22
Traditional healer	15.38	16.51	14.42	7.29	4.88	12.28
Private pharmacy	3.08	4.59	5.77	10.42	15.85	7.29
Private doctor	0.77	0.92	3.85	1.04	8.54	2.69
Private health facility	0.77	1.83	2.88	2.08	2.44	1.92
Public health facility	26.15	33.03	24.04	35.42	32.93	29.94
Other	4.62	6.42	8.65	5.21	1.22	5.37
Total (n)	130	109	104	96	82	521

**Côte d'Ivoire 1994**

<b>Source of Care</b>	<b>Rural (%)</b>	<b>Urban (%)</b>	<b>Total (%)</b>
No care sought outside the home	47.56	35.53	43.14
Traditional healer	13.10	11.13	12.37
Private pharmacy	2.44	5.40	3.53
Private health facility	2.48	2.62	2.53
Public health facility	23.42	39.96	29.49
Other	11.00	5.37	8.94
Total (n)	1,047	607	1,654

**% of people using different sources of care by quintile of wealth index**

<b>Source of Care</b>	<b>Lowest</b>	<b>Second</b>	<b>Middle</b>	<b>Fourth</b>	<b>Highest</b>	<b>Total</b>
No care sought outside the home	53.66	48.39	43.47	36.63	30.27	43.14
Traditional healer	15.26	12.04	13.13	14.08	5.96	12.37
Private pharmacy	1.18	0.34	4.29	4.98	7.96	3.53
Private health facility	2.56	2.20	2.79	2.05	3.19	2.53
Public health facility	13.69	26.73	27.04	36.49	48.14	29.49
Other	13.65	10.30	9.28	5.76	4.49	8.94
Total (n)	365	347	327	341	275	1,654

**Côte d'Ivoire 1998-1999**

Source of Care	Rural (%)	Urban (%)	Total (%)
No care sought outside the home	36.42	37.93	36.88
Traditional healer	24.17	8.24	19.37
Private pharmacy	10.60	10.04	10.43
Private doctor	0.33	0.96	0.52
Private health facility	0.99	2.47	1.44
Public health facility	22.19	37.56	26.82
Other	5.30	2.80	4.54
Total (n)	548	237	785

Quintile data was not included in the survey.

**Ethiopia 2000**

Source of Care	Rural (%)	Urban (%)	Total (%)
No care sought outside the home	78.78	50.03	76.46
Shop	1.81	0.89	1.74
Traditional healer	0.75	0.08	0.70
Private pharmacy	4.07	9.24	4.49
Private doctor	1.83	10.49	2.53
Private health facility	0.61	2.51	0.76
Public health facility	9.32	26.25	10.68
Other	2.83	0.50	2.64
Total (n)	4,362	383	4,745

**% of people using different sources of care by quintile of wealth index**

Source of Care	Lowest	Second	Middle	Fourth	Highest	Total (%)
No care sought outside the home	81.97	80.09	76.47	79.40	58.71	76.46
Shop	1.98	2.09	1.44	2.10	0.81	1.74
Traditional healer	0.62	0.65	1.04	0.88	0.05	0.70
Private pharmacy	2.91	3.02	5.21	3.71	8.98	4.49
Private doctor	1.32	0.91	2.31	2.33	7.42	2.53
Private health facility	0.55	0.65	0.99	0.25	1.60	0.76
Public health facility	7.91	8.93	10.22	8.97	20.59	10.68
Other	2.73	3.67	2.31	2.36	1.84	2.64
Total (n)	982	1,038	1,109	943	672	4,745

**Ghana 1993**

Source of Care	Rural (%)	Urban (%)	Total (%)
No care sought outside the home	36.73	36.18	36.59
Shop	1.48	1.01	1.36
Traditional healer	7.98	3.52	6.78
Private pharmacy	17.81	11.56	16.12
Private doctor	3.34	1.51	2.85
Private health facility	3.15	5.53	3.79
Public health facility	23.01	36.68	26.69
Other	6.49	4.02	5.83
Total (n)	539	199	738

**% of people using different sources of care by quintile of wealth index**

Source of Care	Lowest	Second	Middle	Fourth	Highest	Total(%)
No care sought outside the home	42.34	38.07	30.43	36.30	36.44	36.59
Shop	2.19	1.70	0.62	1.37	0.85	1.36
Traditional healer	10.95	6.82	8.70	4.11	2.54	6.78
Private pharmacy	19.71	17.61	17.39	14.38	10.17	16.12
Private doctor	1.46	2.27	5.59	2.05	2.54	2.85
Private health facility	2.92	3.41	3.11	4.79	5.08	3.79
Public health facility	14.60	23.30	27.33	30.82	39.83	26.69
Other	5.84	6.82	6.83	6.16	2.54	5.83
Total (n)	137	176	161	146	118	738

**Ghana 1998**

Source of Care	Rural (%)	Urban (%)	Total (%)
No care sought outside the home	48.00	46.77	47.69
Shop	0.89	0.46	0.78
Traditional healer	3.24	1.28	2.75
Private pharmacy	21.28	21.76	21.40
Private doctor	0.22	1.05	0.43
Private health facility	3.17	6.53	4.00
Public health facility	19.11	20.02	19.34
Other	4.10	2.14	3.61
Total (n)	811	269	1,080

**% of people using different sources of care by quintile of wealth index**

<b>Source of Care</b>	<b>Lowest</b>	<b>Second</b>	<b>Middle</b>	<b>Fourth</b>	<b>Highest</b>	<b>Total</b>
No care sought outside the home	51.97	51.45	44.40	40.24	46.23	47.69
Shop	1.59	0.00	0.51	0.66	0.85	0.78
Traditional healer	3.45	2.57	2.61	3.49	0.86	2.75
Private pharmacy	15.23	22.57	27.73	24.36	19.63	21.40
Private doctor	0.00	0.78	0.55	0.74	0.23	0.43
Private health facility	1.95	2.71	4.29	5.69	8.10	4.00
Public health facility	20.30	15.00	18.31	21.49	23.29	19.34
Other	5.51	4.93	1.59	3.32	0.81	3.61
Total (n)	312	232	222	170	144	1,080

**Guinea 1999**

<b>Source of Care</b>	<b>Rural (%)</b>	<b>Urban (%)</b>	<b>Total (%)</b>
No care sought outside the home	51.92	31.81	46.92
Traditional healer	12.75	4.30	10.65
Private pharmacy	1.69	6.16	2.80
Private doctor	1.24	1.28	1.25
Private health facility	1.10	1.31	1.15
Public health facility	28.53	53.67	34.78
Other	2.77	1.49	2.45
Total (n)	1,493	495	1,988

**% of people using different sources of care by quintile of wealth index**

<b>Source of Care</b>	<b>Lowest</b>	<b>Second</b>	<b>Middle</b>	<b>Fourth</b>	<b>Highest</b>	<b>Total(%)</b>
No care sought outside the home	55.61	56.19	48.91	39.00	29.99	46.92
Traditional healer	13.07	17.18	10.49	6.69	4.18	10.65
Private pharmacy	1.32	2.86	1.18	4.99	4.23	2.80
Private doctor	1.50	0.78	1.85	0.48	1.63	1.25
Private health facility	1.01	0.84	1.66	0.24	2.22	1.15
Public health facility	23.90	21.13	32.10	46.32	56.65	34.78
Other	3.60	1.01	3.81	2.28	1.09	2.45
Total (n)	507	388	369	389	335	1,988

**Kenya 1993**

Source of Care	Rural (%)	Urban (%)	Total (%)
No care sought outside the home	36.38	19.24	34.47
Shop	20.47	16.23	20.00
Traditional healer	1.99	1.09	1.89
Private pharmacy	1.61	5.47	2.04
Private doctor	4.13	6.85	4.43
Private health facility	9.00	18.73	10.08
Public health facility	26.33	32.40	27.01
Other	0.09	0.00	0.08
Total (n)	2,380	298	2,678

Quintile data was not included in the survey.

**Kenya 1998**

Source of Care	Rural (%)	Urban (%)	Total (%)
No care sought outside the home	37.17	25.44	35.19
Shop	9.44	4.35	8.58
Traditional healer	2.85	0.60	2.47
Private pharmacy	5.73	9.28	6.33
Private doctor	4.63	8.77	5.33
Private health facility	10.33	18.11	11.64
Public health facility	28.14	32.09	28.81
Other	1.71	1.37	1.65

**% of people using different sources of care by quintile of wealth index**

Source of Care	Lowest	Second	Middle	Fourth	Highest	Total(%)
No care sought outside the home	36.08	40.50	35.19	32.13	29.07	35.19
Shop	9.76	8.56	11.16	7.04	4.99	8.58
Traditional healer	4.24	2.39	2.44	0.49	1.69	2.47
Private pharmacy	3.71	4.59	7.45	11.83	5.96	6.33
Private doctor	4.50	3.99	4.98	4.34	10.45	5.33
Private health facility	7.92	13.15	9.32	10.15	20.83	11.64
Public health facility	30.23	26.39	28.80	32.76	25.30	28.81
Other	3.57	0.42	0.66	1.27	1.71	1.65

**Madagascar 1992**

Source of Care	Rural (%)	Urban (%)	Total (%)
No care sought outside the home	54.92	49.73	54.18
Shop	1.43	0.53	1.31
Traditional healer	4.92	2.85	4.62
Private pharmacy	0.96	0.71	0.92
Private doctor	3.14	14.44	4.76
Private health facility	2.19	7.49	2.94
Public health facility	28.28	22.82	27.50
Other	4.17	1.43	3.77
Total (n)	1,843	308	2,151

Quintile data was not included in the survey.

**Madagascar 1997**

Source of Care	Rural (%)	Urban (%)	Total (%)
No care sought outside the home	59.17	48.02	56.81
Shop	5.07	3.62	4.77
Traditional healer	0.29	0.00	0.23
Private pharmacy	0.94	3.03	1.38
Private doctor	6.64	14.90	8.39
Private health facility	2.22	3.83	2.56
Public health facility	24.49	24.98	24.60
Other	1.16	1.61	1.26
Total (n)	1,488	399	1,887

**% of people using different sources of care by quintile of wealth index**

Source of Care	Lowest	Second	Middle	Fourth	Highest	Total(%)
No care sought outside the home	55.43	59.18	61.50	57.05	49.19	56.81
Shop	8.00	6.54	4.13	1.90	0.23	4.77
Traditional healer	0.37	0.34	0.30	0.00	0.00	0.23
Private pharmacy	1.69	0.85	2.54	1.12	0.20	1.38
Private doctor	7.04	7.25	5.57	5.43	21.34	8.39
Private health facility	2.37	2.07	1.31	1.71	6.75	2.56
Public health facility	24.78	21.60	23.62	30.92	20.86	24.60
Other	0.31	2.17	1.02	1.86	1.43	1.26
Total (n)	541	369	363	362	251	1,887

**Malawi 1992**

Source of Care	Rural (%)	Urban (%)	Total (%)
No care sought outside the home	36.40	35.73	36.33
Shop	12.88	9.19	12.48
Traditional healer	3.86	2.11	3.67
Private pharmacy	0.00	0.25	0.03
Private doctor	0.72	2.18	0.88
Private health facility	13.26	10.08	12.91
Public health facility	32.56	40.46	33.42
Other	0.32	0.00	0.29
Total (n)	1,733	210	1,944

**% of people using different sources of care by quintile of wealth index**

Source of Care	Lowest	Second	Middle	Fourth	Highest	Total
No care sought outside the home	41.16	36.89	40.60	32.56	28.34	36.33
Shop	10.69	12.05	14.84	15.63	8.07	12.48
Traditional healer	2.87	6.10	2.25	3.66	4.01	3.67
Private pharmacy	0.00	0.00	0.00	0.00	0.16	0.03
Private doctor	0.37	0.13	0.32	0.40	3.67	0.88
Private health facility	13.36	11.95	9.92	14.61	15.58	12.91
Public health facility	31.43	32.43	32.08	33.14	39.10	33.42
Other	0.12	0.43	0.00	0.00	1.06	0.29
Total (n)	399	360	462	393	329	1,943

**Malawi 2000**

Source of Care	Rural (%)	Urban (%)	Total (%)
No care sought outside the home	42.88	30.78	41.56
Shop	30.10	28.27	29.90
Traditional healer	4.57	2.06	4.30
Private pharmacy	0.13	3.09	0.45
Private doctor	0.32	1.70	0.47
Private health facility	6.41	9.45	6.74
Public health facility	14.88	23.87	15.86
Other	0.72	0.78	0.73
Total (n)	5,026	616	5,641

**% of people using different sources of care by quintile of wealth index**

<b>Source of Care</b>	<b>Lowest</b>	<b>Second</b>	<b>Middle</b>	<b>Fourth</b>	<b>Highest</b>	<b>Total</b>
No care sought outside the home	47.30	45.86	41.70	40.31	30.81	41.54
Shop	28.49	29.58	29.05	32.65	29.69	29.92
Traditional healer	6.00	3.82	3.93	4.35	2.94	4.28
Private pharmacy	0.00	0.03	0.35	0.12	1.99	0.45
Private doctor	0.23	0.19	0.75	0.07	1.26	0.47
Private health facility	4.26	5.10	6.93	5.44	13.07	6.74
Public health facility	12.85	14.98	16.61	16.32	19.33	15.87
Other	0.87	0.45	0.68	0.74	0.91	0.73
Total (n)	1,252	1,133	1,041	1,206	1,006	5,638

**Mali 1995–1996**

<b>Source of Care</b>	<b>Rural (%)</b>	<b>Urban (%)</b>	<b>Total (%)</b>
No care sought outside the home	62.43	39.47	57.12
Shop	6.59	7.64	6.83
Traditional healer	8.93	6.38	8.34
Private pharmacy	6.27	20.01	9.45
Private doctor	0.00	0.86	0.20
Private health facility	2.55	1.34	2.27
Public health facility	10.64	23.95	13.72
Other	2.60	0.34	2.08
Total (n)	1,748	526	2,274

**% of people using different sources of care by quintile of wealth index**

<b>Source of Care</b>	<b>Lowest</b>	<b>Second</b>	<b>Middle</b>	<b>Fourth</b>	<b>Highest</b>	<b>Total</b>
No care sought outside the home	69.48	60.13	60.21	54.09	35.02	57.12
Shop	6.41	7.41	6.17	8.35	5.29	6.83
Traditional healer	9.72	8.64	9.39	7.42	5.78	8.34
Private pharmacy	1.92	6.53	8.58	10.60	24.07	9.45
Private doctor	0.00	0.00	0.00	0.00	1.35	0.20
Private health facility	3.14	3.09	2.40	1.34	0.96	2.27
Public health facility	7.26	10.97	11.38	15.90	27.17	13.72
Other	2.07	3.23	1.87	2.30	0.35	2.08
Total (n)	475	500	478	486	334	2,274

**Mozambique 1997**

Source of Care	Rural (%)	Urban (%)	Total (%)
No care sought outside the home	59.98	41.59	54.61
Shop	0.78	0.39	0.67
Traditional healer	9.11	1.75	6.96
Private pharmacy	0.40	1.91	0.84
Private health facility	0.91	0.38	0.76
Public health facility	26.66	48.59	33.06
Other	2.15	5.40	3.10
Total (n)	1,178	486	1,664

**% of people using different sources of care by quintile of wealth index**

Source of Care	Lowest	Second	Middle	Fourth	Highest	Total
No care sought outside the home	63.45	52.77	59.01	53.22	42.28	54.61
Shop	0.40	1.22	0.34	0.98	0.68	0.67
Traditional healer	10.61	16.70	7.44	2.91	1.07	6.96
Private pharmacy	0.31	0.29	0.23	0.48	2.68	0.84
Private health facility	0.34	0.00	2.87	0.18	0.33	0.76
Public health facility	23.14	28.35	28.81	39.36	45.07	33.06
Other	1.75	0.66	1.30	2.86	7.89	3.10
Total (n)	434	187	325	360	359	1,665

**Namibia 1992**

Source of Care	Rural (%)	Urban (%)	Total (%)
No care sought outside the home	29.69	26.09	28.66
Shop	1.59	2.31	1.80
Traditional healer	3.23	0.48	2.44
Private pharmacy	0.34	1.56	0.69
Private doctor	0.10	4.66	1.41
Private health facility	0.16	0.49	0.25
Public health facility	62.34	61.67	62.15
Other	2.55	2.75	2.61
Total (n)	1,215	490	1,704

**% of people using different sources of care by quintile of wealth index**

<b>Source of Care</b>	<b>Lowest</b>	<b>Second</b>	<b>Middle</b>	<b>Fourth</b>	<b>Highest</b>	<b>Total</b>
No care sought outside the home	32.85	28.79	30.12	25.54	24.72	28.66
Shop	1.36	1.01	0.86	3.21	3.01	1.80
Traditional healer	2.70	3.52	3.11	2.38	0.00	2.44
Private pharmacy	0.22	0.52	0.18	0.00	2.76	0.69
Private doctor	0.00	0.00	0.00	0.40	7.65	1.41
Private health facility	0.22	0.00	0.33	0.00	0.80	0.25
Public health facility	60.73	63.87	63.67	64.39	57.70	62.15
Other	1.91	2.30	1.75	4.07	3.36	2.61
Total (n)	380	406	319	301	298	1,704

**Niger 1992**

<b>Source of Care</b>	<b>Rural (%)</b>	<b>Urban (%)</b>	<b>Total (%)</b>
No care sought outside the home	80.19	53.26	76.65
Shop	5.49	2.44	5.09
Traditional healer	4.42	3.32	4.28
Private pharmacy	0.21	0.00	0.19
Private doctor	0.00	0.11	0.01
Private health facility	0.43	0.45	0.43
Public health facility	8.70	39.73	12.77
Other	0.57	0.68	0.59
Total (n)	1,982	299	2,281

Quintile data was not included in the survey.

**Niger 1998**

<b>Source of Care</b>	<b>Rural (%)</b>	<b>Urban (%)</b>	<b>Total (%)</b>
No care sought outside the home	60.23	41.87	57.34
Shop	15.87	5.93	14.30
Traditional healer	5.75	2.43	5.23
Private pharmacy	0.91	3.32	1.29
Private health facility	0.86	2.39	1.10
Public health facility	13.19	43.13	17.91
Other	3.19	0.95	2.84
Total (n)	1,811	339	2,150

**% of people using different sources of care by quintile of wealth index**

<b>Source of Care</b>	<b>Lowest</b>	<b>Second</b>	<b>Middle</b>	<b>Fourth</b>	<b>Highest</b>	<b>Total</b>
No care sought outside the home	64.57	66.32	58.43	49.26	43.28	57.34
Shop	13.13	11.71	18.70	20.64	7.45	14.30
Traditional healer	6.11	6.27	5.41	5.35	2.29	5.23
Private pharmacy	0.44	0.91	0.00	1.36	4.18	1.29
Private health facility	1.34	0.85	0.29	1.22	2.01	1.10
Public health facility	12.73	11.13	12.03	18.79	39.89	17.91
Other	1.68	2.81	5.13	3.38	0.88	2.84
Total (n)	393	570	413	411	362	2,150

**Nigeria 1990**

<b>Source of Care</b>	<b>Rural (%)</b>	<b>Urban (%)</b>	<b>Total (%)</b>
No care sought outside the home	44.38	34.67	42.65
Shop	13.87	11.63	13.47
Traditional healer	7.06	3.02	6.34
Private pharmacy	3.95	8.45	4.75
Private doctor	1.41	6.79	2.37
Public health facility	27.66	35.28	29.01
Other	1.67	0.15	1.40
Total (n)	1,774	384	2,158

**% of people using different sources of care by quintile of wealth index**

<b>Source of Care</b>	<b>Lowest</b>	<b>Second</b>	<b>Middle</b>	<b>Fourth</b>	<b>Highest</b>	<b>Total</b>
No care sought outside the home	49.08	50.35	40.24	38.51	29.71	42.65
Shop	10.11	12.83	12.06	18.55	14.34	13.47
Traditional healer	10.47	6.79	5.91	5.37	1.55	6.34
Private pharmacy	2.54	1.37	10.97	4.78	6.11	4.75
Private doctor	0.39	1.91	1.92	1.09	7.98	2.37
Public health facility	23.93	25.55	27.29	31.60	40.14	29.01
Other	3.49	1.20	1.62	0.10	0.17	1.40
Total (n)	482	523	380	431	342	2,158

**Nigeria 1999**

<b>Source of Care</b>	<b>Rural (%)</b>	<b>Urban (%)</b>	<b>Total (%)</b>
No care sought outside the home	45.97	29.99	41.91
Shop	2.06	0.61	1.69
Traditional healer	4.61	0.39	3.54
Private pharmacy	16.18	17.76	16.58
Private doctor	0.69	2.83	1.24
Private health facility	6.96	9.68	7.65
Public health facility	23.10	37.72	26.82
Other	0.42	1.00	0.56
Total (n)	740	252	992

Quintile data was not included in the survey.

**Rwanda 1992**

<b>Source of Care</b>	<b>Rural (%)</b>	<b>Urban (%)</b>	<b>Total (%)</b>
No care sought outside the home	59.11	47.90	58.62
Traditional healer	3.77	2.69	3.72
Private pharmacy	3.68	6.29	3.79
Private doctor	0.66	1.80	0.71
Public health facility	26.88	35.63	27.26
Other	5.91	5.69	5.90
Total (n)	2,602	118	2,719

Quintile data was not included in the survey.

**Senegal 1992–1993**

<b>Source of Care</b>	<b>Rural (%)</b>	<b>Urban (%)</b>	<b>Total (%)</b>
No care sought outside the home	65.22	53.22	61.68
Shop	2.70	0.51	2.05
Traditional healer	3.62	2.88	3.40
Private pharmacy	0.64	1.86	1.00
Private doctor	0.28	0.51	0.35
Private health facility	3.26	5.76	4.00
Public health facility	22.50	32.71	25.51
Other	1.77	2.54	2.00
Total (n)	1,409	590	1,999

Quintile was not included in the survey.

**South Africa 1998**

Source of Care	Rural (%)	Urban (%)	Total (%)
No care sought outside the home	36.22	26.24	31.36
Shop	0.40	0.30	0.35
Traditional healer	0.05	0.11	0.08
Private pharmacy	2.05	2.42	2.23
Private doctor	11.66	27.41	19.33
Private health facility	1.02	3.48	2.22
Public health facility	48.09	39.39	43.86
Other	0.50	0.65	0.58
Total (n)	914	867	1,781

**% of people using different sources of care by quintile of wealth index**

Source of Care	Lowest	Second	Middle	Fourth	Highest	Total
No care sought outside the home	35.51	31.61	32.90	29.74	24.92	31.36
Shop	0.62	0.00	0.22	0.50	0.48	0.35
Traditional healer	0.12	0.23	0.00	0.00	0.00	0.08
Private pharmacy	1.33	3.00	1.55	0.36	5.27	2.23
Private doctor	5.67	14.15	15.69	22.97	46.84	19.33
Private health facility	1.32	0.91	1.23	2.40	6.45	2.22
Public health facility	54.36	49.97	48.03	43.30	15.35	43.86
Other	1.06	0.12	0.37	0.72	0.68	0.58
Total (n)	401	419	366	310	285	1,781

**Tanzania 1992**

Source of Care	Rural (%)	Urban (%)	Total (%)
No care sought outside the home	38.76	27.60	36.17
Traditional healer	3.98	0.53	3.18
Private pharmacy	2.80	7.90	3.99
Private health facility	7.47	10.88	8.26
Public health facility	46.26	51.77	47.54
Other	0.73	1.31	0.87
Total (n)	1,899	575	2,475

Quintile data was not included in the survey.

**Tanzania 1996**

Source of Care	Rural (%)	Urban (%)	Total (%)
No care sought outside the home	33.96	21.75	31.60
Traditional healer	1.65	0.10	1.35
Private pharmacy	10.63	9.44	10.40
Private health facility	5.20	11.99	6.51
Public health facility	47.48	55.99	49.12
Other	1.08	0.73	1.01
Total (n)	1,805	432	2,237

**% of people using different sources of care by quintile of wealth index**

Source of Care	Lowest	Second	Middle	Fourth	Highest	Total
No care sought outside the home	41.93	33.69	30.39	26.44	25.33	31.60
Traditional healer	2.38	1.95	1.04	1.34	0.00	1.35
Private pharmacy	10.19	11.96	9.86	10.50	9.75	10.40
Private health facility	4.32	6.68	5.60	6.08	10.37	6.51
Public health facility	39.70	45.73	52.50	53.93	53.57	49.12
Other	1.47	0.00	0.61	1.72	0.97	1.01
Total (n)	485	372	457	500	424	2,237

**Togo 1998**

Source of Care	Rural (%)	Urban (%)	Total (%);
No care sought outside the home	60.87	47.85	57.93
Shop	7.78	6.79	7.56
Traditional healer	3.16	3.97	3.34
Private pharmacy	0.08	1.86	0.48
Private doctor	0.18	1.19	0.41
Private health facility	1.34	7.87	2.82
Public health facility	17.36	21.71	18.34
Other	9.23	8.76	9.13
Total (n)	1,523	445	1,968

**% of people using different sources of care by quintile of wealth index**

<b>Source of Care</b>	<b>Lowest</b>	<b>Second</b>	<b>Middle</b>	<b>Fourth</b>	<b>Highest</b>	<b>Total</b>
No care sought outside the home	64.13	62.83	57.14	55.76	42.79	57.93
Shop	8.40	8.82	8.47	4.85	6.09	7.56
Traditional healer	3.40	3.09	3.65	3.81	2.56	3.34
Private pharmacy	0.00	0.00	0.30	0.43	2.48	0.48
Private doctor	0.18	0.00	0.00	0.43	2.06	0.41
Private health facility	0.52	1.44	1.55	3.49	10.21	2.82
Public health facility	16.23	15.33	18.26	20.13	24.89	18.34
Other	7.14	8.49	10.64	11.09	8.90	9.13
Total (n)	487	446	413	350	272	1,968

**Uganda 1995**

<b>Source of Care</b>	<b>Rural (%)</b>	<b>Urban (%)</b>	<b>Total (%)</b>
No care sought outside the home	26.38	16.10	25.33
Shop	17.13	8.51	16.25
Traditional healer	2.52	1.31	2.39
Private pharmacy	1.80	7.05	2.34
Private doctor	3.51	6.50	3.82
Private health facility	27.21	43.48	28.88
Public health facility	20.07	16.00	19.65
Other	1.38	1.05	1.35
Total (n)	2,736	313	3,049

**% of people using different sources of care by quintile of wealth index**

<b>Source of Care</b>	<b>Lowest</b>	<b>Second</b>	<b>Middle</b>	<b>Fourth</b>	<b>Highest</b>	<b>Total</b>
No care sought outside the home	26.41	27.08	29.29	24.24	18.01	25.33
Shop	18.56	17.82	17.56	13.14	12.98	16.25
Traditional healer	5.40	2.25	0.87	2.04	0.52	2.39
Private pharmacy	1.18	1.91	2.01	2.47	4.80	2.34
Private doctor	4.17	2.60	2.87	5.02	4.62	3.82
Private health facility	21.13	29.22	27.20	32.13	37.66	28.88
Public health facility	21.05	17.85	19.48	19.44	20.49	19.65
Other	2.09	1.28	0.72	1.52	0.92	1.35
Total (n)	710	656	594	593	495	3,049

**Uganda 2000–2001**

Source of Care	Rural (%)	Urban (%)	Total (%)
No care sought outside the home	19.31	8.59	18.17
Shop	7.98	2.01	7.35
Traditional healer	1.03	0.73	1.00
Private pharmacy	10.71	16.54	11.32
Private doctor	0.81	0.73	0.80
Private health facility	34.92	57.21	37.28
Public health facility	21.51	12.31	20.54
Other	3.73	1.87	3.54
Total (n)	3,192	378	3,570

**% of people using different sources of care by quintile of wealth index**

Source of Care	Lowest	Second	Middle	Fourth	Highest	Total
No care sought outside the home	22.26	20.28	20.09	15.33	9.48	18.17
Shop	10.98	8.08	6.89	5.66	3.03	7.35
Traditional healer	1.07	0.11	2.03	1.19	0.75	1.00
Private pharmacy	9.42	8.78	12.11	12.86	15.44	11.32
Private doctor	1.12	0.23	0.91	1.17	0.60	0.80
Private health facility	30.54	33.52	34.89	40.27	53.23	37.28
Public health facility	21.11	25.82	18.52	19.49	15.26	20.54
Other	3.51	3.18	4.55	4.04	2.23	3.54
Total (n)	867	830	670	666	537	3,570

**Zambia 1992**

Source of Care	Rural (%)	Urban (%)	Total (%)
No care sought outside the home	28.44	17.91	23.69
Shop	3.90	7.86	5.69
Traditional healer	5.90	1.94	4.12
Private pharmacy	1.01	6.32	3.41
Private doctor	0.50	2.84	1.56
Private health facility	8.39	14.67	11.22
Public health facility	43.22	45.38	44.20
Other	8.62	3.08	6.12
Total (n)	1,626	1,336	2,962

Quintile data was not included in the survey.

**Zambia 1996**

Source of Care	Rural (%)	Urban (%)	Total (%)
No care sought outside the home	33.86	24.25	29.74
Shop	5.10	8.89	6.72
Traditional healer	6.88	1.01	4.36
Private pharmacy	0.26	4.98	2.28
Private doctor	0.54	1.75	1.06
Private health facility	4.16	11.25	7.20
Public health facility	44.22	45.98	44.98
Other	4.98	1.89	3.65
Total (n)	1,881	1,412	3,293

**% of people using different sources of care by quintile of wealth index**

Source of Care	Lowest	Second	Middle	Fourth	Highest	Total
No care sought outside the home	36.02	35.32	32.49	24.27	21.32	29.74
Shop	3.84	4.98	6.44	10.12	8.04	6.72
Traditional healer	8.00	7.35	4.22	1.76	0.53	4.36
Private pharmacy	0.28	0.00	0.72	5.60	4.09	2.28
Private doctor	0.00	0.43	0.00	2.36	2.27	1.06
Private health facility	2.96	4.79	5.09	1.78	22.85	7.20
Public health facility	43.76	43.44	45.97	51.79	38.83	44.98
Other	5.14	3.69	5.08	2.32	2.07	3.65
Total (n)	825	512	552	762	642	3,293

**Zambia 2001–2002**

Source of Care	Rural (%)	Urban (%)	Total (%)
No care sought outside the home	30.00	32.22	30.72
Shop	3.72	4.25	3.89
Traditional healer	4.48	1.54	3.54
Private pharmacy	0.99	5.73	2.51
Private doctor	0.49	0.77	0.58
Private health facility	11.88	6.98	10.31
Public health facility	46.10	47.10	46.42
Other	2.33	1.41	2.04
Total (n)	1,848	873	2,721

**Zimbabwe 1994**

Source of Care	Rural (%)	Urban (%)	Total (%)
No care sought outside the home	34.06	32.68	33.75
Shop	15.87	7.48	13.98
Traditional healer	3.70	2.38	3.40
Private pharmacy	1.76	5.67	2.64
Private doctor	0.74	10.74	2.99
Private health facility	6.70	2.12	5.67
Public health facility	33.97	37.47	34.76
Other	3.21	1.46	2.81
Total (n)	983	286	1,269

**% of people using different sources of care by quintile of wealth index**

Source of Care	Lowest	Second	Middle	Fourth	Highest	Total
No care sought outside the home	39.63	33.79	31.67	28.86	32.22	33.75
Shop	12.88	16.09	19.13	13.28	8.12	13.98
Traditional healer	4.79	4.61	1.84	3.61	0.91	3.40
Private pharmacy	0.87	1.60	1.87	4.62	5.34	2.64
Private doctor	0.00	0.45	0.91	3.85	13.02	2.99
Private health facility	4.91	8.40	7.77	3.65	3.96	5.67
Public health facility	33.40	30.70	32.93	40.55	36.41	34.76
Other	3.52	4.37	3.89	1.57	0.00	2.81
Total (n)	349	237	228	266	189	1,269

**Zimbabwe 1999**

Source of Care	Rural (%)	Urban (%)	Total (%)
No care sought outside the home	40.56	42.70	41.21
Shop	10.53	9.46	10.21
Traditional healer	1.35	0.00	0.94
Private pharmacy	1.42	6.44	2.94
Private doctor	0.22	13.31	4.20
Private health facility	5.04	5.63	5.22
Public health facility	36.32	22.47	32.11
Other	4.56	0.00	3.17
Total (n)	999	436	1,436

**% of people using different sources of care by quintile of wealth index**

Source of Care	Lowest	Second	Middle	Fourth	Highest	Total
No care sought outside the home	44.06	41.89	38.21	40.35	41.38	41.21
Shop	8.58	9.62	12.13	10.19	10.68	10.21
Traditional healer	1.83	0.55	1.82	0.41	0.00	0.94
Private pharmacy	0.79	1.25	1.61	5.66	5.48	2.94
Private doctor	0.26	0.37	0.00	6.65	14.49	4.20
Private health facility	5.43	2.20	4.95	9.83	2.97	5.22
Public health facility	35.65	40.05	35.41	24.53	25.00	32.11
Other	3.40	4.08	5.88	2.37	0.00	3.17
Total (n)	307	277	280	311	261	1,436

**Use of public and private services among people from the highest income quintile who sought care when the child was sick**

Among those who sought care outside the home,  
% who went to:

Country and year of DHS	Private sector	Public sector	Other	Total	% seeking care outside home
Burkina 99	12%	83%	5%	100%	48.9
CAR 95	17%	83%	0%	100%	48.0
Guinea 99	18%	81%	2%	100%	70.0
Mozambique 97	8%	78%	14%	100%	57.7
Namibia 92	19%	77%	4%	100%	75.3
Tanzania 96	27%	72%	1%	100%	74.7
Niger 98	28%	70%	2%	100%	56.7
Cote d'Ivoire 94	25%	69%	6%	100%	69.7
Chad 97	31%	63%	7%	100%	40.4
Ghana 93	33%	63%	4%	100%	63.6
Cameroon 91	34%	60%	6%	100%	50.2
Nigeria 90	43%	57%	0%	100%	70.3
Malawi 92	44%	55%	1%	100%	71.7
Ethiopia 00	46%	50%	4%	100%	41.3
Zambia 96	48%	49%	3%	100%	78.7
Comoros 96	49%	49%	2%	100%	67.1
Cameroon 98	50%	48%	2%	100%	52.3

*(continued on next page)*

**Use of public and private services among people from the highest income quintile who sought care when the child was sick** *(continued)*

**Among those who sought care outside the home,  
% who went to:**

<b>Country and year of DHS</b>	<b>Private sector</b>	<b>Public sector</b>	<b>Other</b>	<b>Total</b>	<b>% seeking care outside home</b>
Benin 96	53%	46%	1%	100%	51.2
Togo 98	41%	44%	16%	100%	57.2
Ghana 98	55%	43%	2%	100%	53.8
Mali 96	58%	42%	1%	100%	65.0
Madagascar 97	56%	41%	3%	100%	50.8
Gabon 00	56%	38%	7%	100%	79.0
Kenya 98	62%	36%	2%	100%	70.9
Benin 01	58%	35%	7%	100%	43.4
Malawi 00	71%	28%	1%	100%	69.2
Uganda 95	74%	25%	1%	100%	82.0
S. Africa 98	79%	20%	1%	100%	75.1
Uganda 01	81%	17%	2%	100%	90.5
Gross average:	44%	52%	4%	100%	62.9

## Annex 2: Case Studies of Franchises in Africa

### TOP Reseau, Madagascar

In 2000, Population Services International, a NGO, launched “TOP Reseau,” a franchise of reproductive health care, with a US\$1 million grant from the Bill and Melinda Gate Foundation. PSI acts as a franchiser. There are 17 clinics in the network, all in the city of Tamatave and surrounding rural areas.

The clinics were invited to join the franchise after interviews and evaluations. A detailed contract specifies the franchise arrangement. Extensive and continual training is provided to improve both technical skills and management capacity, with an emphasis on youth-friendly services. PSI has created and refined a training manual on youth-friendly services, as well as other operational manuals, curricula, client kits, and flip-chart visual aids for providers and youth clients (primarily 15 to 24 years of age).

The clinics in the network generally provide a full range of services through general practitioner physicians. The clinics, all of which display a matching TOP Reseau logo, benefit from marketing and media promotion on television and radio, and from referrals from other components of the project coordinated by PSI. TOP Reseau builds its client base through the work of peer educators in the schools, community events, and other activities. Peer educators

are paid US\$150 per month (from donor funds) and must lead at least 40 education sessions per month. At typical educational session, peer educators would distribute literature, discuss reproductive health issues, and lead condom demonstrations. Peer educators play an important role in improving franchisee clinics’ use rate. “My business has increased 25% since I joined the franchise, and 60% to 70% of my clients are now youth,” said one doctor.

Diagnosis and treatment for sexually transmitted infections (STIs) draw many of the youth. While the HIV prevalence rate is less than 1% nationwide, the STI rate is as high as 30% in some areas, a concern for many youth. Other services include family planning counseling, pregnancy testing and counseling, as well as general services such as immunizations, physical exams, breast exams, and pap smears. The providers currently pay a modest membership fee to TOP Reseau, but indicated a willingness to pay more for franchise services as their business continues to increase.

In the first two years, 17 clinics served total of 2,500 clients, with about half of the visits related to reproductive health issue. The project faces high costs, however, and large payments to peer educators may not be replicated elsewhere. In order to sustain and expand the project, the franchiser plans to (1) develop relationships with the private sector and other community organizations; (2) document the

impact of franchising techniques; and (3) explore ways to diversify funding and generate revenue.

*Source:* LaVake, Steven, “Applying Social Franchising Techniques to Youth Reproductive Health /HIV Services,” Youth Issues Paper 2, Family Health International, 2003.

*Contact:* www.psi.org

## **KMET, Kenya**

In 1996, KMET, a NGO, started operation of a reproductive health franchise in Kisumu, Western Province, and is established in hard-to-reach areas of five of Kenya’s eight provinces. KMET acts as a franchiser and started the operation by training private doctors and consultants in safe abortion practices and post-abortion care. The program quickly grew to include midwives, clinical officers, and nurse practitioners, and as of 2001 all new providers were mid-level provider cadres.

Providers are required to meet set facility standards. In exchange, they receive free training, a free initial MVA kit, and regular delivery of contraceptive commodities to their clinic. Franchisees pay some token annual membership fee, which makes them eligible to participate in a revolving loan program. KMET has extended medical training to include family planning and other reproductive health services, including STI management and home-based care for HIV/AIDS. As a result of their involvement in HIV/AIDS, they started training community-based workers (CBWs) in early 2002 in a number of pilot locations. CBWs receive instruction from KMET trainers in home-based care, with a focus on support for AIDS patients. The CBW network is currently active only in the Kisumu area, but expansion is planned.

### **Financial support**

KMET received a 5-year grant from Family Planning International Assistance (FPIA) in 1996.

This was extended for a second 5-year period; current support from FPIA is approximately US\$120,000 per year. In addition, KMET receives US\$25,000 per year for specific activities to support two member providers and related community-based distribution of family planning products on the remote Mfangano Island in Lake Victoria. KMET also receives free in-kind family planning commodities from the government, which is passed on at no cost to participating members and placed in condom-distribution boxes in bars and other locations targeting at-risk populations.

### **Expenditures**

The bulk of KMET’s expenditures is for staff cost. KMET employs four full-time staff, an executive director, and support staff. KMET rents one building near the town of Kisumu, and two provincial satellite offices. KMET owns two 4-wheel drive pickup trucks, which are used to transport staff and to deliver family planning supplies to members.

### **Activities**

In addition to having 125 franchisees, KMET operates one health clinic itself, which employs two nurses and one paramedic, and is further supported by volunteers from the nearby community. There are approximately 200 registered members of the KMET network working in five provinces.<sup>4</sup>In addition to the provider network, KMET has produced models in advocacy and policy development; in participatory learning practices and collaborative community networks; and in curriculum development, peer education, and provider-training programs. The government, USAID, and other health organi-

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<sup>4</sup> Although this is the number of registered members, initial survey results suggest that some of these members are not currently active, and so these must be verified by the ongoing survey.

zations have replicated these models. The projects are funded minimally, and operate primarily through volunteers organized by the KMET staff.

### Cost-effectiveness

KMET has not calculated or kept records specifically for cost-effectiveness. Nonetheless, using their MIS data on provider activities, together with their volume of free-condom distribution, it is possible to calculate a Cost per Couple Year of Protection (Cost/CYP) for their activities of approximately US\$4.11. While this figure is based on a number of assumptions, it does represent a cost/CYP value at the lower end of all supported family planning programs in Sub-Saharan Africa.<sup>5</sup>

*Source:* Montagu, Dominic, "Output based services for health and their potential application in Kenya," June 2003

*Contact:* Solomon Orero, KMET *Solorero@hotmail.com*

### Sustainable Healthcare Enterprise Foundation (SHEF), Kenya

In April 2000, the Sustainable Healthcare Enterprise Foundation's Child and Family Welfare Project launched a franchise of drug shops, all operating under the Child and Family Welfare (CFW) brand. The shops are owned and run by community health workers who have undergone training by the Anglican Church, and have received an additional four weeks training from CFW upon initiation. CFW Shops sell 18 essential drugs, all of which must be purchased from the CFW headquarters. No non-CFW drugs are allowed to be sold from a franchise.

In April 2003, the network expanded to include medical clinics staffed by nurses, also operating under the Child and Family Welfare (CFW) brand. New services added include HIV/

AIDS counseling, home based care, and deworming of children. The Clinics are operated by nurses, who receive a four week training, primarily in business management. The CFW Clinics sell 81 essential drugs, and are also permitted to charge for diagnosis and treatment of more general illnesses. As with the shops, only drugs bought from CFW headquarters are permitted in the franchise outlets. Prices are clearly advertised, and regular controls are implemented. As of December 2003, SHEF/CFW operated 40 franchised drug shops and 20 franchised clinics.

### Financial support

SHEF/CFW currently operates with an annual budget of approximately US\$250,000. Over 80% of the shops are operating in a self-sustaining manner. All CFW shops pay franchise fees to the SHEF/CFW (15% markup on drugs, and 5% of gross income). SHEF/CFW estimates that it could be financially self-sufficient as a franchiser with 500 franchised shops. With the recent introduction of nurse-run CFW Clinics, which have higher incomes and therefore pay higher franchise fees, this calculation may change.

### Result to date

SHEF/CFW franchisees had treated approximately 250,000 patients as of March 2003. The founder evaluates that keys to their success include strict implementation of rules and standards (e.g., disqualification of franchisees if there is violation), and making sure that there is proprietary value in the business for franchisees.

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<sup>5</sup> Assumptions are made as to use of free condoms, calculated as 1/3 of the rate of purchased condoms. In addition, many of the services included, such as surgical sterilization, would likely occur to some extent without the involvement of KMET

*Source:* Montagu, Dominic, “Output based services for health and their potential application in Kenya,” June 2003. Kimbo, Liza, presentation at Engaging the private Sector in Franchising for the Public Good: Technical Seminar Series, May 2003. CFW Shops Website, <http://www.cfwshops.org>.

Contact: Liza Kimbo [liza@cfwshops.org](mailto:liza@cfwshops.org)

## **New Start, Zimbabwe**

In order to respond to the HIV/AIDS crisis, the HIV/AIDS and TB Unit of the Zimbabwean Ministry of Health and Child Welfare began a national franchise of Voluntary Counseling and Testing (VCT), New Start, in 1999. The U.S. Agency for International Development (USAID) provides funding, while Population Services International (PSI) provides technical and managerial assistance. New Start targets high-risk population such as young couples, adolescents, commercial sex workers, transport industry workers, and other “mobile” populations.

At New Start test centers, counselors advise clients before and after each HIV test. The counselors are trained in protocols and procedures to provide on-site, state-of-the-art, rapid HIV testing, combined with pre- and post-test counseling sessions that include referrals—when appropriate—to community support groups. For the first two years, New Start used standard testing technology, which required clients to wait a week before getting the results. However, because of the time lag, a large portion of New Start clients did not return for their results. To improve the situation, New Start network introduced new rapid HIV tests in 2001. The new tests permit clients to receive their results within an hour, which increased the portion of clients who receive their results from 77% to 97%.

New Start was launched with only one center, and has since grown into a network of 12 centers throughout the country. The network has

seen 57,000 clients through December 2001, and the average number of monthly clients has increased from 230 in 1999 to more than 4,000 in 2002. PSI estimates that 120,000 cases of primary and secondary HIV cases were averted in 2002.

New Start Centers are established in high-traffic areas or at institutions that already provide health-related services, in order to help reduce the uneasiness many VCT clients feel due to the stigma of HIV. Ten of New Start centers integrate VCT services into existing health service delivery institutions, such as public clinics and hospitals, non-governmental organizations, and private health facilities. The other two centers are “free-standing” sites, which are operated and managed directly by PSI.

Quality is maintained through agreements between PSI/Zimbabwe and the health centers that stipulate the standards to which the centers must adhere, and by regularly conducting “mystery client surveys,” in which researchers pose as clients. New Start counselors undergo extensive initial and follow-up training.

PSI says one factor that contributed to the success of the project is strategic and culturally sensitive multi-media communication campaigns through TV, radio, and print. PSI operates similar franchising on family health and VCT in Angola, Botswana, Burkina Faso, Madagascar, Mali, Mozambique, Namibia, Rwanda, Swaziland and Togo.

*Source:* PROFILE : New Hope with New Start, PSI, May 2002. Presentation made at *Social Franchising of TB and TB/HIV in Low Resource Settings Meeting* at the Rockefeller Foundation, April 2003.

## **ProFam, Zimbabwe**

PSI/Zimbabwe began the Professional Family Planning Services Project (ProFam) in October 1997 to increase demand for and supply of reproductive health services in the private sector.

The project trains private-sector, medical-service providers such as doctors, independent nurses, and pharmacists, who in turn provide quality reproductive health services and contraceptive products at affordable prices.

As the declining value of local currency forced the price of ProFam products beyond the reach of its target consumers, the initiative was redesigned to provide products at subsidized prices to ensure affordability.



## Annex 3: Case Studies of Vouchers in Africa

### Vouchers for Insecticide-Treated Bed Nets in Tanzania

The KINET project in Tanzania employed a competitive voucher program to subsidize insecticide-treated bed nets, which have been shown to give substantial protection from malaria, in two districts of southern Tanzania. The vouchers were targeted to pregnant women and women with children under five years of age. The project distributed discount vouchers through mission and government maternal and child health clinics, with the aim of:

- reducing the price of treated nets for pregnant women and women with young children
- drawing attention to the group most at risk of severe disease
- promoting increased equity among pregnant women and young children.

Vouchers were distributed to women when they came to the clinics for treatment. Clinic staff wrote the name, date, and contact details on the part of the voucher given to the women and the part returned to the project team. A mark was made on the health card of the mother or child to indicate that a voucher had been given. Each voucher could be used as part payment (500 Tanzanian shillings) for a treated net (total cost of 3,000 shillings). The nets were available

through a network of public and private providers, including shopkeepers, health workers, and village leaders. These agents were given a credit of 550 shillings (including a 50-shilling handling charge) for each voucher by the wholesaler or by the project when they purchased the nets. Wholesalers purchased nets directly from the project and were given a credit of 600 shillings for each voucher returned to the project.

Overall, 23% of the more than 65,000 socially marketed mosquito nets sold during the project period were purchased with vouchers. Voucher return rates were extremely high: a total of 8,000 vouchers were issued, and of these, 7,720 were returned. There was some evidence of higher voucher use among least poor women, as opposed to the poorest women (many of whom could not afford a net, even with a voucher). However, two years after the program was instituted, awareness of the program among target groups was only 43%, and only 12% of women had used a voucher to purchase a net (although some claimed to have already purchased one). There was some indirect evidence of misuse; however, the extent was difficult to measure. Nonetheless, it seemed likely that some vouchers were used by ineligible household members and households from other areas.

Evaluation of the project revealed that a substantial amount of time—several years—was needed for people to understand and participate in the program. A promotional campaign that

involves multiple communication channels may be warranted. The voucher program did, however, serve as a strong link between the public health system and private sales agents, optimizing the skills of each to increase the coverage of treated nets. Finally, the program also served as a promotional tool to heighten awareness of the health benefit of treated nets—and to identify the group most at risk of severe malaria—among family members and members of the community in general.

*Source:* Mushi, Adiel K., Joanna RM Armstrong Schellenberg, Haji Mponda, and Christian Lengeler, “Targeted subsidy for malaria control with treated nets using a discount voucher scheme in Tanzania,” *Health Policy and Planning*, 18(2): 163–71, 2003.

### **A voucher program for delivering emergency contraception to young people in Zambia**

This voucher program was undertaken as part of a study in Lusaka and its environs to determine the most effective channels for delivering “youth-friendly” emergency contraceptive services. Two earlier studies had shown that (i) access to family planning services is severely limited for many potential users, including youth, in part due to cultural norms and provider biases; and (ii) that young people were not seeking out emergency contraception in part because of lack of anonymity or privacy at local clinics or counseling centers. The study thus aimed to gauge, both quantitatively and qualitatively, preferences for sources of information and services among youth.

The study identified four different types of health workers to provide information on emergency contraception and/or actual emergency contraception pills (ECPs). The four groups were peer counselors, based at public sector health facilities; clinic-based outpatient health care providers; private pharmacists; and community sales

agents. All groups were trained to provide information on emergency contraception and distribute vouchers for ECPs. Staff of the public clinics and private pharmacies was also trained to provide the pills, but regulatory restrictions prevented peer counselors and sales agents from directly providing ECPs.

When potential users were given information about emergency contraception by any participating health worker, they were given a voucher, which could then be redeemed for a pack of ECPs, either by the same health worker or by any one of the project’s participating providers. On each voucher, the information provider indicated the age of the client and whether the client was in or out of school, and could also indicate the type of provider he/she was. Once the card was redeemed for a pack of pills, the supplier noted on the back of the card the category to which he/she belonged. Clients who came to a supplier without a card were asked where they had received information about emergency contraception, and the card was filled out appropriately. If the supplier was also the initial source of information, the supplier completed both sides of the card. The number of vouchers given to each category of health workers was recorded to keep track of the number of contacts made.

Providers were supplied with stocks of ECPs. At the public clinics vouchers could be redeemed for ECPs free of charge. The private pharmacies were permitted to charge, and the maximum price was set at 500 Kwacha (US\$0.13). The normal market price was 15,000 Kwacha (US\$3.75). Throughout the study, redeemed vouchers were collected on a monthly basis. The data were then processed, thereby allowing the research to track over time the frequency and patterns by which the vouchers were issued and redeemed.

Between February 26 and September 30, 2000, 3,517 vouchers had been distributed to the four types of workers. Of those, 1,798 vouchers had been given to clients, and 421 were redeemed by women between the ages of 12

and 45. Pharmacists clearly emerged as the most frequently used provider of ECPs, although they were also one of the most difficult to coordinate and organize for training purposes. Their fairly anonymous approach, though perhaps less than ideal from an informational perspective, made them more attractive sources of information and ECPs. Young people tended to distrust more traditional providers of family planning services. The second choice of provider varied with age, with peer counselors being more popular among younger clients and clinic/outpatient nurses being more popular among older clients.

*Source:* Skibiak, John P., Mangala Chambeshi-Moyo, and Yusuf Ahmed, “Testing alternative channels for providing emergency contraception to young women,” 2001.

## **A voucher program in the Nyeri Youth Health Project in Kenya**

The Nyeri Youth Health Project (NYHP) is a pilot community-based project for young people living in Nyeri, the capital of Kenya’s Central Province, which is the homeland for the Kikuyu, Kenya’s largest ethnic group. The project is a collaborative effort between the Population Council and the Family Planning Association of Kenya. Earlier studies in Nyeri revealed that young people and parents preferred that adults, rather than peers, give sexual and reproductive health information to young people (this is consistent with local Kikuyu culture).

The goals of the NYHP, targeted at unmarried people between the ages of 10 and 24 (as well as the adults who influence their environment), were to:

- delay the onset of sexual activity among youth not yet sexually active
- prevent sexually experienced youth from suffering negative consequences of sexual activity

- create a reproductive health information and service environment responsive to the needs of young people.

The project was piloted for three years and had two components: information and referral, and service provision. Adult educators were used in the *information* component. Young parents were recommended from the community to serve as “Friends of Youth” (FOY), who were paid an honorarium for their services. They were trained and assigned an area of operation. They reached young people through existing groups and institutions, or they formed young people into their own groups. By the end of the pilot period (1998-2000), about one-third of young people in the project area had had direct contact with a FOY.

In the *service* component, a network of private and public service providers were used to reach the largest number of young people. The providers’ skills were updated, and they were trained on “youth friendliness.” In all, there were 12 service outlets participating in the project—including seven private clinics, two public facilities, a lab, one chemist, and one counselor. FOYs issued vouchers and a list of service providers to young people. In addition, service providers used the voucher to refer young people to other providers, such as a lab for tests, if needed. The voucher entitled the young person to services at a subsidized cost. The program was designed so that all parties contributed to the cost of providing the service. The young person paid KSH 50 (about US\$0.60), the providers waived their consultation fee, and FPAK paid for any additional costs over and above that, including drugs for treating STIs and lab tests. If the young person could not pay the fee, it was waived.

The voucher itself had three sections: one section was retained by the FOY as a record of who had been referred; the other two sections were given to the young person who, in turn, gave them to the provider. One of these two sections was submitted to the Family Planning

Association of Kenya (FPAK) with the diagnosis and the treatment given so that FPAK could reimburse the cost of services. The coupons had serial numbers. If a coupon was issued by a FOY, but not returned to FPAK—implying that the young person did not go for the services—the issuing FOY was given the serial number of the coupon and asked to follow up with the young person. During the pilot phase of the project, nearly 100% of the vouchers were used, because young people saved money by using the coupon and because there was a mechanism to follow up if services were not sought within a reasonable time.

During the 3-year project, 2,800 young people were referred and received services using this system. The majority of young people received treatment for STIs (about 55%). After that, family planning was the most popular service

received by girls (15%) and male circumcision for boys (15%). Originally, male circumcision was not one of the services offered, but young men in the project area requested that it be provided, as it was part of a socially recognized rite of passage into adulthood. The cost to FPAK of subsidizing the services was approximately \$7 per contact.

An evaluation of the program revealed that in 2001, compared with 1997, fewer Nyeri boys and girls had initiated sex, more had abstained or used condoms, fewer had multiple sexual partners, and more communicated with a parent or other adult. In contrast, behavior in a neighboring control area worsened over the period.

*Source:* Erulkar, Annabel, Personal communication relayed through Anna Gorter, 2003.

## Annex 4: Case Studies of Contracting for Health Service Provision in Africa

### Contracting for Hospital Services in Zimbabwe

In Zimbabwe, the Ministry of Health has maintained a long-standing contract with Wankie Colliery, a 400-bed hospital, to provide the services of a district hospital. Patients who are characterized as “government responsibility” (patients exempt from user fees at public hospitals) may be treated at the hospital on a fee-for-service basis. A government official stationed in the hospital certifies the eligibility of the patient, the patient is treated, and the hospital sends the bill for treatment to the Ministry of Health.

The original contract was signed in the 1950s, without a competitive tendering process and prompted by the lack of government hospitals in the area. The contract does not specify charge rates, although a fee-for-service system has operated since the inception of the contract. There is no formal monitoring of quality of services or operation of the contract.

An analysis of this contract by McPake and Hongoro in 1995 revealed several important lessons. Because there was no competition and the government did not retain its capacity to offer services, the monopoly position of Colliery in the district was entrenched, rather than challenged by the contract. This and the failure of the government to appropriately screen patients for their ability to pay and need for hospital services led to excessive provision.

The contract did not manage to contain costs, a result of overuse and the fee-for-service nature of the contract. Approximately 70% of provincial non-salary recurrent expenditure was allocated to the hospital, yet the hospital was accessible to only a minority of the population. The absence of skilled personnel to appropriately monitor the contract and screen patients was an important constraint affecting the outcome of the arrangement. The contract was ultimately terminated due to disagreements over revisions (Mills 1997).

*Source:* McPake, Barbara and Charles Hongoro, “Contracting Out of Clinical Services in Zimbabwe,” *Social Science and Medicine*. 41(1): 13–24, 1995.

Mills, Anne (1997). “Contractual relationships between Government and the commercial private sector in developing countries”, in *Private health providers in developing countries: serving the public interest*, ed. Sara Bennett, Barbara McPake, and Anne Mills, Zed Books: London & New Jersey, p. 189–213.

### Contracting with General Practitioners in South Africa

In both the Western and Eastern Cape of South Africa, provincial governments have long-standing contracts (dating to the apartheid era) with general practitioners, referred to as part-time

district surgeons, to provide clinical and other medical services in a defined geographical area, predominantly rural. South Africa has a well-developed private health sector, and few general practitioners are willing to work for the public sector, particularly in rural areas. The departments of health of provincial governments therefore contracted with private physicians to work part-time provide predominantly curative primary care services in rural areas. Contracts entail a basic fee-for-service agreement, specifying a general list of medical services to be provided.

A careful analysis of this contracting program (Palmer 2003; Palmer and Mills 2003) found that the contracts were incomplete and open to interpretation by the practitioners. No standards for quality were outlined in the contract. Sanctions (termination of contract) for negligence, breach of material conditions, or misconduct were included in the contract; however, examples of what such misbehavior entailed were not given. Many of the practitioners interviewed claimed that there was very little monitoring or supervision. Rather, interactions between purchaser and provider were governed more by interpersonal relationships, and a sense of mutual dependence increased the tendency of the two to cooperate.

Provincial governments depended on the practitioners for service, as there were not sufficient providers to promote competition, and providers were dependent on the contract for their income. Further, the providers' impetus to provide quality care was driven by a necessity to maintain their reputation, particularly among closely knit communities, and, for many, personal values and an obligation to the communities they served. The quality of care often varied on the basis of the extent of this commitment. In fact, many practitioners were operating without an effective contract.

In this case, a kind of relational contract, rather than classical contract developed, as the provincial governments' capacity and resources to monitor were limited by the difficulty of

specifying and monitoring complex services, particularly in rural areas. The weakness of the formal contract meant that practitioners decided for themselves how to deliver services, with professional and ethical standards the key motivation.

*Sources:* Palmer, Natasha and Anne Mills, "Classical versus Relational Approaches to Understanding Controls on a Contract with Independent GPs in South Africa," *Health Economics* 12: 1005–20, 2003.

Palmer, Natasha, "Does Duty Call: Contracts and GPs in South Africa," *Insights Health*, March 2003.

### **Contracting for Basic Health Services in the Democratic Republic of Congo**

This US\$49 million, Bank-financed health project is a sub-component of an emergency multi-sector rehabilitation and reconstruction program (EMRRP) for the Democratic Republic of Congo (DRC). Approximately 90% of the funding came in the form of an IDA grant. Of the total, US\$42 million covered 67 health zones and 8 million people. The remaining US\$7 million was used to provide institutional support and strengthening at the central and provincial level. The project was launched in September 2003.

Healthcare in the DRC is allotted according to a health zones system, of which 50% were co-managed by NGOs or other agencies. The role of contracting was to use these health zones, scale-up existing projects to deliver a "minimum package of care," and help the government build the institutions necessary to deliver healthcare in the long term.

The project is being implemented in two phases. Phase I entails reaching the target health zones, and Phase 2 involves developing a long-term strategy and supporting central and provincial capacity building.

For Phase 1, nine NGOs were selected, based on their presence and success in providing health care in the target health zones, mainly along National Road One (HZ). An interest in expanding assistance to the surrounding HZ and the ability to provide a broad spectrum of development assistance were also important. Other criteria included a maximum 12% administrative fee; good working relationship with local communities and authorities; a successful track record in resource management; and a willingness to co-manage projects with regional/district medical offices.

The selected NGOs were given an initial US\$80,000 contract to:

- visit each of the health zones
- discuss the project with local and regional authorities
- visit the direct medical offices to discuss project implementation
- complete a rapid inventory for each health zone
- assess the need for rehabilitation
- develop the overall project proposal and budget
- write a one-year action plan and budget.

Two agencies had oversight over the NGOs. The MOH held a supervisory role and monitored technical aspects of the project. The MOH, in turn, signed a memorandum of understanding with the Bureau Central de Coordination (BCECO), who served as the contracting agency with the NGOs and handled compliance with procurement and fiduciary issues.

The project is in its early stages; however, several issues have already emerged. Procurement became problematic due to differences of interpretation in procurement guidelines. This was resolved with the help of a Bank procurement specialist. The concept of an *Annual Procurement Plan* was also introduced in 2004. The other challenges include the need to motivate poorly paid civil servants to effectively monitor contracts; balance the need for close

supervision with the high cost; and ensure that financial management compliance remains a priority.

*Source:* Eva Jarawan, Lead Health Specialist, AFTH3, World Bank.

### **Contracting for Nutrition Services: The Secaline Project in Madagascar and the Community Nutrition Project in Senegal**

The Secaline project in Madagascar and the Community Nutrition Project (CNP) in Senegal are two examples of contracting out programs in which a delegated contract management approach was used to carry out large-scale nutrition projects targeted at children and pregnant and lactating women. Secaline was funded primarily by UNICEF (91%), with user contributions, the Government of Madagascar, the World Bank, the World Food Program, and the Government of Japan contributing the rest. The CNP was funded by the World Bank, the World Food Program, KfW, the government, and community contributions. The two projects targeted women and children living in poor and semi-urban areas, which were not adequately served by the government or other providers.

The Secaline project covered 534 villages in two regions, serving more than 300,000 people, and the CNP covered 14 cities, serving more than 200,000 people. Both projects provided the following services at the community level:

- monthly growth monitoring of children in the program
- weekly nutrition and health education sessions for women
- referral to health services for unvaccinated children and pregnant women, for severely malnourished children, or for sick beneficiaries

- home visits to follow up on beneficiaries who were referred or who did not use the available services
- food supplementation to malnourished children
- improved access to water stand pipes (Senegal) or referral to a social fund for income generating activities (Madagascar).

In Madagascar, services were provided by a Community Nutrition Worker (CNW), generally a woman from the village, and in Senegal, by a Groupement d'Interet Economique (GIE), a legal entity consisting of a group of four young people, typically unemployed, living in the target neighborhood. These workers are trained by project staff (Madagascar) or by local consultants or training institutions (Senegal); they were supervised by NGOs (Madagascar) or NGOs or other GIEs (Senegal). All relationships were contractual.

In both projects, the functions contracted out included overall management, service delivery, supervision, and research and training (contracted to local consultants or institutions). In Madagascar, a project management unit linked to the office of the prime minister and two regional management units were established to manage contracts for the government. NGOs were contracted (via an open tender process) to manage the CNWs (chosen on the basis of strict criteria; verbal contract established).

Technical coordination and project management accounted for 13% of the project's cost. In the CNP, Agetip, an NGO, signed a convention with the government to execute the project. It contracted local NGOs and GIEs (via open tender), who in turn oversaw (other) GIEs (also contracted through open tender) delivering services. Agetip charged the government 17% of the project's cost for operation, monitoring, and evaluation.

Contracts given to NGOs and GIEs specified the work to be done as well as the performance expected. A minimum number of services to be delivered was specified, as was attendance in weekly educational sessions. Management information systems in both projects served to regulate performance. Close supervision by Agetip and project units lessened the risk of falsified data. In Senegal, competition was encouraged among local youth groups as well as NGOs to win the bid, and then to perform adequately to have their contract renewed. In Madagascar, because the project was located in rural areas with few competitors, quality was ensured by allowing a center to remain open only if it met strict standards.

The Secaline project and CNP were able to achieve strong results by using the private sector and community members—who were not healthcare professionals—to provide nutrition services. Both programs lowered malnutrition rates substantially (from 20%–30% to 5%–10% in Madagascar; and from 60%–70% to 20%–30% in Senegal). In Senegal, severe malnutrition disappeared in children aged 6–11 months, and moderate malnutrition for ages 6–35 months dropped from 28% to 24%. The heavy donor contribution to these programs raises the issue of sustainability, although both programs have addressed this through capacity-building at the community and institutional level.

*Source:* Marek, Tonia, Issakha Diallo, Biram Ndiaye, and Jean Rakotosalama, "Successful contracting of prevention services: fighting malnutrition in Senegal and Madagascar," *Health Policy and Planning*, 14(4): 382–89, 1999.

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