Major Applied Research

No. 4: Working Paper 1

Extending Coverage of Priority Health Care Services through Collaboration with the Private Sector: Selected Experiences of USAID Cooperating Agencies

February 1998

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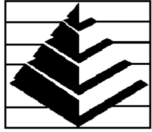

Mission

The Partnerships for Health Reform (PHR) Project seeks to improve people's health in low- and middle-income countries by supporting health sector reforms that ensure equitable access to efficient, sustainable, quality health care services. In partnership with local stakeholders, PHR promotes an integrated approach to health reform and builds capacity in the following key areas:

- *better informed and more participatory policy processes in health sector reform;*
- *more equitable and sustainable health financing systems;*
- *improved incentives within health systems to encourage agents to use and deliver efficient and quality health services; and*
- *enhanced organization and management of health care systems and institutions to support specific health sector reforms.*

PHR advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and promotes the exchange of information on critical health reform issues.

February 1998

Recommended Citation

Skaar, Christina M., M.A. February 1998. *Extending Coverage of Priority Health Services through Collaboration with the Private Sector: Selected Experiences of USAID Cooperating Agencies.* Major Applied Research No. 4. Working Paper 1. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc.

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Contract No.: HRN-5974-C-00-5024-00
Project No.: 936-5974.13

Submitted to: USAID

and: Robert Emrey, COTR
Health Policy and Sector Reform Division
Office of Health and Nutrition
Center for Population, Health and Nutrition
Bureau for Global Programs, Field Support and Research
United States Agency for International Development

Abstract

As it has become apparent in most regions that developing countries' public sectors lack the resources to meet the health care needs of their populations, the United States Agency for International Development (USAID) has sought increased collaboration with the private sector in the last decade. This paper presents an overview of the variety of activities cooperating agencies (CA) have undertaken in collaboration with the private sector to extend coverage of priority health services. USAID has defined priority health care services to include maternal and child health, reproductive health, family planning, and sexually transmitted diseases/acquired immunodeficiency syndrome services. The general methods of collaboration employed, types of private providers and services involved, and geographic regions and populations covered are described. An assessment of the collaboration is also included, incorporating an analysis of how the different aspects of these projects are combined. Information was gathered largely through CA annual reports, outside evaluations, discussions with project staff, and other materials produced and disseminated by the CAs. The review was constrained by time and availability of documents and is not an exhaustive survey. It presents the most up-to-date portrayal of ongoing public-private partnerships.

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Acronyms

ACCESS	Access to Family Planning through Women Managers
AIDS	Acquired Immunodeficiency Syndrome
AIDSCAP	AIDS Control and Prevention Project
APOLO	*Apoyo a Organizaciones Sociales*
AVSC	Association for Voluntary Surgical Contraception
BASICS	Basic Support for Institutionalizing Child Survival
BFA	Bangkok Fights AIDS
BKKBN	*Badan Koordinasi Keluarga Berencana Nasional*
BRI	Bank Rakyat Indonesia
CA	Cooperating Agency
CBO	Community-based Organization
CBSM	Community-based Social Marketing
CEMOPLAF	Centro Médico de Orientación y Planificación Familiar
CEO	Chief Executive Officer
CSM	Contraceptive Social Marketing
CSSS	Clinic of Sao Sebastiao
FEE	*Fundación Eugenio Espejo*
FGM	Female Genital Mutilation
FHI	Family Health International
FP	Family Planning
GRACSA	*Grasas y Aceites, S.A.*
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
IBI	Indonesian National Midwives Association
IEC	Information, Education, and Communication
IMPA	Independent Medical Practitioners Association
INDESUI	*Instituto Dominicano para la Prevención y Asistencia a la Depresión y Suicidio*
INOPAL	*Investigación Operativa y Asistencia Técnica en Planificación Familiar y Salud Materno-Infantil en América Latina y el Caribe*

LAM/NFP	Lactational Amenorrhea Method/Natural Family Planning
LTM	Long-term Method
MCH	Maternal and Child Health
MEXFAM	*Fundación Mexicana de Planificación Familiar*
NGO	Non-governmental Organization
NPNMA	Nigerian Private Nurse Midwife Association
OR	Operations Research
ORS	Oral Rehydration Solution
PCS/PIP	Populations Communication Services/Population Information Program
PHN	Population, Health and Nutrition
PHR	Partnerships for Health Reform
PROFIT	Promoting Financial Investments and Transfers
PVO	Private Voluntary Organization
RH	Reproductive Health
SDA-RHS	Seventh Day Adventist Rural Health Service
SOMARC	Social Marketing for Change
SUSTAIN	Sharing U.S. Technology to Aid in the Improvement of Nutrition
SUWATA	*Shirika La Uchumika Wanawake Tanzania*
STD	Sexually Transmitted Disease
TA	Technical Assistance
TBA	Traditional Birth Attendant
TIPPS	Technical Information on Population for the Private Sector
TOT	Training of Trainers
USAID	U.S. Agency for International Development
WACH	Women's and Children's Health Project

Foreword

Part of the mission of the Partnerships in Health Reform Project (PHR) is to advance "knowledge and methodologies to develop, implement, and monitor health reforms and their impact." This goal is addressed not only through PHR's technical assistance work but also through its Applied Research program, designed to complement and support technical assistance activities.

The research topics that PHR is pursuing are those in which there is substantial interest on the part of policymakers, but only limited hard empirical evidence to guide policy makers and policy implementors. Currently researcher are investigating six main areas:

- Analyzing the process of health financing reform
- The impact of alternative provider payment systems
- Expanding coverage of priority services through the private sector
- Equity of health sector revenue generation and allocation patterns
- Impact of health sector reform on public sector health worker motivation
- Decentralization: local level priority setting and allocation
- Each major research project comprises multi-country studies. Such cross-country comparisons will cast light on the appropriateness and success of different reform strategies and policies in varying country contexts.

These working papers reflect the first phase of the research process. The papers are varied; they include literature reviews, conceptual papers, single country-case studies, and document reviews. None of the papers is a polished final product; rather, they are intended to further the research process—shedding further light on what seemed to be a promising avenue for research or exploring the literature around a particular issue. While they are written primarily to help guide the research team, they are also likely to be of interest to other researchers, or policymakers interested in particular issues or countries.

Ultimately, the working papers will contribute to more final and thorough pieces of research work emanating from the Applied Research program. The final reports will be disseminated by PHR Resource Center and via the PHR website.

Acknowledgments

The author wishes to acknowledge the assistance and cooperation received from the many U.S. Agency for International Development cooperating agencies and staff contacted. Comments on an earlier draft of this paper were received from Sara Bennett and Peter Berman.

Executive Summary

Until relatively recently, cooperating agencies (CA) for the U.S. Agency for International Development's (USAID) Center for Population, Health and Nutrition (PHN) have worked primarily with host country governments' ministries of health and public health care workers. In the last decade, however, USAID has branched out in terms of increased collaboration with the private sector. This paper presents an overview of the varieties of activities CAs have undertaken in collaboration with the private sector to extend coverage of PHN's priority health services. While almost all CAs have some type of involvement with the private sector, they have different levels of interaction—from intense to indirect involvement.

USAID-funded projects employ a variety of methods when working with the private sector to expand priority health service coverage. Technical assistance (TA) is the most common and varied type of assistance provided to both the private and public sectors. It involves transferring technical knowledge to another organization or individual. Training is similar to TA, but it is somewhat more specific. While TA usually involves a process, training covers the transfer of particular skills or knowledge. Funding is often provided to private providers, but it is usually limited to covering expenses for specific activities. A few CAs offer loans to private-sector organizations or individuals in certain situations.

Several CAs help their private-sector partners with materials development and dissemination. Materials development is an activity that CAs will often fund or subsidize, and it is usually part of a more comprehensive project or information, education, and communication strategy. Some CAs use their influence and connections to bring together organizations to facilitate dialogues and establish networks. These organizations can be a group of non-governmental organizations (NGO) or a mix of government agencies, for-profit providers, and commercial sector entities. Building these coalitions can enhance and expand service delivery by pooling resources and creating partnerships to make maximum use of available human and financial resources. In addition, social marketing has become a powerful tool for organizations to promote services and products. By using commercial marketing tools and strategies, social marketing projects work to create demand for health care commodities and services. CAs also work with the private sector in the areas of policy and advocacy, which include helping host governments to incorporate private-sector practices and to work with the private-sector expanding service delivery coverage. Related to policy work are health sector reform initiatives. These approaches are unique in that the direct recipient of assistance are not private providers themselves but often the government and/or NGOs and other stakeholders concerned with health issues.

As there are different ways in which CAs assist private providers, there are different types of private providers that participate in these partnerships. The majority of interactions with the private-sector involve partnerships with some type of NGO. USAID also funds projects involving clinics, hospitals, employer-based systems, associations, and individual private practices. The actual care providers range from physicians, midwives, and pharmacists to community health workers.

After examining the methods of intervention and the types of private providers involved in public- and private-sector partnerships, some trends become apparent in terms of how the collaboration is arranged. The CAs, whose goal is private-sector collaboration, have initiated a wide range of innovative projects with a number of diverse providers. For those CAs that are not designed specifically for private, for-profit sector collaboration, the involvement is more limited. In those situations, partnerships are generally with NGOs. For most CAs, the typical partnership with the private sector involves providing training and/or TA in family planning/contraceptive technology to NGOs to improve or expand service delivery.

It is difficult to draw conclusions when looking at how USAID-funded projects are grouped regionally, since much of the grouping is determined by USAID's own priorities or the status of countries as "joint programming and planning" countries. CAs place emphasis on those countries that USAID has determined to be priorities. There are, however, some broad regional trends. For example, the majority of acquire immunodeficiency syndrome-related projects are concentrated in Africa and Asia. While the rate of infections in Asia is rising faster than anywhere else in the world, Africa still has the largest percentage of human immunodeficiency virus infections. Another regional trend seems to exist with for-profit providers. In the Asia/Near East region, there appears to be more projects with for-profit private providers than in other regions.

Evaluations of both completed and on-going projects can provide useful information on private-sector collaboration for those CAs currently working with the private sector as well as for future projects. Evaluations, conducted by outside, objective personnel and combined with lessons learned produced by the CAs or the evaluators, can paint a realistic picture of a project's successes and failures.

Many health services have been traditionally provided by the public sector, often with donor involvement. Donors, however, have been turning to the private sector more and more in efforts to expand the coverage of priority health services. Currently the majority of USAID CAs have initiated partnerships with the private sector to varying degrees. The number of private-sector partnerships has been growing over the past decade, with some CAs having extensive involvement with private-sector projects. It becomes clear after examining the different examples that no two private-sector projects are exactly the same. There is no single approach to designing private-sector partnerships. The number of variables is high as is the number of strategies. Each project should be designed to fit the particular needs of the situation by using the appropriate strategies and targeting the appropriate provider or partner.

1. Introduction

Diminishing levels of funding for family planning programs and increasing needs have forced the United States Agency for International Development (USAID) to look for new ways to assist host country governments. The agency is learning to adapt its programs and activities to become more cost effective, efficient, and sustainable. Until relatively recently, cooperating agencies (CA) from USAID's Center for Population, Health and Nutrition (PHN) focused their efforts on providing assistance to ministries of health and public health care workers. It has become apparent in most regions that the public sector lacks the resources, both human and financial, to meet the health care needs of their populations. International donors and developing country governments are exploring ways to use funds to finance or promote the private provision of health services as an alternative to expanding public provision. USAID has branched out in terms of increased collaboration with the private sector in the last decade. The agency sees the private sector as an important means to achieve goal of expanding coverage of health care services in the developing world.

The objective of this paper is to present an overview of the variety of activities PHN CAs have undertaken in collaboration with the private sector to extend coverage of priority health services. USAID has defined what they call priority health care services to include maternal and child health (MCH), reproductive health, family planning, and sexually transmitted diseases/acquired immunodeficiency syndrome (STD/AIDS) services. For the purposes of this paper, the private sector includes commercial organizations, for-profit entities, private health practitioners, and non-governmental organizations (NGO), both for-profit and not-for-profit. To help understand the extent and type of collaboration between USAID and the private sector, the general methods of collaboration employed, types of private providers and services that are involved, and geographic regions and populations that are covered are described. An assessment of the collaboration is also included, incorporating an analysis of how the different aspects of these projects are combined. Are there, for example, trends in how types of provider, service and assistance are grouped and, if so, are there any wide gaps in this coverage?

Information was gathered largely through annual or semi-annual reports prepared by the CAs, outside evaluations completed on the projects, discussions with current members of the projects, and various other documents, reports, and materials produced and disseminated by the CAs. The review was constrained by time and availability of documents and thus, given the extent of CA activities with the private sector, is not an exhaustive survey. It presents the most up-to-date portrayal of ongoing public-private partnerships. Every effort was made to obtain current or recent information, but in instances where current information was unavailable, the most recent documentation was used.

2. USAID's Involvement with the Private Health Sector

USAID, along with other U.S. government agencies, has become results oriented. As part of its Strategic Objectives, it has produced a set of Program Results to guide the activities of their Cooperating Agencies. The Program Results are designed to provide CAs with a list of concrete results to which CA activities should be directed. The following Program Results[1] are applicable:

1.3 Enhanced capacity for public, private, NGO, and community-based organizations to design, implement, evaluate, and finance sustainable family planning programs,

2.2 Improved policies and increased public- and private-sector resources and capacity to deliver key reproductive health services,

4.3 Enhanced capacity for public, private, NGO, and community-based organizations to design, implement, evaluate, and finance effective human immunodeficiency virus/sexually transmitted disease (HIV/STD) prevention and care programs.

In addition to the Strategic Objectives, USAID activities are driven to some extent by the New Partnerships Initiative launched by U.S. Vice President Gore in March 1995 at the World Summit for Social Development. This initiative is designed to foster partnerships between key actors working towards sustainable development at the local level, including civil society, institutions of democratic governance, and the business community. Its Resource Guide provides programming tools to help missions bolster community involvement in the development process. Intended to increase local empowerment and promote sustainability, USAID's New Partnerships Initiative "seeks to unleash the entrepreneurial talent and resources of communities to build new coalitions and to find new opportunities for growth."[2]

USAID explicitly supports collaboration with the private sector. U.S. funding for international population activities has steadily decreased during the past several years and by investing in projects with the private sector, USAID hopes to make the most of its donor dollars. Learning to provide priority services within a for-profit context or one lacking donor funds, these projects work towards sustainability with the help of USAID's CAs.

Sustainability is the key concept for international population, health, and nutrition programs in the 1990s, and designing and implementing successful and sustainable programs is the goal for those working in this field. This strategy logically lends itself to private-sector involvement. In an environment of decreasing resources and increased need, CAs must do more with less. Not only is

[1]USAID Bureau for Global Programs, Field Support and Research. 1995. *Strategic Plan Center for Population, Health and Nutrition.*

[2]NPI Resource Guide 1997.

there a greater demand for services, there has also been a concerted effort to improve the quality of services. Responsibility for the delivery of health services is no longer seen as strictly the focus of the public sector. NGOs and the commercial sector are perceived as key players to improve the delivery of health care services in the developing world. By exchanging knowledge, ideas, and technical expertise with the private sector, CAs are striving to design and implement programs that will continue long after the financial and technical support from donor agencies is over.

Related to sustainability is the concept of capacity building. The capacity of organizations or individuals to maintain a private practice or succeed in the private sector is strengthened or built with the help of donor agencies. To build the capacity of a particular organization, CAs provide the tools or skills they feel are needed to run a successful business and operate without outside funding. The type of support depends, of course, on the situation and existing skills of the private-sector organization. NGOs that have a history of relying on donor funds need to build their capacity in areas relating to cost recovery, income-generation, and efficiency. Similarly, individual or groups of physicians or midwives who want to start a private practice need to build capacity in business skills and possibly modern reproductive and MCH techniques. Whatever the situation demands, CAs focus on filling in necessary gaps to build the capacity of private-sector entities, so that these entities may offer high quality health services to populations on demand as well as maintain successful businesses.

Another factor in USAID's increasing interest in private-sector collaborative projects is the presumed greater cost effectiveness of the private sector as compared to the public sector. The assumption is that the private sector—especially the for-profit sector which is being driven by profits and/or financial survival—operates generally more efficiently than the public sector does. Some public-sector health programs have gained a reputation of inefficiency and wastefulness. Scarcity of funds leads USAID to seek out in-country partners who can do the most with available resources, and at the same time, have the greatest impact. USAID and other donors, therefore, have turned to the private sector to learn and incorporate its cost-saving and efficient methods for improving and expanding public health initiatives.

USAID's first large projects aimed specifically at collaboration with the private sector were the Enterprise Project (1985–90) and the Technical Information on Population for the Private Sector (TIPPS) Project (1985–90). The goal of the Enterprise Project was to "identify, develop, and test private-sector models which would demonstrate the ability of the private-sector to provide family planning services on a sustainable basis, largely or entirely at their own cost."[3] Similarly the TIPPS Project undertook to "increase the allocation of private-sector resources to family planning by promoting an understanding of the benefits of birth spacing in private and commercial systems."[4]

Enterprise and TIPPS operated simultaneously, and it was understood that the projects would work closely together to develop private-sector activities. USAID envisioned TIPPS focusing on demand creation, complementing Enterprise's role in the provision of direct technical assistance (TA) to commercial companies. This cooperative relationship was never quite achieved due to

[3]The Enterprise Program. *Final Report.*

[4]TIPPS. *Semi Annual Report #5, September 1987–February 1988.*

insufficient planning, overlapping scopes of work, and different program approaches.[5] Through discussions with USAID, however, TIPPS and Enterprise negotiated a division of labor and worked toward fostering a more collaborative relationship. Lessons from both projects reflect the learning that private-sector projects have the potential to be successful and sustainable, and that there is a demand for such collaboration. Both projects also took note of the large variety of external factors at work and the need for flexibility. Enterprise and TIPPS laid the groundwork for the current CAs working with the private sector, and these CAs can improve their initiatives based on the lessons learned from these projects.

[5]Population Technical Assistance Project. October 1989.

3. Levels of Private-Sector Involvement

While almost all CAs have some type of involvement with the private sector, different types of agencies have different levels of interaction. These interactions or collaborations can be categorized into four broad groups.

1. *Intense involvement.* These CAs work almost exclusively with the private sector, often the commercial for-profit sector. Their mandate or primary strategy is to design projects with the private sector, often providing TA in business and financial strategies (examples: Promoting Financial Investments and Transfers [PROFIT], the Initiatives Project, and Social Marketing for Change [SOMARC]).

2. *Moderate involvement*. These CAs frequently work with the private sector largely because that collaboration helps them meet project goals. They choose to involve the private sector because these organizations are the most appropriate partners. Collaboration is often with primary health care and reproductive health NGOs (examples: AIDS Control and Prevention Project [AIDSCAP] and Basic Support for Institutionalizing Child Survival [BASICS]).

3. *Limited or sporadic involvement.* The majority of CAs fall into this category. Although collaboration with the private sector is strongly encouraged, these CAs primarily work with the ministry of health and public health sector. They have selected projects with the private sector (usually NGOs), which respond to a particular set of needs (examples: Access to Family Planning through Women Managers [ACCESS] and MotherCare).

4. *Indirect involvement*. These CAs work with the private sector, but not directly with service delivery. While their activities may indirectly affect the availability and/or quality of service delivery and directly affect health outcomes, they are involved with such peripheral activities as information, education, and communication, environmental health; technology research (policy, health sector reform); and micronutrient intervention (examples: HealthTech, POLICY, Partnerships for Health Reform [PHR], Opportunities for Micronutrient Interventions [OMNI], and Sharing U.S. Technology to Aid in the Improvement of Nutrition [SUSTAIN]).

Because the focus of this paper is on extending coverage of health care services through private-sector involvement, discussion will concentrate on the first three categories.

4. Methods of Intervention

USAID-funded projects employ a variety of methods when working with the private sector to expand priority health service coverage. How CAs decide to assist private-sector organizations depends on different factors. One of the most obvious and crucial factors is the nature and expertise of the particular agency itself. CAs with limited financial resources but high technical skills will most likely focus their assistance on training and TA. Larger CAs, on the other hand, may provide project start-up funds and loans. Other important factors include the type of provider involved, type of private organization, location of the project, needs of both the organization and the population, and resources available. No situation is exactly the same when designing and implementing projects, therefore CAs must take all factors into account. It is often the case that a project will involve a combination of methods to achieve its goals. CAs with different skills and expertise can work together in some cases to provide the appropriate mix of services and assistance.

Types of collaboration or assistance provided can be generalized into several broad categories. Table 1 shows how frequently different types of interventions are used. The remainder of this section describes the various forms of interventions in more detail.

Table 1

CAs Approaches to Private-Sector Collaboration by Method of Investigation*

	Population	Health
TA**	27	15
Training	20	4
Funding	6	5
Loans	4	0
Materials Development	7	0
Coalition Building	1	1
Social Marketing	5	4
Policy	2	3

Based on review of 16 CAs and 69 programs.

*Information is based on the programs listed in Annex A. The programs listed in the table represent only a sampling of private-sector collaboration; thus the list is neither exhaustive nor comprehensive. This table is intended only to provide the reader with an approximate overview of how programs are distributed among types of collaboration.

4.1 Technical Assistance

Technical Assistance is probably the most common as well as the most varied type of assistance provided to both the private and public sectors. It involves transferring technical knowledge to another organization or individual. TA can range in content from contraceptive technology and STD/AIDS case management to marketing strategies and business plan

preparation. Often TA for the private sector falls into the classifications of service delivery or business management and marketing.

Service delivery TA involves activities related to general reproductive health, family planning, child survival, MCH, and STD/AIDS. TA can be general or specific. In Pakistan, for example, BASICS, MotherCare, and Wellstart provided TA to reproductive health NGOs to develop and expand their capacity in reproductive and child health programming. A more specific example is a project in Haiti where the Breastfeeding/Maternal and Child Health Division of the Institute for Reproductive Health provided TA to PROFAMILIA, a family planning NGO, to incorporate the lactational amenorrhea method and natural family planning into existing family planning service delivery activities. Commonly a CA provides TA to an NGO or group of private providers to help them incorporate family planning or reproductive health into their existing health services.

Technical Assistance also includes the use of operations research (OR) as a means to expand coverage of priority services. The Population Council, for example, is active in diverse regions performing OR and TA to improve the quality, accessibility, and cost-effectiveness of family planning, reproductive health, and MCH delivery systems. As a result of a Population Council/*INvestigación OPerativa y Asistencia Técnica en Planificación Familiar y Salud Materno-Infantil en América Latina y el Caribe* (INOPAL) OR project, a Brazilian health maintenance organization (HMO), Medical Protection to Companies Ltd. (PROMEDICA), added postpartum/postabortion family planning services because the research demonstrated the cost savings of offering such services.

Ecuador: Technical Assistance to InSalud

In Ecuador, the Initiatives Project provided TA to InSalud, a private, for-profit organization in Guayaquil, to help them take over the operation of public health clinics and open several new clinics. TA in capital acquisition, organizational development, strategic planning, financial analysis, business plan development, and marketing was provided. The project designed a series of marketing surveys to develop a profile of the needs, demands and health seeking behaviors of potential clients. The objective of the clinics is to provide financially sustainable basic health care services to middle- and low-income populations.

TA in the fields of business management, financial systems, and marketing is extremely important for expanding priority health care coverage through the private sector. To be sustainable and profitable, organizations that may have the medical knowledge and service delivery expertise to provide quality health care services also need the skills to operate a successful business. USAID-funded projects such as PROFIT and the Initiatives Project were very active in providing this type of assistance.

Specific TA may include helping devise a business plan, performing market research to determine the population's ability to pay, or assisting in the development of appropriate management and financial systems. In Ghana, Initiatives provided TA to a private insurance company to increase operational efficiency, perform market surveys, and adopt a management information system. INOPAL III and Family Health International, as a part of the Contraceptive Technology and Family Planning Research Program, provided TA in cost containment, cost recovery, and income-generation for a network of reproductive health clinics in Ecuador. In

Mexico, *Fundación Mexicana de Planificación Familiar* (MEXFAM), a family planning NGO, received assistance from SOMARC with market research and TA to fully develop an integrated marketing strategy to coordinate service, price, promotion, and location. This type of assistance is relatively new to a field that has historically dealt with service delivery and that has limited experience with the for-profit sector.

4.2 Training

Training is similar to TA, and the two terms are sometimes used interchangeably. Training, however, is somewhat more specific. While TA usually involves a process (i.e., incorporating family planning into existing services or starting a private practice), training covers the transfer of particular skills or knowledge (teaching how to insert an IUD or perform a no-scalpel vasectomy). The two forms of assistance are often combined, but they should be distinguished as a separate terms. As with TA, training is provided in a variety of areas. The level, content, and intensity of the training depend on the skills of the individuals to be trained and the capacity in which they work. To build capacity for private-sector organizations, CAs have provided training in modern contraceptive methods, postpartum family planning, STD/AIDS, MCH, nutrition, management leadership, marketing techniques, OR, and monitoring and evaluation.

Training is generally a crucial element of any project, whether it is in collaboration with the public or private sector. CA personnel possess extensive technical and managerial skills in many disciplines. Through training, these skills can be transferred and shared with private-sector partners.

Training of trainers (TOT) is a common method of transferring skills to a large number of host country nationals, utilizing relatively few resources. Using this approach, CA representatives train master trainers who then in turn train others. For example, in Tanzania, AIDSCAP provided a TOT for NGOs in the areas of HIV/AIDS; knowledge, attitudes, and practices research; peer education; home-based care; materials development; and case management. TOTs contribute to the sustainability of an organization by enabling it to continue training other health professionals or administrators after the collaboration with the donor is over. Master trainers can also help the organization grow and expand in terms of the number of people served and areas covered.

Training can also be in the form of workshops, group seminars, or even one-on-one situations. The ACCESS Project, under the direction of the Center for Development and Population Activities, works through a network of women family planning managers that the center has trained. ACCESS uses this network of nearly 4,000 individuals throughout the world to work with a variety of organizations, including those in the private sector. Building on the experience and skills of the network, ACCESS works to improve access to quality family planning and reproductive health services. It is obvious that projects such as ACCESS rely heavily on the training aspect of their collaborations with the private sector.

4.3 Funding/Financing

Funding is often provided to private providers, but it is usually limited to covering expenses for specific activities. There are, however, instances when a CA may cover start-up costs and

continue to finance the organization until it is self-sustaining. During the project implementation phase, SOMARC normally covers the majority of advertising and promotional costs of its social marketing products, but once the product or service becomes profitable, the private organization assumes these expenses.

Direct funding more often involves a particular set of activities, such as financing some sort of expansion or the purchase of products or equipment. The Rational Pharmaceutical Management Project, for example, provided funding and TA to establish a drug information center for a NGO in Nepal. CAs have also covered the costs of training or professional seminars, purchased computer equipment and vehicles, and subsidized materials development and dissemination. In the Dominican Republic, AIDSCAP provided the NGO *Instituto Dominicano para la prevención y asistencia a la Depresión y Suicidio* (INDESUI) with the computer equipment and database to increase the capacity of their hotline that offers information on STD/HIV/AIDS as well as other services. Another method of direct funding involves paying a portion or all of an employee's salary. Funding is also combined with other forms of assistance such as training or TA.

4.4 Loans

Loans are offered to private-sector organizations or individuals in limited situations and only by a few CAs. PROFIT established loan funds for both physicians and midwives, and the project has also provided loans to medical centers, HMOs, and clinics for start-up costs or expansion. In the case of the physician and midwife projects, loans were offered to help start or expand private practices. The loans were made available through local banks or other lending institutions. By offering low-interest loans combined with TA in business management and contraceptive technology, PROFIT provided these private practitioners with many of the tools necessary for operating a successful business.

Indonesia: PROFIT's Revolving Loan Fund for Midwives

To help Indonesian midwives establish or expand private practices to include family planning and reproductive health, PROFIT initiated a $1 million revolving loan fund. The program, which provided low interest loans to midwives for private practice, was designed to operate in 50 districts in five provinces. PROFIT collaborated with the Bank Rakyat Indonesia (BRI), the Indonesian National Midwives Association (IBI), and the National Family Planning Coordinating Board (*Badan Koordinasi Keluarga Berencana Nasional*, BKKBN) to establish the fund.

PROFIT made a $500,000 contribution that was matched by BRI. IBI identified the borrowers through its member chapters, and BKKBN promoted and monitored the program. In addition, PROFIT provided $254,000 in TA to manage, coordinate, and monitor the fund's operations and performance.

The midwives also received training in preparing business plans. As of March 1997, loans had been made to 490 midwives. Some of the lessons learned from this effort include: (1) there should be a realistic assessment of each partner's capabilities, objectives and organizational structure to allow for potential weaknesses to be handled during project design; (2) support from a committed and influential partner is important for success; and (3) endorsement from a well respected professional association provides credibility to the project.

SOMARC has also offered loans in some countries. For example, in Turkey it is providing low interest loans for doctors who want to improve their office facilities or participate in clinical training activities. SOMARC and Johnson & Johnson used a loan mechanism in Zimbabwe to provide funding for entrepreneurs to set up rural condom distribution businesses. Johnson & Johnson provided training in sales, merchandising, and product knowledge and guaranteed the low-interest loans. Providing loans is a relatively new way to encourage private-sector provision of priority health services and help health care providers to start or improve their private practices.

4.5 Materials Development

Several CAs help their private-sector partners with materials development and dissemination. Materials range in form from posters, brochures, curriculum, newsletters, and videos to manuals, managers' kits, flip charts and a variety of other publications and training/educational materials. By helping develop appropriate materials that reach the target population, donors improve the legitimacy, visibility, and impact of the private organizations.

Materials development is usually part of a more comprehensive project or information, education, and communication strategy. To build the skills of the private partner to continue these activities on their own, materials development is usually combined with TA. For example, the Populations Communication Services/Population Information Program (PCS/PIP) of The Johns Hopkins University worked with government departments, indigenous NGOs, and other CAs in Bangladesh in a nationwide maternal and child health/family planning (MCH/FP) information, education, and communication strategy. As a part of this strategy, PCS/PIP developed and distributed interpersonal communication and counseling materials, including an IPC/C training curriculum for use by government and non-government MCH/FP organizations.[6]

4.6 Coalition Building

Some CAs use their influence and connections to bring together organizations to facilitate dialogues and establish networks. These organizations can be a group of NGOs or a mix of government agencies, for-profit providers and commercial sector entities. Building these coalitions can enhance and expand service delivery by pooling resources and creating networks to maximize the use of available human and financial resources.

[6]Johns Hopkins School of Hygiene and Public Health. 1996.

Thailand: AIDSCAP's Bangkok Fights AIDS Project

One of AIDSCAP's largest and most successful projects may be the Bangkok Comprehensive Project—Bangkok Fights AIDS (BFA) which concluded in September 1996. BFA was conducted in collaboration with more than 20 agencies—both government and NGOs—and attempted to slow the spread of HIV through interactive and interpersonal communications and the mass media. Lower-income young people, aged 15 to 29, were targeted in the effort.

One component of BFA, the Service Worker Outreach Project, consisted of four indigenous NGOs. It conducted training workshops for factory workers, waitresses, motorcycle taxi drivers and other low-income workers. AIDSCAP's efforts were focused on bringing together the different organizations and providing mechanisms for the coalition to continue after AIDSCAP left the project. BFA culminated in an AIDS Forum at which the Bangkok City government formally took over coordination of the project.

AIDSCAP is very active in building coalitions between private-sector organizations, NGOs and government agencies to lower HIV rates and promote prevention programs. Given the nature of the HIV/AIDS epidemic and the rate at which the virus is spreading, the public sector needs the cooperation and assistance of the private sector and NGOs. CAs often combine coalition building with some sort of TA to improve or enhance the skills of the participation organizations. As a part of its private practitioner component of the Public/Private Sector Working Group, BASICS identified urban private practitioners and community-based organizations in Lagos, Nigeria to form partnerships to improve childcare, focusing on immunizations. These partnerships worked with BASICS to prioritize the community's health problems and develop objectives and workplans.[7]

4.7 Social Marketing

Social marketing has become a powerful tool for organizations, services and products. By using commercial marketing tools and strategies, these projects work to create demand for health care commodities and/or services. Social marketing, by its nature, involves private-sector partners. Although the public sector could benefit from social marketing strategies to reach a broader number of clients, the private sector is more likely to employ these techniques to increase its client base, recover marketing costs, and become profitable and sustainable. Private providers, commercial distributors, pharmacists, and NGOs are involved with USAID-funded social marketing projects.

Since the early 1980s SOMARC is the major USAID-funded project active in this field. It works to increase awareness of and demand for high quality reproductive health products and services through the use of market research, strategic planning, advertising, public relations, and other marketing tools. SOMARC has marketed contraceptives with private-sector partners throughout the world. Starting with a comprehensive market research study, it worked with MEXFAM on a new marketing strategy to strengthen its image, improve its visibility, and increase the number of its clients. SOMARC has begun to expand into marketing of services as well. In

[7]BASICS. 1996.

Turkey, it created a private reproductive health network, bringing together existing providers to expand access and improve quality and affordability of private-sector family planning services.

Uzbekistan: SOMARC's Red Apple Program

The goal of the Red Apple Program in Uzbekistan is to shift from public- to private-sector delivery of contraceptives and increase demand. It operates in two major cities and two oblasts with plans for expansion into three additional oblasts. The program created the Red Apple brand of oral contraceptives and injectables and promotes the product through a strategic marketing and communications plan. SOMARC offers contraceptive technology training seminars for health care providers, including obstetrics/gynecology specialists, general practitioners, midwives, and pharmacists. Since the program's inception in 1996, more than 700 health care providers have been trained in the newest contraceptive technology and how to create product awareness among clients. The project has established a long-term training with the Tashkent Pharmaceutical Institute, and SOMARC is transferring its training methodology to the institute to build in-house capacity in this area.

The goal of SOMARC projects is to achieve self-sufficiency and sustainability. It defines sustainability "as the organizational, technical, and financial capacity of programs to continue beyond a . . . project's contract period. Projects are sustainable if marketing activities can continue without additional donor financing or technical assistance."[8] While SOMARC is still the leader in USAID's social marketing efforts, other CAs such as AIDSCAP, BASICS, and PROFIT have adopted this approach. AIDSCAP and SOMARC worked together on a number of AIDS-related social marketing projects in Africa, Asia and the Near East, and the Caribbean. To help prevent diarrheal disease, BASICS and the Environmental Health Project have launched a hand-washing social marketing campaign in collaboration with soap producers in Central America. Social marketing is becoming a common tool for USAID in its private-sector collaborations.

4.8 Policy/Health Sector Reform

Another distinct way in which CAs involve the private sector is through policy work. This includes helping host governments to incorporate private-sector practices in their operations and work with the private sector to expand health service delivery coverage. Related to policy work are health sector reform initiatives. These initiatives are unique in that the direct recipient of assistance is often the government and/or NGOs and stakeholders concerned with health issues, not private providers themselves.

The POLICY Project brings together government policy makers with non-governmental and private-sector actors to facilitate dialogues on health care issues. POLICY also helps NGOs and professional associations increase their knowledge of advocacy in order to become more active in the policy and reform process. POLICY strives to improve participation of stakeholders—including those in the private sector—to advocate for family planning and reproductive health issues in policy debates. In addition, POLICY uses market segmentation techniques to promote more equitable use of public resources. For example, it undertook a market segmentation analysis in Turkey and planned a Public-Private Partnership Workshop based on the

[8]SOMARC III. 1995.

results.[9] The goal of market segmentation is to target public resources toward services for those who are least able to pay, allowing the private sector to serve those who are more affluent.

Another CA whose work is important to this area is the Partnerships for Health Reform Project. Its purpose is to foster health sector reform and provide assistance to reform efforts to improve the efficiency, sustainability, quality and effectiveness of health systems in the developing world. In terms of expanding priority health service coverage through the private sector, PHR informs policy makers of reform issues involving the private sector, conducts research and collects data on both public and private health sub-sectors. It brings together the private sector, NGOs, and governments to discuss reform options.

As part of an overall initiative to improve the management and sustainability of reproductive health programs, PHR is working to "improve knowledge of policy makers and program managers about specific demand and supply-side constraints that may be hindering optimal utilization of maternal and reproductive services in their countries, and effect policy and programmatic reforms to address these constraints."[10] Another PHR/Data for Decision Making effort, the National Health Accounts Initiative, collects national health expenditure and financing data from the public and private health sectors. This data will be used as a tool to track shifts in resource allocation, identify resource constraints or erroneous allocations, improve the overall management of health resource allocation, and potentially influence regulation and health reform efforts.

[9]The POLICY Project. 1997.

[10]Partnerships for Health Reform. 1997.

5. Types of Private Providers

As there are different ways in which CAs assist private providers, there are different types of private providers that participate in these partnerships. The majority of interactions with the private sector involve partnerships with some type of NGO (see Table 2). USAID also funds projects involving clinics, hospitals, associations and individual private practices. Within these settings, providers can be community health workers, physicians, nurse-midwives, or pharmacists. Private-sector partners also include entrepreneurs, companies, and manufacturers. The type of private providers dictates the type of collaboration that is undertaken. Other considerations are the size of the organization, its history, and level of sophistication.

Table 2

Relative Distribution of Private-Sector Collaboration among Types of Providers*

	POPULATION	HEALTH
Physicians	10	1
Midwives	8	1
Pharmacists	3	1
Community Health	6	2
Employer-based	1	0
Hospitals/clinics	9	2
NGOs	14	10

Based on review of 16 CAs and 69 programs.

* Information is based on the programs listed in Annex A. The programs listed in the table represent a sampling of private-sector collaboration; the table is neither exhaustive nor comprehensive. It is intended only to provide the reader with an approximate overview of how programs are distributed among types of provider.

5.1 Physicians (General Practitioners and Ob/Gyn Specialists)

Physicians who participate in USAID-funded projects are normally either general practitioners or ob/gyn specialists. Private-sector physicians receive assistance in the areas of contraceptive technology, STD/AIDS case management, incorporation of family planning services, business and management skills, and loan financing. Family planning is the most common type of assistance. Doctors with existing private practices receive help in integrating family planning into their range of services and updating their skills. An example of such assistance is the Awareness Project of the Institute for Reproductive Health which provided training to obstetricians and fertility practice physicians in Ecuador on reproductive health awareness issues.

Physicians may receive loans or assistance to hone their business management skills. This type of assistance expands priority service delivery, either by increasing the types of services offered by existing private practitioners or enabling physicians to start new practices. In many

populations there are clients who are willing to pay for services that have traditionally been provided by the public sector, especially if private physicians offer those services.

Jamaica: Family Health International Physician Training

In Jamaica, Family Health International worked with the Medical Association of Jamaica to conduct a series of seminars for private-sector physicians to increase their provision of family planning services. Financial and technical assistance was provided for a total of eight seminar series for approximately 200 physicians and health care providers per series. The goal of the seminars was to provide current and accurate information to private-sector physicians on contraceptive methods and family planning services and to encourage their participation as family planning providers. The project also worked to enhance the institutional capability of the Medical Association of Jamaica to organize and conduct continuing seminars for health care providers.

5.2 Midwives

Midwives are a very important resource in expanding coverage of priority services, because they provide a wide range of services in both urban and rural environments and are usually more affordable than physicians. Private-sector midwives mainly need assistance in improving and updating their health service skills, informing their clients of their range of services, and learning the business skills necessary to maintain a private practice. Clients often perceive midwives as only providing childbirth services. Midwives and physicians, however, provide a similar range of basic services, especially in terms of reproductive health and preventive health services. Midwives have historically played a role in USAID-funded projects, and they have become significant players in efforts to involve the private sector in priority service delivery.

CAs work with midwife associations or NGOs. The assistance provided is very similar to that given to physicians. Many projects aim to improve the accessibility, quality of services, and reputation of midwives. SOMARC worked with the Uganda Private Midwives Association to place midwives in community markets on market day creating an alternative distribution system for affordable, high-quality family planning services. Each midwife was provided with training, a sales booth, products, promotional materials, and a uniform

Midwives also receive training in business management skills to help them survive without outside funding. The ACCESS Project provided members of the Indonesian Midwife Association with training and TA in management and leadership as well as gender advocacy. There have also been projects offering loans for midwives to begin or expand a private practice. While concentrating on MCH, midwives can benefit by expanding their services and strengthening their business status through collaboration with USAID-funded projects.

5.3 Pharmacists

Partnerships with pharmacists are becoming more common because many people depend on the pharmacy for their family planning products. CAs have recognized the role that pharmacists can play in expanding and promoting use of family planning methods and they have began to

initiate more projects with these providers. Most projects include training on contraceptive technology and TA in the marketing of products.

Nigeria: Midwives Receive TA from Initiatives Project

In Nigeria, the Nigerian Private Nurse Midwife Association (NPNMA)/Osun State received assistance from the Initiatives Project in the development of appropriate management and financial systems. NPNMA is an association of independent primary care practitioners whose services are accessible to approximately 126,000 low-income families in Osogbo. The Initiatives Project assisted NPNMA/Osun to prepare a business plan outlining its strategy to strengthen the association and the individual member facilities.

In response to the increasingly competitive health care market in Osun, the Initiatives Project also funded a series of focus group discussions to determine what services clients use, where they receive these services, how much they are willing to pay, and their impressions of midwives as basic health care providers. The information is being used to target outreach and health education programs that present midwives as qualified providers of basic preventive and curative health care.

SOMARC, which has trained pharmacists in contraceptive technology and safety as well as Depo-Provera use in several countries, has tried an innovative follow-up approach to assure continuity of care after pharmacists completed training. A "mystery shopper" study was designed to evaluate how well the pharmacies were delivering Depo-Provera. Posing as a client, the mystery shopper would ask the pharmacist key questions about correct use, side effects, and contraindications of the product. Compiling this information helps SOMARC identify the strengths and weaknesses of their program and then make the necessary adjustments.

To increase the supply of modern contraceptives within the private sector in Romania, PROFIT conducted a training of trainers for pharmacists and adapted and translated training curriculum and materials. The training consisted of contraceptive technology, ways to provide quality care, and sound business practices.

Pharmacists are often an important source of advice for people, and they are a particularly vital source of family planning commodities. By promoting pharmacists' involvement with family planning, CAs have tried to increase the number of clients using contraceptives and improve the quality of information clients receive at pharmacies.

5.4 Community Health Workers

Many NGOs rely on community health workers to provide non-surgical, basic health services to their clients. These health workers have been an indispensable part of CA projects for many years. They are capable of providing a range of services, including family planning counseling, service delivery, and child survival interventions. Not only are they an inexpensive way to expand priority service delivery, they may be capable of reaching clients in underserved areas, such as remote rural sites. These health workers often have established networks of clients. While they have a base of health care knowledge, CAs increase their skills through training in family planning service delivery, modern contraception, MCH issues, and STD/AIDS.

Currently in Nigeria, BASICS is working with Community Partners for Health to improve maternal and child health practices, including prevention practices and home-based care for sick children. Through this initiative, traditional birth attendants have been trained in pre-natal care, labor and delivery, and postnatal care. The inclusion of the traditional birth attendants was crucial to the Community Partners for Health to improve services to clientele who only visit health facilities when there are complications at birth.[11]

5.5 Employer-Based Systems

A few projects have explored initiating, expanding, or improving the services provided by employer-based systems. They have utilized different strategies ranging from providing direct assistance and subsidies to employees to working through business and professional associations. The PROFIT Project worked to promote employer-based family planning service delivery. For example, in Uttar Pradesh, India, PROFIT supported the Mawana Sugar Works to establish a comprehensive, in-house maternal/child and reproductive health programs for their workers and dependents.

Employer-based systems usually offer basic health services, but not necessarily family planning related services. For projects involving existing employer-based systems, the task has been to educate them about benefits of expanding coverage, usually family planning services. After convincing the employer about the merits of such an expansion, the CA then provides training and TA in the appropriate services as well as contraceptive technology.

Projects involving employer-based systems are considerably more complex than merely offering TA to individual providers. As a PROFIT report states, "The idiosyncrasies of the business environment in various countries and the uniqueness of each employer's situation mean that flexibility and experimentation must be critical elements of employer-based family planning programs."[12] PROFIT has published a number of recommendations for future employer-based projects, including carefully identifying the partner's needs, enlisting the support of umbrella business and professional organizations, setting feasible and appropriate objectives, and investing in long-term follow-up.

5.6 Hospitals/Clinics

Hospitals and, to a larger extent, clinics have received assistance from CAs to expand provision of priority services. Projects involving small community health clinics are very common, but there are also partnerships with larger hospitals. Clinics and hospitals often receive similar types of assistance that are provided to physicians and midwives, but on a larger scale. Like other private providers, hospitals and clinics often need help in business, management, and administration skills to survive and prosper in the private sector. They also require technical skill enhancement in terms of updated or improved medical and clinical services.

[11] BASICS 1997.

[12] Epstein, Eve E. 1996.

There are several examples of CAs providing training and TA to health providers in clinics in reproductive health, family planning, MCH, and STD/AIDS. Clinics and hospitals offer a full range of health services, but clinics can be specialized. AIDSCAP and the Association for Voluntary Surgical Contraception (AVSC) International worked together in Bangladesh with NGO maternal/child health clinics, providing TA and managerial support so that clinics could offer STD diagnosis and treatment. In addition, clinics are receiving help with the business side of running a clinic. For example, a network of reproductive health clinics received training and TA in cost containment, cost recovery, and income-generation from Family Health International in Ecuador.

Projects have been designed to improve service delivery in hospitals in some countries. In the Philippines, PROFIT designed a low-cost, pre-paid health care plan called HealthSaver in collaboration with PhilamCare Health Systems, Inc., the leading HMO in the Philippines. HealthSaver offers outpatient and inpatient services, including family planning at two hospitals to members of the Philippines' informal economic sector.

Brazil: PROFIT Supports Hospital Purchase

The PROFIT Project, in an effort to improve the access and quality of maternal and child health/family planning services in Maceio, Brazil, purchased a hospital, Clinic of Sao Sebastiao (CSSS), jointly with the HMO UNIMED Maceio. By owning a hospital, UNIMED Maceio hoped to control costs and reduce payments to third-party providers. The plan was for UNIMED Maceio to use the cost savings that were expected from owning a hospital to support MCH/FP activities. After completing a baseline survey of female members of the HMO, PROFIT concluded that the MCH/FP clinic should be promoted to low-income women. Due to several problems, the clinic's opening was delayed for almost two years. UNIMED Maceio was resistant to expanding the target market to include low-income women; some UNIMED Maceio physicians felt threatened by potential competition from the new clinic; and there was a lack of interest in family planning among the newly elected UNIMED Maceio management.

Once opened, the clinic offered ob/gyn consultations, diagnostic services, family planning, and vaccinations. Due to the partner's unwillingness to operate the clinic so it would have a real family planning impact—combined with the implementation problems—PROFIT and USAID agreed that the subproject should be terminated. Only a year after the clinic opened, PROFIT sold its share of CSSS Hospital to UNIMED Maceio.

6. Assessment of Patterns of Collaboration

After examining the methods of intervention and the types of private providers involved in public- and private-sector partnerships, it is interesting to look at how the overall collaborations are arranged. Understanding that these partnerships are varied, some trends are notable. The collaborating agencies whose goal is private-sector collaboration have initiated a wide range of innovative projects with a number of diverse providers. For those CAs that are not designed specifically for private, for-profit sector collaboration, the involvement is more limited. In those situations, the partnerships are generally with NGOs.

For most CAs, the typical partnership with the private sector involves providing training and/or TA in family planning/contraceptive technology to NGOs to improve or expand service delivery. Slight variations occur within this model. The TA may be focused on maternal/child health or child survival, and the project may include materials development and/or some sort of coalition building or networking.

Several other types of collaboration efforts have become increasingly common. Striving to promote sustainability and build institutional capacity for their partners, a number of CAs have become active in providing business and management skills training and TA in conjunction with their health services assistance. STD/AIDS activities, primarily with NGOs, have also become very prevalent. As STD/AIDS projects become more integrated, they will most likely be included in increasing numbers of partnerships with private, for-profit organizations.

While both midwives and physicians have historically been important for maternal/child health, child survival, family planning, and reproductive health projects, more efforts have been designed not only to improve quality of their service delivery, but to help them in terms of the business logistics of operating a private practice. CAs are also working more with pharmacists to increase the availability of condoms, oral contraceptives, and Depo-Provera. Similarly non-traditional partners such as pharmaceutical and commercial contraceptive companies have become more common in USAID's effort to promote the availability and affordability of contraceptives and oral rehydration salts, among other public health products.

There are a few gaps in the pattern of collaboration with the private sector. STD/AIDS projects have been concentrated with NGOs, while there are relatively few initiatives with for-profit clinics or private practitioners. A similar assessment could be made of child survival programs, outside the efforts of the BASICS Project. NGOs play a major role in providing priority services, but represent only a small portion of the private health practitioners that could benefit from USAID-funded projects.

There has been some, but not many, projects involving hospitals. It seems that private hospitals could benefit from the same type of assistance given to physicians and midwives in

private practice. Hospitals have the potential to reach a large number of clients and could possibly realize substantial cost savings and improved efficiency with CA assistance.

7. Geographic Patterns

It is difficult to draw conclusions when looking at how projects are grouped regionally, since much of that is determined by USAID's own listing of priority, or "joint programming and planning" countries. Collaborating agencies emphasize these countries. With that understanding, it is possible to make some broad observations about why different projects may be undertaken in certain countries or regions. There are at least two regional trends that merit attention: (1) STD/HIV/AIDS projects focused in Sub-Saharan Africa; and (2) TA and financial assistance projects associated with for-profit private providers in Asia.

The majority of AIDS related projects are concentrated in Africa and Asia. While the rate of infections in Asia is rising faster than anywhere in the world, Africa still has the largest percentage of HIV infections. AIDSCAP reports that "Sub-Saharan Africa, representing about 60 percent of the world's total HIV infections, accounts for almost 90 percent of the current 13.3 million HIV infections in adults and adolescents in Africa."[13] While AIDSCAP and other CAs active with STD/HIV/AIDS prevention and case management projects do not exclude other regions, their efforts are prevalent in African countries such as Kenya, Nigeria, and Tanzania. Typical intervention activities consist of providing existing NGOs or providers with updated information on HIV/AIDS TA and training in case management prevention, social marketing and condom promotion activities.

Another regional trend appears to exist with for-profit providers. In the Asia/Near East region, there seems to be more projects with for-profit private providers than in other regions. This may be due to lower levels of public-sector health care spending in many countries in the region. According to the *World Development Report 1993, Investing in Health*, countries such as India, Pakistan, and Bangladesh have relatively low public health expenditure.[14] These countries are also characterized as having high private spending for traditional medicine and for drugs. PROFIT, which has had more for-profit, private-sector projects than any other CA, initiated several projects involving physicians, midwives, hospitals, and employer-based systems in this region.

[13]AIDSCAP 1996.

[14]World Bank 1993.

8. Evaluations/Lessons Learned

Evaluations of both completed and on-going projects can provide useful information on private-sector collaboration for those CAs currently working with the private sector as well as for future projects. Evaluations, conducted by outside, objective personnel, combined with lessons learned produced by the CAs or the evaluators, document successes and failures. Based on evaluations of PROFIT, TIPPS, SOMARC, and BASICS, the work of CAs concentrating on the private sector has been commendable and largely successful. In all cases, recommendations were made to continue private-sector programs. In some cases, recommendations for improvement were directed at USAID management and/or mission participation. In other cases, evaluations were focused on more technical programmatic issues. Frequent comments included the importance of involving both the missions and in-country partners in the design of sub-projects; employing individuals with expertise in business and finance; and utilizing more investment and business approaches when dealing with the private/commercial sector.

Recognizing the experimental nature of the TIPPS Project, the midterm evaluators identified the importance of private-sector collaboration and made recommendations for future private-sector projects They praised the overall design of the project and the skills of the staff with such comments as "An important element in the success of the staff has been their ability to work as professionals with all levels of for-profit management. They have adopted a clear, business-like style. They have also demonstrated their ability and willingness to work with governments and PVOs; the skills for working with each group are very different."[15] According to the evaluators, TIPPS had clear objectives and was well designed and effectively managed by USAID. TIPPS successfully stimulated the interest of company managers and showed that some companies were willing to finance and deliver family planning services to their employees if convinced of the financial and/or health benefits of the service. Concluding that TIPPS provided a firm foundation for follow-on activity, the evaluation recommended that a future project maintain a similar mission but expand in the following ways:

- Increase capacity to negotiate or provide start-up/ongoing subsidies for companies that incur costs in family planning provision;
- Provide sufficient resources to enable staff to act as brokers between companies and family planning service providers;
- Include a mandate to ensure companies institutionalize policies for family planning service delivery; and
- Provide a new prototype of business analysis that requires less time and expertise to complete.

[15] Midterm Evaluation of the Technical Information on Population for the Private Sector (TIPPS) Project, Population Technical Assistance Project, October 1989, Report No. 88-009-092, p. ix.

The evaluation also stressed the importance of in-country staff evaluation systems built into operation procedures, collaboration with other projects and CAs, and inclusion of USAID supervisory personnel with private-sector experience.

An evaluation of the SOMARC III Project, completed in 1996, focused largely on technical issues related to its activities, rather than the project design or management. This was probably due to the fact that SOMARC has been operating since 1983, and it has had ample time to become established and develop effective operating systems as well as strong relationships with USAID missions and private-sector partners. The midterm evaluation praised the outputs of SOMARC III, especially in light of their recently expanded objectives, and it recommended a follow-on project be continued after 1997. "CSM (contraceptive social marketing) has much to offer USAID in its population, health and nutrition activities, and various directional options can be taken . . . The team believes that SOMARC's skills lie especially in the careful development and promotion of LTMs (long-term methods), particularly involving Depo-Provera in countries where there already exists a product selling operation."[16]

The private-sector work of BASICS was evaluated positively, but was seen as too limited. "As a 'flagship project' in Child Survival, BASICS should also logically provide direction and leadership in promising areas where there is less experience and/or areas interventions have been less well defined. However, there has been relatively little emphasis on . . . working with private-sector partners (including commercial groups, NGO's, and private practitioners). Although BASICS has some important and innovative activities in each of these areas, there are compelling arguments for doing more."[17]

The mid-term evaluation of PROFIT cited the innovative and business-like nature of the project, promoted pursuing future work in the commercial sector, and included several recommendations and lessons learned (see Annex B). While the work of PROFIT broke new ground with private-sector commercial partnerships, evaluators noted the difficulties encountered by the project. The problems included: some key underlying project assumptions were invalid; more time (5 to 7 years) was needed to develop an investment project sufficiently; and USAID should have had more realistic/modest expectations when undertaking innovative investment projects. Another problem was cited in regard to mission enthusiasm about or commitment to commercial sector activities. "While PROFIT was conceived in a climate ripe for commercial-sector interventions, by 1991 when the contractor was getting started, the push from the center (USAID/W) had weakened, and USAID Missions gave a lower priority to commercial-sector activities."[18] The evaluators also noted that missions are not accustomed to dealing with CA staff whose primary expertise is finance and business and suggested that USAID staff be trained to appreciate business and investment approaches in order to explore private-sector health care options. A recommendation was also made to involve key mission staff who have experience with commercial sector models in the design of future projects.

Despite the problems encountered, the evaluators stated that PROFIT was ahead of its time, considering the increasing amount of interest among governments and NGOs in sustainability and

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[16]Population Technical Assistance Project 1996b.

[17]Health Technical Services Project 1997.

[18]Population Technical Assistance Project 1996a.

private-sector initiatives. PROFIT also developed promising models, and it was successful in producing a series of reports documenting the models as well as lessons learned. The experiences of PROFIT in serving as a catalyst in promoting the private sector and meeting missions' needs for assistance from a business-oriented contractor provide helpful insight for future projects. Considering USAID's traditional methods of dealing with the public sector—including non-profit NGOs—and the recent push for quick field results, PROFIT faced a difficult challenge in developing and implementing commercial sector family planning projects. However, the evaluators concluded that PROFIT was an innovative and important follow-on project to TIPPS and Enterprise, and it provided useful models for future private-sector projects.

The evaluators of TIPPS and PROFIT also had specific recommendations for future private, commercial sector projects and USAID's approach to these types of activities. According to the TIPPS evaluators:

> "Success in working with for-profit business requires a distinctive business-like style that mirrors the operating style and procedures of private business. The ability of staff to be flexible and to make rapid on-site decisions is critical to effective working relations and project success. This point is relevant to AID and is crucial to the success of the project."[19]

And the evaluators of PROFIT state:

> "USAID's future approach must continue to be experimental; these efforts and their costs should be seen as a form of research and development for the Agency. The approach should also be comprehensive, working from the 'top down' on broad policy issues that affect privatization and the commercial sector's role. It should also work from the 'bottom up' through continued support for testing and development of the 'how to' models. The effectiveness of this endeavor in the future will depend in part on USAID's ability to adapt its own culture, structure, and procedures to permit new ways of doing business."[20]

PROFIT recently completed its contract with USAID, and it produced a number of "keys of success" that came out of their experiences with the private sector (see Annex B). These keys include a supportive environment, market opportunities, commercial orientation, integrated approach, effective partners, realistic objectives, and flexibility. While all factors need not be present in every case, the more that exist, the greater the probability of success.[21] The BASICS Project came to similar conclusions. "The foundation for a successful partnership between the two sectors will include a viable commercial infrastructure, government support for interaction with the commercial sector, a person who can facilitate the potential public/private partnership, and, in general, an awareness among the target audience of the need for the product to be promoted."[22]

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[19]Population Technical Assistance Project 1989.

[20]Population Technical Assistance Project 1996.

[21]PROFIT 1997.

[22]Slater and Saade 1996.

Having completed their activities in March 1997, the Initiatives Project also compiled a list of lessons learned from their private-sector projects. A few of these lessons are listed below (for a complete list, see Annex B):

- NGOs providing basic health and family planning services are genuinely interested in increasing their financial independence from donor grants and subsidies, but they require sustained, intensive TA to move in this direction.
- Development of viable business plans requires sustained, organization-specific TA.
- Donor provision of initial start-up capital in the form of grants, time-limited subsidies, or shared financing of basic equipment may be required under certain circumstances.
- Creating demand for health care services begins with identifying current client expectations and demands, and it includes attention to issues affecting service availability, quality, and accessibility.
- Client health seeking behaviors and the motivations and practices of private-sector health providers are complex, situation-specific, and, in some cases, incongruent with common assumptions about the provision of, and access, to private health and family planning services.[23]

While the lessons learned from Initiatives are more detailed and specific, they contain similar conclusions to those of PROFIT and BASICS.

[23]Initiatives Project 1997.

9. Conclusions

The changing focus of international donor-funded health, population, and nutrition programs is necessitated by increasing health service needs in the developing world and often decreasing funds available from host country governments as well as from the donors themselves. Many health services have been traditionally provided by the public sector, frequently with donor involvement. Donors, however, are now turning to the private sector in efforts to expand the coverage of priority health services. The majority of USAID's CAs have initiated partnerships with the private sector. The number of private-sector partnerships has been growing over the past decade, with some CAs having extensive involvement with private-sector projects.

From the review undertaken here, it is clear that no two private-sector projects are exactly the same. There is no single approach to designing private-sector partnerships: the number of variables is high as is the number of strategies. Flexibility appears to be the key throughout the process. Each project should be designed to fit the particular needs of the situation by using appropriate strategies and targeting the appropriate provider or partner.

Successful—and sustainable—private-sector projects must also be far-sighted. Short-term returns are not the goal of such projects. These initiatives have to be concerned with longevity; therefore all participants need to be patient and work towards long-term impact. The ultimate goal of private-sector partnerships is to ensure that the partner is able to continue high quality service delivery long after the partnership is over.

Annex A:

Selected Programs that Have Utilized the Private Sector to Extend Priority Health Care Services

Selected Programs that Have Utilized the Private Sector to Extend Priority Health Care Services*

USAID Project	Program Name	Country	Type of Service/Care	Kind of Private Provider	Form of Assistance	Time Frame	Size or Scope of Program
ACCESS		Tanzania	Reproductive health (RH) and FP service delivery	NGO - Shirika La Uchumika Wanawake Tanzania (SUWATA)	Project funding and TA in innovative service delivery, integration of MCH and child survival, and program planning and management	5/95-7/97	1 NGO - has served over 200,000 clients since 1995
ACCESS		Indonesia	RH and FP service delivery	Midwife NGO - IBI	TA and training to IBI members in management and leadership and gender and advocacy	4/96-present	Nationwide NGO
ACCESS		Nepal	FP service delivery	NGOs	Funding, training, and TA in integrating FP, RH, MCH, and STD/AIDS service delivery	1993-present	4 NGOs involved in partnership
AIDSCAP		Nigeria	-Counseling -Community awareness -Peer education	NGOs working in AIDS prevention	Facilitated the organization of a consortium of NGOs	1995	17 NGOs involved in South Western and Lagos clusters
AIDSCAP	Tanzania AIDS Project (TAP) - 1 of several TAP subprojects	Tanzania	-Information dissemination -Counseling -Case management	NGOs working in AIDS prevention	TOT in areas of HIV/AIDS; knowledge, attitudes, and practices research; peer education; home-based care; materials development; and case management	1995	189 trainers trained by TAP who trained another 1,587
AIDSCAP		Zimbabwe	Information dissemination	Zimbabwe Broadcasting Corporation	Funding for a radio show and television program on HIV/AIDS	1996	Over 2 million people were reached with HIV prevention education messages
AIDSCAP and AVSC International	Strengthening STD Screening Case Management in Selected NGO FP/MCH Clinics Project	Bangladesh	STD diagnosis and treatment	NGO MCH clinics	TA and managerial support to upgrade clinics to provide STD diagnosis and treatment	1995-97	20 clinics

AIDSCAP	Independent Medical Practitioners Association (IMPA) Continuing Education Program	Sri Lanka	STD management	General practitioners - IMPA	Development of a set of 10 long-distance training modules that can be used for self-learning and small TOT	1995-97	130 practitioners were trained in 1996
AIDSCAP		Dominican Republic	STD/HIV/AIDS information services via a hotline	NGO hotline	Provided the NGO INDESUI with updated information, computer equipment, and database to respond to callers countrywide	1996	Hotline service available nationwide
AVSC International		Bangladesh	FP	NGOs	TA, TOT, and support of training courses in clinical contraception	ongoing	4 NGOs to receive grants to initiate clinical training courses
AVSC International		Bolivia	FP and RH	NGO network - midwives, physicians, and health service providers	-Training physicians in RH -Training service providers in counseling and FP -Training midwives in RH and service delivery	ongoing	Over 100 service providers to be trained
AVSC International		Ethiopia	FP and RH	Physicians, nurses, and health service providers	-Training in sterilization and contraceptive methods -Training in FP counseling and technology, infection prevention, and STD/HIV information/counseling	ongoing	Over 100 service providers to be trained
BASICS with Private Voluntary Organization for Health II		India	Primary health care services	Health care NGOs	Technical and administrative assistance	1996-97	10+ NGOs involved
BASICS		Ecuador	Primary health care services	NGOs under the umbrella organization APOLO	TA - strategic planning workshops including social marketing and qualitative research, preparation of reference, and training materials	1995-97	Several NGOs are involved
BASICS with PAHO, Ministry of Health (MOH), and UNICEF		Bolivia	Increase the availability, accessibility, and use of oral rehydration solution (ORS)	Pharmaceutical companies	TA in social marketing	1995-97	National project with 2 participating companies

BASICS	Female Genital Mutilation (FGM) Project	Kenya	Information, education, and communication (IEC) interventions in an effort to eradicate FGM	NGO - Seventh Day Adventist Rural Health Service (SDA-RHS)	Subcontract with SDA-RHS	ongoing	Nyamira District
BASICS with local governments in Lagos State	Partnerships for Child Health	Nigeria	Primary health care and children's health care community-based organization (CBO)	Local health facilities - clinics, hospitals, practitioners, and CBOs	TA - held planning workshops to prioritize each community's health problems and to develop objectives and workplans	ongoing	6 communities in 5 local governments in Lagos State
BASICS Environmental Health Project	Handwashing Campaign	Central America	Disease prevention	Soap manufacturers	-Market research -Development of marketing strategy	1996-97	6 soap producers from Guatemala, El Salvador, Honduras, Nicaragua, and Costa Rica
BASICS UNICEF		Malawi	ORS distributed through public and private channels	Pharmaceutical company	Market research and TA in social marketing	1995	ORS to be distributed nationwide
Contraceptive Technology and Family Planning Research Program - Family Health International (FHI)	Improvement and Expansion of Family Planning Services	Ethiopia	FP service delivery	FP NGOs	TA in monitoring and evaluation to help increase capacity	1996-97	Activities are part of national private-sector FP project
Contraceptive Technology and Family Planning Research Program - FHI	Role of the Private Sector in Family Planning	Niger	FP service delivery	Private physicians and nurses/ midwives	Study to determine current provision of FP by private providers, their interest in providing such services, experience, and training. Results to help USAID/Niger and MOH to design private-sector FP project.	1996-97	Nationwide
Contraceptive Technology and Family Planning Research Program - FHI	PROSALUD Quality of Care Assessment	Bolivia	Primary health care	Network of community-sponsored health clinics	Quality of care assessment at selected clinics and development of measurement tools to monitor and improve services	1996-97	Data collected in El Alto, Santa Cruz, and La Paz

Contraceptive Technology and Family Planning Research Program - FHI and INOPAL III	Technical Assistance in Sustainability	Ecuador	RH	Network of reproductive health clinics	Training and TA in the areas of cost containment, cost recovery, and income-generation	1993-96	Network includes 20 clinics in Ecuador
Contraceptive Technology and Family Planning Research Program - FHI	Family Planning Seminars for Private Sector	Jamaica	FP service delivery	Private-sector physicians	Training seminars to provide current, accurate information on contraceptive methods and FP services	1995-97	-Seminars conducted in Montego Bay, Kingston, Mandeville -8 seminar series conducted with approximately 200 providers attending each series
Initiatives Project		Ecuador	Basic health services	Community health clinics - Fundación Eugenio Espejo (FEE)	TA in organizational development, strategic planning, business plan development, and marketing to help FEE expand its services	1995-97	Southern Quito - Expanded clinic services to serve approximately 10,000 persons, focusing on needs of women and children
Initiatives Project		Ecuador	Basic health services	Private for-profit clinic formed by physicians - The Institute for Integral Health (InSalud Cia. Ltda.)	TA in capital acquisition, organizational development, strategic planning, financial analysis, and business plan development to aid InSalud in taking over public clinics and opening new ones	1995-97	Main health center in south Guayaquil
Initiatives Project		Guatemala	Basic health services	Rural healthcare NGO - The Guatemalan Association for the Promotion of Rural Health (Guatesalud)	TA to support the design and implementation of an organization-wide quality of care program	1994-97	Network of 33 clinics serving approximately 40,000 people
Initiatives Project		Ghana	Health insurance for basic health and FP services	Private insurance company - The Nationwide Mutual Medical Insurance Company	-TA to support operational efficiency -Market surveys -Support in the adoption of a management information system (MIS)	1993-96	50,000 beneficiaries associated with 21 companies enrolled in the plan

Initiatives Project		Nigeria	Basic health services	Nurses and midwives - The Nigerian Private Nurses and Midwives Association	TA in developing appropriate management and financial systems	1993-96	Services available to low-income families in Osogbo, Osun State
Initiatives Project	NGO Sustainability Assistance	Nigeria	Variety of health services	NGOs	TA in enhancing revenue-generation in the form of one-on-one consulting	1993-96	Approximately 30 different NGOs were involved
INOPAL II Population Council		Brazil	FP	For-profit HMO (PROMEDICA)	OR to determine the costs and benefits of providing postparatum/postpartum IUDs and other temporary methods		1 HMO in Bahia
INOPAL II Population Council		Guatemala	FP	Non-profit HMO (AGROSALUD)	TA in provider training, supervision, MIS, and evaluation to help AGROSALUD to add FP services		HMO serving over 24,000 workers
Institute for Reproductive Health - Breastfeeding/ MCH Division	Breastfeeding/ Lactational Amenorrhea Method/natural Family Planning (LAM/NFP) Interface	Zambia	NFP service delivery	NFP clinic - teacher/trainers Family Life Movement of Zambia	-Training -Materials development	5/94-3/96	20-30 trainers and field workers trained initially - Expanded into service in 12 Lusaka-based clinics and 2 others
Institute for Reproductive Health - Breastfeeding/ MCH Division	Incorporation of LAM into a Multimethod Service Delivery FP Program	Ecuador	FP service delivery	Multimethod FP service providers Centro Médico de Orientación y Planificación Familiar (CEMOPLAF), private NGO	-Training -Materials development -TA	8/90-6/95	20 clinics throughout Ecuador, with a network of 500 CBDs
Institute for Reproductive Health - Breastfeeding/ MCH Division	Breastfeeding and LAM Support Project	Jordan	FP service delivery	-Primary Health Care Clinics/ NGOs - Center for Consultation, Technical Services and Studies, University of Jordan	-Training -Materials development	1/96-4/97	Several health care clinics throughout Jordan were involved
Institute for Reproductive Health - The Awareness Project		Philippines	NFP services	NGO	Training and TA in monitoring and evaluation, MIS, OR, and project development		$60,000 of technical support and training

Institute for Reproductive Health - The Awareness Project		Ecuador	RH awareness	Obstetricians and fertility practice physicians, medical students, faculty, and community health workers	Training	4-week course	
MotherCare BASICS		India	Anemia treatment	NGOs	TA to programs addressing issues related to anemia and evaluating interventions	1994-97	
MotherCare BASICS Wellstart Expanded Promotion of Breastfeeding	Pakistan NGO Initiative	Pakistan	Reproductive health	NGOs	TA to develop/expand the capacity of local NGOs in reproductive and child health programming	10/95-9/98	
PHR		Jordan	Basic health care	N/A	Plans to conduct a study of private and public providers in order to recommend policies to strengthen public-private partnerships and to conduct a review of accreditation and licensing rules for private providers	Ongoing	
PHR		Zambia	Basic health care	Clinics	Plans to assist the government in conducting pre-implementation market analysis for design of franchising private clinics as part of overall health sector reform initiative	Ongoing	
PHR		India	MCH	Community-based health care	Supported a stakeholders analysis, which included political leaders, government officials, NGOs, government health institutions, and private providers as part of the Women's and Children's Health Project (WACH)	1997	
POLICY		Kenya	STD/AIDS	AIDS NGO Consortium	Conducted workshop on a technical update on HIV/AIDS, including strategies for care and prevention	1997	40 NGO members attended, with ministry or health representatives, government officials, and donors

POLICY		Haiti	FP and RH	NGOs	Assisted in the development of NGO policies to strengthen their FP/RH activities	1997	Nationwide
POLICY		Romania	RH	NGO coalition	-Helped form a coalition and coordinated activities/ meetings -Drafted materials to raise awareness of the newly formed coalition	1996-97	Approximately 25 NGOs involved
Population Information Program - Johns Hopkins University		Bangladesh	FP and MCH	NGOs	Helped to develop an interpersonal communication and counseling training curriculum for health and FP organizations	1996	Materials to be available nationwide
Population Information Program - Johns Hopkins University		Nigeria	FP, MCH, and RH	Traditional birth attendants (TBA) and community health workers	-Supported training for 50 TBAs and development of training manual -Developed IEC Resource Kit for community health workers	1996	Training conducted in northern Nigeria
Population Information Program - Johns Hopkins University		Nicaragua	FP and RH	NGOs - PROFAMILIA	Training and TA in IEC and interpersonal communication and counseling	1996	1 NGO with service nationwide
PROFIT with SOMARC III and Pathfinder	CEPEO Commodities Procurement Organization	Brazil	FP/ contraceptives	Commercial contraceptive company	Company was started by PROFIT, then sold it to the current management	1994-1997	Salvador, Bahia, and Brazil
PROFIT	Mawana Sugar Works	India	MCH and RH	Employer provided in-house health services (MCH and RH)	TA for project design and startup	1996-1997	Uttar Pradesh, India - Mawana Sugar Works - 7,500 initially, could expand to 45,000 more
PROFIT	Community-Based Social Marketing (CBSM)	India	Contraceptive distribution (mainly condoms)	Local entrepreneurs selling condoms and sanitary napkins using a CBSM approach	TA and financial support	1996-1997	Madras, Tamil, Nadu, and India
PROFIT	Revolving Loan Fund for Midwives	Indonesia	FP service delivery	Midwives	$1 million Revolving Loan Fund to help midwives establish or expand private practices	1995-1997	Provinces of East, Central, and West Java, Jakarta, and Bali

PROFIT	Managed Health Care System	Kenya	Primary health care including FP service delivery	-Primary health care, FP, and MCH service delivery -1 large medical center and 3 outreach clinics	Supported AAR Health Services in developing a managed health care system for employees and dependents	1995-1997	AAR Health Services, Nairobi, Kenya - serving over 20,000 members
PROFIT	Low-Cost Health Care Plan	Philippines	Health care including FP service delivery	2 hospitals providing outpatient and inpatient health care services, including FP	-Designed a low-cost, pre-paid health care plan: HealthSaver -Provided a loan to PhilamCare (HMO) for startup costs and provided TA	1994-1997	-Two hospitals, 1 in Manila and 1 in Cebu -Enrollment had reached 2,100 by August 1996
PROFIT	Physicians' Loan Fund	Philippines	Health services including FP and RH	Physicians	-$300,000 loan fund to provide credit and training to encourage physicians to establish or expand private practices -Supported FP and business management training programs	1995-1997	
PROFIT	Promotion of Modern Contraceptives and Pharmacist Services	Romania	Modern contraceptive provision	Pharmacists	-Conducted research with pharmacists and young adults -Designed and launched media campaign -Trained trainers and pharmacists	1995-1997	Urban areas throughout Romania
PROFIT	Private Sector Initiative	Zimbabwe	FP	Nurses/midwives, doctors, and pharmacists	-Extensive efforts in training, research, and TA to increase number of private providers capable of FP service delivery -Sponsored conferences and meetings of private and public representatives to discuss availability of appropriate priced contraceptives	1995-1997	Urban areas throughout Zimbabwe
PROFIT	UNIMED Maceio	Brazil	MCH and FP services including vaccinations	Hospital - Clinic of Sao Sebastiao	Hospital was purchased jointly with a Brazilian HMO	6/93-5/97	1 hospital
Rational Pharmaceutical Management Project/USP		Nepal	Primary health care	NGO - Resource Center for Primary Health Care	Funding and TA to establish a drug info center for community health workers	5 years	

Rational Pharmaceutical Management Project/USP		Nepal	Pharmaceutical services	Professional association - Nepal Chemists and Druggists Association	Funding and TA to establish a drug information center	5 years	Center to serve 8,000 registered chemists and drug sellers
SOMARC	Red Apple Program	Uzbekistan	FP	Ob/gyn specialists, general practitioners, midwives, and pharmacists	-Created Red Apple brand name for oral contraceptives and contraceptive injectables available in private clinics and pharmacies -Trained healthcare providers and pharmacists in contraceptive technology and counseling techniques	1995-present	Project active in 2 oblasts and 2 major cities
SOMARC	Malawi Social Marketing Project	Malawi	FP - retail contraceptives	Retail distributor of condoms	TA in marketing and distribution for Protector Condoms through the Lever Brothers Malawi	1991	Nationwide
SOMARC	MEXFAM Case Study	Mexico	FP	NGO	-Assistance with market research -TA to develop fully integrated marketing strategy that coordinates service, price, promotion, and location	1992	Approximately 4 clinics involved
SOMARC		Uganda	FP	Midwives	-Established midwives in individual market place businesses -Provided training, a sales booth, uniform, and social marketing products	1993	Pilot program involving 50 markets
SOMARC		Turkey	FP and women's health	Physicians	Provided loans to physicians participating in the Women's Health and Family Planning Service Network to improve office facilities and pay for clinical training activities	1995-ongoing	

SOMARC	Jordan Birth Spacing Project	Jordan	FP	Physicians	-Training in contraceptive technologies and in clinical techniques of IUD insertion -Promoting of private-sector service providers by mass media messages -Expanding the image of contraceptive methods widely available in the commercial sector	1995-ongoing	Nationwide
SUSTAIN	Central American Regional Micronutrient Initiative	Nicaragua, Honduras, Guatemala, and El Salvador	Food processing/ production	Wheat milling industries	Training and specialized TA in iron fortification	1996-present	Several wheat milling companies in 4 Central American countries
SUSTAIN	Assessment of Soy Processing Operation	Nicaragua	Food processing/ production	Soy processor - Centro Médico de Orientación y Planficación Familiar (GRACSA)	TA to evaluate changes necessary to expand into soy milk production and other soy products for human consumption	1997	1 company
SUSTAIN	Dairy Processing Training	Russia	Food processing/ production	Dairy processors	Workshops were given on dairy product processing, production, packaging, and marketing	1995	2 workshops held

* This table includes a brief description of only a *sampling* of private-sector programs intended to give the reader an overview of the types of programs recently initiated by USAID cooperating agencies. This is neither an exhaustive nor comprehensive catalog.

Annex B

Lessons Learned:
TIPPS, Initiatives, and PROFIT

Lessons Learned—TIPPS

The experiences of the TIPPS[24] project provide a rich source of data on how AID should proceed in its continuing efforts to involve the for-profit sector in family planning service delivery. Several of the lessons are highly positive and affirm AID's decision to establish this project. Other lessons reflect the unexpected obstacles met by TIPPS during the process of implementation and the suitability of its responses.

The most salient of these lessons are:

- The TIPPS project demonstrates that an AID-supported intervention can convince a range of corporations to add family planning services as a benefit and to agree to absorb the full cost of providing services to employees.
- Demand for TIPPS' services has greatly exceeded the resources available, but the size of the potential market for private-sector collaboration is not known. This point needs attention.
- Company executives are often as impressed by the health implications of providing family planning service benefits as they are by the financial arguments.
- The success of the TIPPS model has been, and will to some extent continue to be, dependent upon external factors such as the existence of favorable macroeconomic conditions, existence of organizations that meet the demand generated for family planning services, and—over the long term— its institutionalization within company benefit programs.
- Some companies can cover the full cost of an additional benefit while others need some degree of subsidy to provide family planning benefits. Although those needing some modest seed money were not an original target of project activities, inclusion of a small sample of such companies was a legitimate extension of the TIPPS approach.
- The cost benefit model, the basis of the business analysis, is technically sound and has proven to be a very effective tool in convincing Chief Executive Officers (CEOs) to institute family planning services.
- Surveys are an integral and essential part of the model., Independently they have persuaded CEOs and benefits managers of the advantages of providing family planning services. The desire to scale back the scope and cost of this research technique should be explored.
- Success in working with for-profit businesses requires a distinctive business-like style that mirrors the operative style and procedures of the private sector. The ability of staff to be flexible and make rapid on-site decisions is critical to effective working relations

[24]Population Technical Assistance Project 1989.

and project success. This point is relevant to AID's operations, and it is crucial to project success.

- Considerably more involvement of project staff than anticipated was needed both to enlist middle level corporate management in project activities and identify organizations that could provide family planning services to company employees. Considerable efforts in the areas of presentations, brokering, and follow-up—more than originally contemplated—were essential to getting programs in place and implemented by corporations.

Lessons Learned—The Initiatives Project: Private Initiatives for Primary Healthcare

The following lessons learned are taken from a project publication.[25]

Technical Assistance

- The process of supporting the development of private-sector health care organizations has important implications for any program that includes sustainability as an objective.
- The ability to utilize technical assistance depends on key organizational and infrastructural prerequisites.
- The strategic vision of a private organization's leader(s) is a key element in the development and implementation of a service expansion program.
- Technical assistance can have immediate cost consequences for its recipients that may not be offset by revenue increases in the short-run.
- Development of viable business plans requires sustained, organization-specific technical assistance.
- Political and personal factors are at least as important as the technical quality of an organization's business plan in the acquisition of local capital to support service expansion plans.
- The marketing function—in terms of both organizational structure and individual orientation—requires special attention from the earliest stages of the technical assistance program.
- The effective utilization of marketing information in developing financial and service delivery plans requires sustained, group-specific technical assistance.
- Non-governmental organizations providing basic health and family planning services are genuinely interested in increasing their financial independence from donor grants and subsidies (i.e., financial sustainability), but require sustained, intensive technical assistance to move in this direction.

[25] Initiatives Project 1997.

Project Design

- Donor provision of initial start-up capital in the form of grants, time-limited subsidies, or shared financing of basic equipment may be required under certain circumstances.
- The traditional prerogatives of private ownership can limit the role of the community in the determination and delivery of basic health services.
- Expanding service coverage through the development of private provider networks can be significantly constrained by a lack of adequate managerial resources for which technical assistance may only partially compensate.
- "Creating demand" for health care services begins with identifying current client expectations and demands, and includes attention to issues affecting service availability, quality, and accessibility.
- Client health seeking behaviors, and the motivations and practices of private-sector health providers are complex, situation-specific, and, in some cases, incongruent with common assumptions about the provision of, and access to, private health and family planning services.
- The orientation of health and family planning providers to a client-based model of service sustainability can be done effectively within a workshop format.
- Experience with donor-supported "development" projects can hamper efforts to develop or enhance the sustainability of service operations.
- The level of local coordination among donor policies and actions has important implications for the viability of private health care services.

Documentation

- Case studies are an appropriate approach to documenting and disseminating the organizational development process.
- Data demands should contribute to the sustainability of the organization being assisted.

Lessons Learned—The PROFIT Project

The body of the evaluation report of the PROFIT Project[26] contains numerous lessons learned. The following is a summary of the more general and important lessons.

USAID Project Design

- As suggested in the evaluation of antecedent private-sector projects, there is merit in concentrating the efforts of new or innovative operations in a limited number of countries to achieve a critical mass of inputs and subprojects.

- Adequate contractor staff presence in the field is important for maintaining critical continuity of operations and relationships wit key stakeholders throughout the life of the country program.

- USAID's decreasing resource levels suggest that the cost recovery or resource leveraging strategies developed under the PROFIT, SOMARC, and similar programs need to be fully documented and disseminated for application to other relevant PHN projects.

- A prerequisite for working successfully in the commercial sector through USAID Mission is that the Mission should have a well defined strategic objective in this area. For example, USAID/Zimbabwe bilateral agreement states that the role of the commercial sector in service delivery will be increased by a certain percentage. In Indonesia, privatization is a goal of the government of Indonesia as well as USAID.

- The time frame (life of contract) for a highly creative or innovative contract may need to be longer than the usual five-year norm to permit adequate time for start-up and gestation.

- The role and effectiveness of technical advisory groups for PHN contracts appear to vary widely. A more uniform USAID framework for the composition and role of such groups could lead to their more effective use.

- Given the rapid pace of environmental change, USAID may need new project management systems and practices that can quickly change directions when key planning assumptions prove to be invalid or overtaken by events (including objective decision processes to terminate activities which are not achieving essential programmatic impact).

- Changing USAID funding and staffing constraints may require more flexible structures and staffing configurations to encourage inter-project (inter-contract) collaboration and sharing of specialized talent. Projects and contracts sometimes appear to operate in a rather narrow and self-contained mode that leads to duplication of cost and effort.

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[26] Population Technical Assistance Project 1996.

Strategies in the Commercial Sector

- A key lesson for USAID is that it should have ventured into the world of innovative investments much more cautiously and with fewer dollars. Such an altered emphasis would have sent a different message to bidders on the Request for Proposal and would probably have resulted in staff composition that is better able to follow up previous projects' experiences and also break some new ground.

- USAID loans for risk-sharing can provide the critical catalyst needed to stimulate local private investment in new efforts to offer lower-cost health insurance and services.

- It is possible to get providers to borrow funds to add family planning and other reproductive health services and to stimulate them to commit their own resources to these endeavors. Family planning appears to be too narrow a niche among health services to get providers interested. The profitability of such endeavors is not yet known.

- The combination of professional deal makers (those with financial and business skills and experience) and on-the-ground collaborators who know the local setting, public-sector health service delivery, and health financing is essential.

- The commercial sector is widely variant, almost idiosyncratic, and typically more fiscally conservative and risk-adverse than USAID had assumed previously.

- Economic and financial reasons for undertaking an activity are only one of a number of reasons why a company will become a partner in an FP/RH venture.

- The existence of opportunities for impact in FP/RH through the commercial private health sector was affected by various factors including the stage of development of family planning in these countries. USAID and PROFIT might have benefitted from a conceptual framework outlining the stages of development of family planning in developing countries. Such a framework could have been used to market the project to USAID Missions and also decide the nature and mix of its interventions in FP/RH. This framework could also be used to identify the desirable interventions to be done by other USAID projects (such as addressing governmental policies and structural reforms) that could affect the creation of opportunities in the commercial private health sector.

- Developing investments for family planning/reproductive health in the commercial private sector requires a number of important ingredients or conditions:

    - Access to capital

    - A favorable environment and sufficient market in which a business venture can be established and become profitable

    - An active private health infrastructure with providers and/or insurers

    - Partner entrepreneurs who run client-oriented and socially-minded enterprises

    - Good management and administrative capacity by the partner

- The funds should be a mix of equity, loans, and guarantees, and they should be coupled with infusions of technology, technical assistance, and training as appropriate. A critical part of the investment is the start-up and on-going provision of technical assistance.

Subproject Development and Implementation

- Significant technical assistance was provided by PROFIT in the course of developing and implementing subprojects. While this need was clearly anticipated in the contract, it should be reiterated as a lesson learned.

- Subprojects that are commercially-based ventures should have the latitude to pursue business opportunities (e.g., adding new products) that enhance their sustainability and are at the same time consistent with the original subproject goals.

- Project designs for USAID-funded PHN loan funds need to define clearly the linkages between the use of the loan funds and improved PHN outputs (and any expected impact on local or national PHN improvement measures).

- Subprojects must address real needs (of unserved groups or populations served by the public sector that can pay) and not simply provide funds to for-profits groups so they can improved services to already served middle and upper classes.

- Developing subprojects with for-profit groups requires good “due diligence” analysis of who the groups are and whether they share common goals with the funding source.

- Careful monitoring of risky subprojects with for-profit groups is important as well as having a mechanism for terminating subprojects that stray from their original purpose and no longer serve the intended beneficiaries or objectives.

- Characteristics of successful subprojects with the public sector are shared goals between the recipient and USAID, strong and enlightened public-sector support, and a continuing relationship with key actors in the public sector.

Other Project Components

Research

- A research agenda based on expressed consumer needs and interests rather than research reports distributed post-hoc is more likely to engage the interest and satisfy the needs of those consumers. Had circumstances permitted, earlier efforts to involve the Missions in identifying research topics might have led to greater interest in project activities on the part of USAID Missions.

- Operations research (OR) is powerful because it can help answer one basic question for USAID Missions, business leaders, and health professionals: “Compared to what?” Since there are OR contractors with whom to collaborate, a project such as PROFIT can work together with others to conduct OR as appropriate.

Dissemination

- The dissemination plan and criteria for selecting the research and other information that will be transmitted through the plan must be genuinely strategic: it should follow a careful analysis which examines who needs what information in order to do what to help solve what problem.

- USAID Mission PHN staff are not ready-made consumers of what the project has to offer. Earlier attempts to ascertain their informational needs and interests and kinds of formats and channels they prefer might have contributed to greater Mission interest in the project.

USAID Leadership and Staffing

- The introduction of innovative program approaches (such as PROFIT) needs to receive a relatively high level of USAID senior management support and direct involvement in both Washington and the Missions, if they are to succeed. Otherwise, the perceived higher risk in implementing such new initiatives may cause them to receive less attention than more traditional or continuing programs.

- Some USAID Mission staff are not accustomed to dealing with CA staff with primary expertise in finance and business. For PROFIT-types of endeavors to be successful in the future, USAID staff will need training to better appreciate how to draw on investment and business approaches to expand private-sector options for health service delivery. In addition, USAID may need to hire individuals with different expertise to implement endeavors in the commercial sector successfully. This is still a new area for USAID PHN programs, and it requires new expertise as well as training of existing staff.

- Central USAID management staff must develop mutual and continuous life-of-project partnerships among Washington, Mission, and cooperating country staffs to ensure good implementation of central projects. These partnerships should begin with the conceptualization phase of new projects. This is especially important when new concepts and endeavors are being launched through USAID projects.

Annex C:

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