

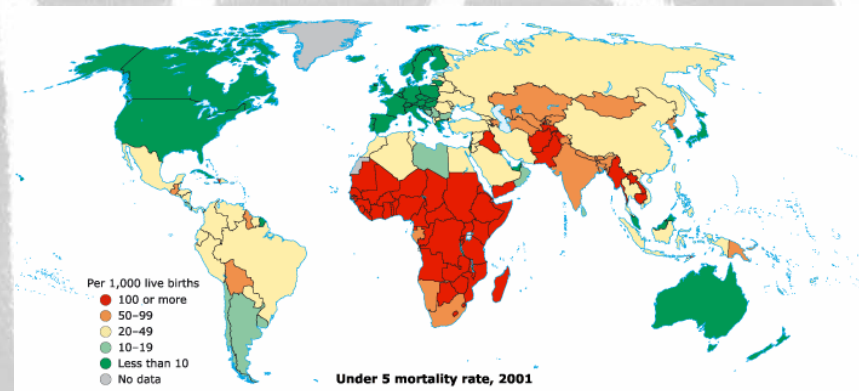


# **Public-Private Partnerships for Health**

**Helping Achieve the Health  
Goals for Africa**

# Keeping Our Promises

- **African Governments committed themselves by 2015 to**
  - **Reduce Under 5 Mortality by two thirds**
  - **Reduce Maternal Mortality by  $\frac{3}{4}$**
  - **Halt and begin to reverse the spread of HIV**

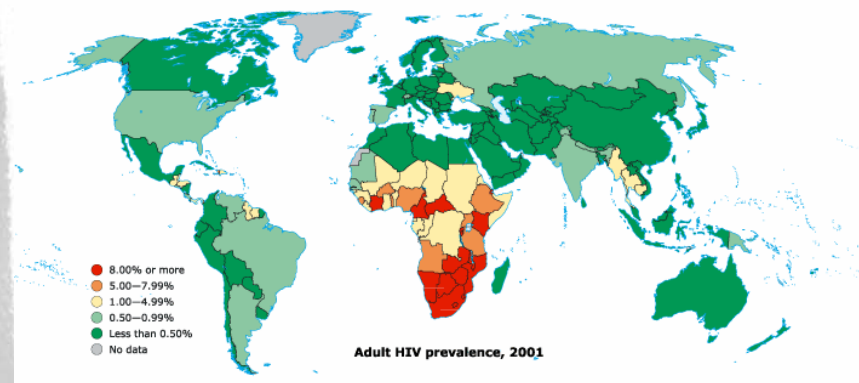


“We will have time to reach the Millennium Development Goals – worldwide and in most, or even all, individual countries – but only if we break with business as usual.” Kofi Annan

# Keeping Our Promises

**In fact it may take Sub Saharan Africa much longer to achieve these goals**

- Under 5 Mortality  
Goal not before 2140**
- Maternal Mortality  
Goal not before 2100**



“To achieve the health-related Millennium Development Goals, the delivery of health services will need to improve....Contracting with non-State entities is a means for improving health care delivery”

# Problem of Capacity

- **There are 750,000 health workers for 682 million people in Sub Saharan Africa. This is about 1.3% of the world's health workforce, while Africa suffers from 25% of the world's burden of disease**



# Working Together will Help

- **But progress towards the health related goals can be accelerated if the public and private sectors work together – *but first we need to break down some myths***

“For achieving health related goals, it is useful when parties come together that don't normally work together. They could achieve a bigger aim than each of them individually could come to achieve on their own.”

# Who Uses What?

## The Myth

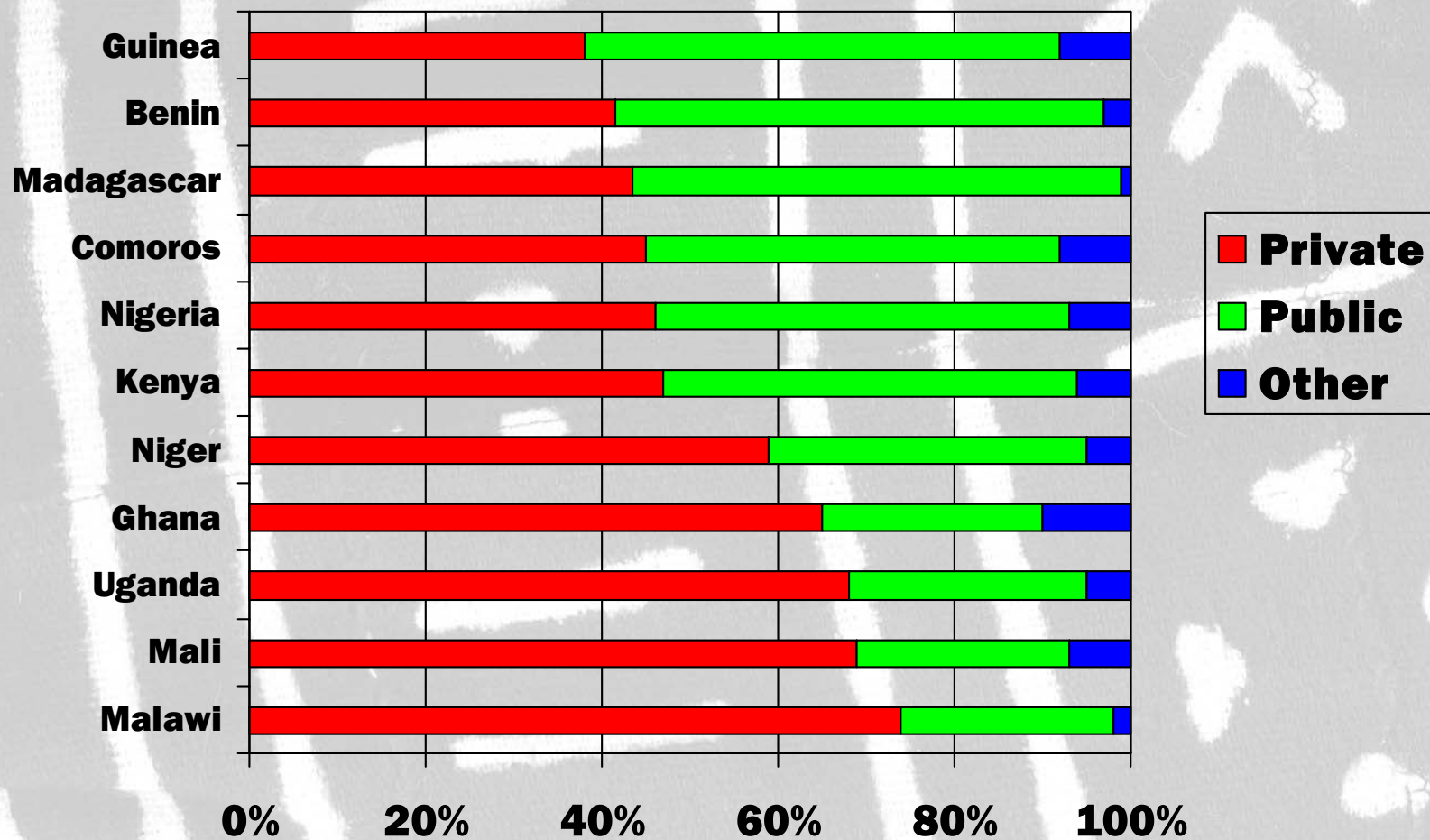
- **“The private sector is for the rich and the public sector is for the poor”**



## The Facts

- In fact, many poor use the private sector in Africa (– in Malawi **3 out of 4 people** turn to the private sector (a shop) when their child is sick. In Mali its **69% of the poor**. In Niger its **more than half** of the poor.
- The rich, in fact, benefit from the public sector. In Mauritania **40% of the richest people benefit from 72% of the public subsidies given to hospitals**. In Guinea **40% of MOH spending on hospitals entirely benefits 20% of the rich**.

## Use of Private & Public Facilities Among Poorest Quintile



Sara Project, AED, Washington DC, March 2004 (data as published in "Trends and Opportunities in Public-Private Partnerships" by Marek et al, World Bank, July 2005)

# Who Pays for What

## The Myth

- “Health is mainly financed by the public sector”



## • The facts

- In fact data from 10 Eastern and Southern African Countries suggests the opposite; **More than ½ the expenditures on health comes from the private sector.**
- In Guinea **85% of total health expenditure comes from out of pocket expenditure**
- In Mauritania they account for **26% of total health expenditure**



# How much is there?

## The Myth

- **“The private sector is not very developed in Africa”**



## • The facts

- Yet in reality the percentage of Doctors working in the private sector in Africa is the same as Latin America (even though the GDP is very different)
- In Tanzania, for example, **1/3 of the dispensaries** are run by the private sector

# Moving Forward

- So there is a **vibrant** private sector in Africa that the **poor are already using** extensively, and whose resources could be better harnessed through more **effective partnerships** with the public sector
- Combining these resources in a way that **increases quality and use**, can help accelerate progress for the Health Related MDGs

“By engaging the private sector, it’s a win-win situation with respect to the public and private partnership...all benefit.”

# **What is a Partnership?**

- **A public/private partnership is an explicit joint programme or project involving private and public collaboration to provide health services and products.**
  - **Takes different forms (e.g . Franchising, Contracting or the use of Vouchers)**
  - **Helps improve quality and reduce costs and increase demand for services.**

# Franchising

- **In Madagascar, a project called TOP Reseau with 17 clinics in Tamatave, helped increase demand. One doctor reported that his business increased by 25%**

August 2004  
Research Brief No. 4

## Franchised Youth Clinics Motivate Behavior Change in Madagascar

**KEY WORDS:** HIV/AIDS, adolescent sexual health, sexual behavior, youth, risk assessment, youth behavior change

A study of PSI's TOP Réseau network of franchised youth clinics in Madagascar demonstrates that the program contributed to removing barriers to condom use and motivated sexually experienced young people to use condoms.

**Background**  
The HIV prevalence rate in Madagascar was estimated at 1.7% at the end of 2003, but is expected to rise dramatically in the near future, particularly among youth. Sexually-transmitted infections (STIs), which increase risk of HIV transmission, are prevalent among youth. Malagasy youth initiate sexual activity early and have low knowledge of HIV and STIs: a 1997 survey suggested that 50% of 15- to 24-year-old women had never heard of

an STI, over 30% had never heard of AIDS and only 11% reported ever using a condom.

In January 2001, PSI launched a social franchise<sup>1</sup> of adolescent reproductive health clinics called TOP Réseau with support from the Bill and Melinda Gates Foundation. TOP Réseau clinics supplied youth-friendly, high-quality and affordable reproductive health services to young people aged 15 to 24. A complementary communication campaign promoted the franchised clinics and motivated youth to adopt safer behavior, including abstinence, correct and consistent condom use and the treatment of STIs. Mass media and interpersonal communication included peer educators, televised youth debates, mobile video unit shows and radio and tele-



During PSI/Madagascar's TOP Réseau outreach activities, peer educators distribute educational materials, promote safer sexual behavior and provide information which enables youth to better protect themselves from sexually-transmitted infection and HIV/AIDS.

<sup>1</sup> A franchise is a contractual relationship between a franchisee (e.g. a private clinic) and a franchisor (e.g. PSI/Madagascar) in which the former agrees to provide a product or service in accordance with an overall blueprint devised by the franchisor (Stanworth et al. 1993).

PSI

Research Brief

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# Vouchers

- **In Nyeri (Kenya), a youth health project using vouchers generated impact. As a result of the project fewer youth initiated sexual contact, fewer had multiple partners and more communicated with a partner or adult.**



# Contracting

- **In India, an NGO was contracted to provide services for TB detection and treatment.**
  - **The NGO found 21 % more cases and a 14% better treatment rate. They were able to do all this for \$20 less (per case) than the public provider.**

# Political Support

- **In order to work – these partnerships require political support at the highest levels.**



# Minimizing Resistance

- **There can be resistance to partnerships**
  - **perception issues of private sector**
  - **but do they -PPP- really have impact?**
  - **Roles of each sector seen as overlapping**
- **These can be overcome through dialogue with and among stakeholders**





# **Practical Steps For Now**

- ✓ **Provide Information on the subject to local stakeholders**
- ✓ **Request the World Bank or WHO to provide support to develop PPP**
- ✓ **Establish a group of interested parties (including entrepreneurs) that will develop a National PPP Agenda**
- ✓ **Monitor the progress in implementing that agenda**

# For More Information

**Background paper is  
available at**

**[http://www-  
wds.worldbank.org/  
external](http://www-wds.worldbank.org/external)**

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