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The Private Sector Partnerships-*One* Project

End of Project Report 2004–2009

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PSP-*One*
PRIVATE SECTOR PARTNERSHIPS FOR BETTER HEALTH

PRIVATE SECTOR PARTNERHIPS-*ONE*: The Private Sector Partnerships-*One* project (PSP-*One*) was the first task order under USAID's Private Sector Program. This five-year global project aimed to increase the use of family planning and other health products and services through increased private sector participation in health service delivery and financing.

ACKNOWLEDGEMENTS: The PSP-*One* team wishes to give special thanks to the private sector team at USAID's Office of Population and Reproductive Health and the Office of HIV/AIDS, comprising Marguerite Farrell (Cognizant Technical Officer), Jasmine Baleva (Senior Technical Advisor), Patricia Mengech, Shyami de Silva, and Susan Wright, for their active engagement and sage guidance throughout the implementation of the PSP-*One* project.

ABSTRACT: The PSP-*One* project, implemented from September 17, 2004 to September 29, 2009, was the first of 15 task orders awarded by USAID's Office of Population and Reproductive Health under its Private Sector Program. The project's primary aim was to increase the sustainable provision and use of family planning and other health products and services. Within the broader Private Sector Program, PSP-*One* also served as USAID's primary vehicle to support core-funded activities related to private sector innovation, collaboration, knowledge sharing, and research, monitoring and evaluation. For USAID missions that did not wish to issue their own Private Sector Program task order, PSP-*One* also offered a mechanism to program field support. During its five-year lifespan, the project applied its expertise in 31 countries across Africa, Asia, Latin America, and Eastern Europe. PSP-*One* activities spanned a broad range of technical areas including public-private partnerships, social marketing and pharmaceutical partnerships, private provider networks and social franchising, "base-of-the-pyramid" market-based partnerships, behavior change communications, policy, quality improvement, and health financing. This PSP-*One* final report shares PSP-*One*'s most important findings and lessons learned through the presentation of 14 country case studies and a summary of the project's tools and global research.

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NOTE: Some text in this report appears in previous PSP-*One* publications.

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CONTENTS

ACRONYMS

AGPMPN	Association of General and Private Medical Practitioners of Nigeria
AIDS	Acquire Immune Deficiency Syndrome
ART	Anti-retroviral Treatment
ASHONPLAFA	Honduran Family Planning Association
BCC	Behavior Change Communication
BoH	Banking on Health
CAYCEQ	Comisión de Asesoria y Control de Estableciementos Quimico-Biologicos
CCM	Country Coordinating Mechanism
CMS	Commercial Market Strategies
COPE	Client-Oriented, Provider-Efficient
COSSEPP-VIH	National Public-Private Sectors' Commission against HIV
CT	Counseling and Testing
DMPA	Depot Medroxyprogesterone Acetate
DRACES	Departamento de Regulación de los Establecimientos de Salud
FLAS	Family Life Association of Swaziland
FP	Family Planning
FSW	Female Sex Worker
GDA	Global Development Alliance
HIV	Human Immunodeficiency Virus
HLL	Hindustan Latex Ltd.
HMCAN	Health & Managed Care Association of Nigeria
HMO	Health Maintenance Organization
HUL	Hindustan Unilever Ltd.
INNS	Nicaraguan Social Security Institute
IPPF	International Planned Parenthood Federation
IC	Injectable Contraceptive
IQC	Indefinite Quantity Contract
IR	Intermediate Result
ISMP	Indian Systems of Medicine Practitioners
KAP	Knowledge, Attitude and Practice
KfW	Kreditanstalt für Wiederaufbau
MARP	Most At-Risk Population
MC	Male Circumcision
MCH	Maternal and Child Health
MCFW	Managed Care and Family Wellness
MCPR	Modern Contraceptive Prevalence Rate
MDGs	Millennium Development Goals
MFI	Micro-finance Institution
MOH	Ministry of Health
NAFDAC	Nigerian Authority for Food and Drug Association Control
NGO	Non-governmental Organization
NHIS	National Health Insurance Scheme
OB/GYN	Obstetrician/Gynecologist
OC	Oral Contraceptive
ORS	Oral Rehydration Solution
PACT-CRH	Program for Advancement of Commercial Technology–Child and Reproductive Health
PASMO	Pan American Social Marketing Organization
PSI	Population Services International
PSP	Private Sector Program
PSP-*One*	Private Sector Partnerships-*One*
QA	Quality Assurance
QI	Quality Improvement
R&D	Research and Development
RH	Reproductive Health
SE	Shakti Entrepreneur
SFH	Society for Family Health
Shakti h@BOP	Shakti Health at the Base of the Pyramid
SMO	Social Marketing Organization
SOMARC	Social Marketing for Change
SR	Sub-result
STI	Sexually Transmitted Infection
THT	Total Health Trust
UPMA	Uganda Private Midwives Association
URC	University Research Corporation
USAID	United States Agency for International Development
WHO	World Health Organization

1 Overview

INTRODUCTION

The United States Agency for International Development (USAID) has been a leader in working with the private sector to achieve family planning (FP) goals for more than 20 years. Through its investments in social marketing, pharmaceutical partnerships, social franchising, and other private sector initiatives, the agency has demonstrated that engaging the private sector can be a highly successful, if not essential, strategy for meeting FP and other health needs in the developing world. USAID designed the Private Sector Program (PSP) Indefinite Quantity Contract (IQC) to build on these investments and to explore promising new models of private sector participation.

The Private Sector Partnerships-*One* project (PSP-*One*), implemented from September 17, 2004 to September 29, 2009, was the first of 15 task orders awarded under the PSP IQC. The project's primary aim was to increase the sustainable provision and use of FP and other health products and services. Within the broader PSP, it also served as USAID's primary vehicle to support core-funded activities related to private sector innovation, collaboration, and knowledge advancement. For USAID missions that did not wish to issue their own PSP task order, PSP-*One* also offered a mechanism to program field support. The project's total funding ceiling was $59,129,638, with a field support ceiling of $34,190,105 and a core support ceiling of $24,939,533.

With strong health systems and private health sector experience, Abt Associates provided technical leadership and overall management of the PSP-*One* contract (GPO-I-00-04-00007-00). Abt's implementation partners were Tulane University and Family Health International, which contributed research, monitoring, and evalution expertise; IntraHealth International, which led PSP-*One*'s health care quality improvement (QI) initiatives; Population Services International (PSI), which spearheaded social marketing programs promoting affordable health products; and Banyan Global, Dillon Allman and Partners, Forum One Communications, and O'Hanlon Health Consulting, which provided expertise in access to finance, commercial alliances, communications technology, and policy respectively.

During its five-year lifespan, the project applied its expertise in 31 countries across Africa, Asia, Latin America, and Eastern Europe. PSP-*One* activities spanned a broad range of technical areas including public-private partnerships, social marketing and pharmaceutical partnerships, private provider networks and social franchising, "base-of-the-pyramid" market-based partnerships, behavior change communications (BCC), policy, QI, and health financing.

The aim of this final report is to share PSP-*One*'s most important findings and lessons learned in the hope that they will be useful in the design and implementation of future private health sector initiatives. The document presents case studies in the project's four main activity areas: 1) increasing demand; 2) strengthening supply; 3) improving the policy environment; and 4) scaling-up FP service provision. The report also highlights tools developed by the project and the ways in which PSP-*One* worked to advance knowledge through its global research agenda.

Although the project was managed by USAID's Office of Population and Reproductive Health, PSP-*One* also received funding from other health offices and regional bureaus. Nearly one-third of the project's funding came from the Office of HIV/AIDs. Therefore, while the focus of this report is on FP, highlights from PSP-*One*'s work in HIV/AIDS and other health areas are presented as well.

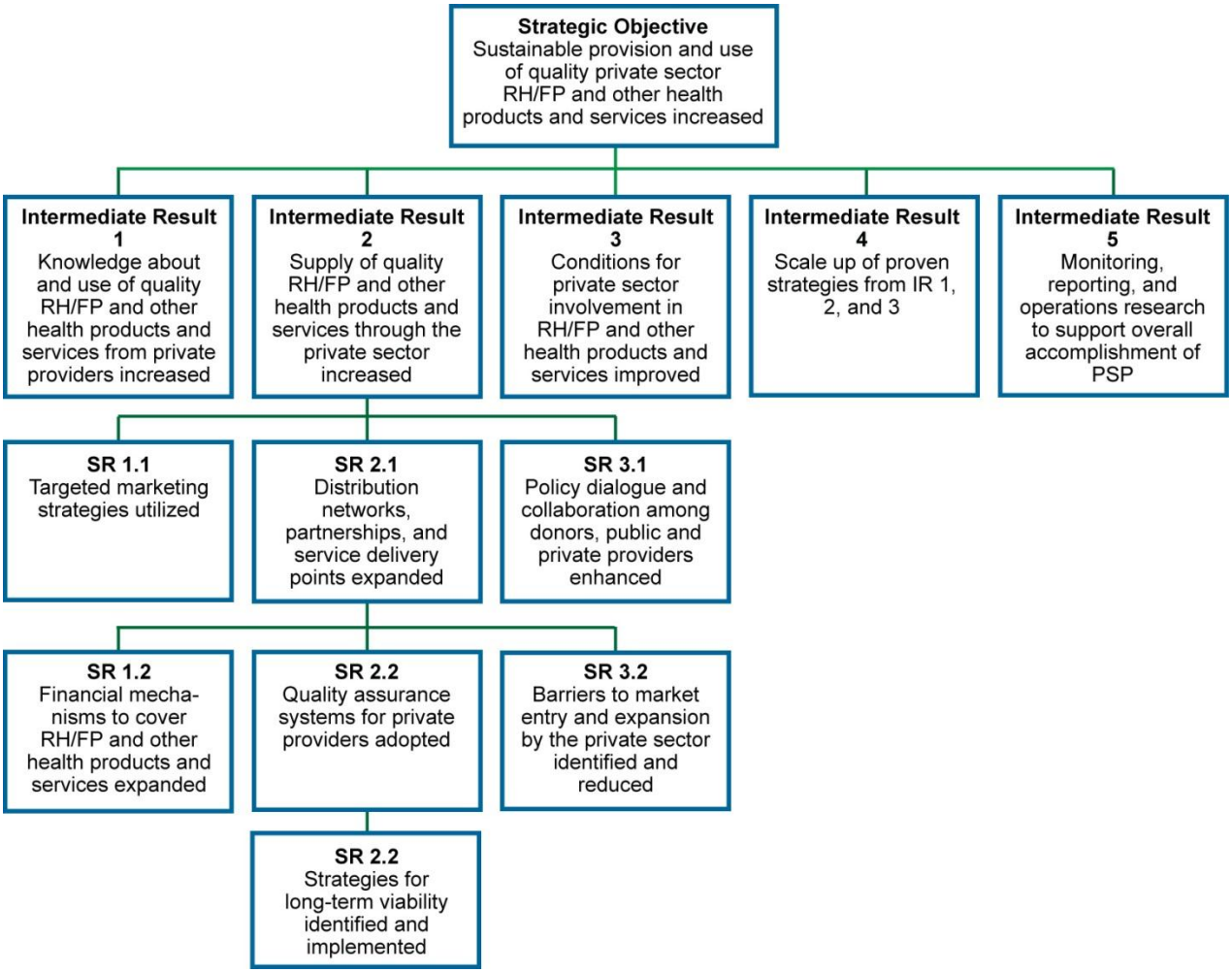
PURPOSE OF THE PSP-*One* PROJECT

It is now widely acknowledged that substantially more resources are needed to meet the three Millennium Development Goals (MDGs) related to basic health services, including FP (Sachs 2010). USAID has long recognized the potential for the private sector – with its vast infrastructure of outlets, distribution networks, and human and financial resources – to contribute to such priority health needs. Social marketing, social franchising, pharmaceutical partnerships, work-based programs, corporate social responsibility, public-private partnerships, health financing, and facilitating access to credit are among the many private sector strategies that the agency has invested in since the mid-1980s.

USAID designed the PSP-*One* project not only to build on many of these approaches, but also to pioneer new ones. PSP-*One* was to develop new Global Development Alliance (GDA)-type partnerships, foster market-based solutions for reaching the "last mile," and ramp up global and local collaboration among donors, program implementers, and the public and private sectors. The project's mandate also included providing technical leadership with an emphasis on identifying and showcasing emerging private health sector trends and models, mainstreaming private sector approaches, and establishing forums for global collaboration. Finally, PSP-*One* was to play a coordinating role within the PSP IQC by annually synthesizing and disseminating the results of USAID's 15 PSP task orders.

The PSP-*One* Results Framework (Figure 1 below) summarizes the project's specific health objectives and shows the breadth of its technical mandate. The overarching strategic objective was "sustainable

Figure 1: The PSP-One Project Results Framework



provision and use of quality private sector RH (reproductive health)/FP and other health products and services increased." Five intermediate results (IRs) and seven sub-results (SRs) supported this objective.

Taken together, these IRs and SRs focused on increasing knowledge about and financial access to private sector FP and other health services (i.e., demand), strengthening the supply of private sector health services, creating a supportive policy environment, scaling up proven private sector approaches, and advancing knowledge about "what works" through research, monitoring, and evaluation.

STRATEGIC APPROACH

The following six operating principles summarize PSP-*One*'s strategic approach to achieving the project's mandate:

1. Shift the profit motive to meet public health goals. Some of the most successful approaches to expanding private sector participation are those that stimulate the profit motive by reducing the costs and/or increasing the revenue associated with the provision of FP and other health services. PSP-*One* technical areas that supported this principle include policy, pharmaceutical partnerships, and base-of-the-pyramid market-based partnerships. The following case studies provide examples of PSP-*One*'s work in these areas: 1) "Nigeria: Introducing an Affordable Commercial Oral Contraceptive through a Southern-Based Partnership"; 2) "India: Leveraging an Innovative Rural Distribution System"; and 3) "Zambia: The Policy Dividend of Compromise and Patience."

2. Meet the health needs of consumers with targeted interventions and information. PSP-*One's* interventions took into account that different population segments have different health needs and beliefs and are in different stages of behavior change. Guided by market research, PSP-*One* developed behavior change initiatives that targeted specific population sub-groups with FP messages and services tailored to their specific needs. Case study examples include: 1) "India: Condom, Just Say It! Repositioning Condoms for FP"; 2) "India: Meeting the FP Needs of Young Married Couples through the 'Saathiya' Trusted

Partner Campaign"; and 3) "Nicaragua: Extending Health Insurance to the Informal Sector."

3. Tailor QI approaches to the specific needs of private providers: Compared with the public-sector, private sector health providers tend to be more isolated from professional colleagues, less likely to receive technical updates and trainings, and less informed about national health strategies and standards of care. As a result, the private sector is often less knowledgeable about best practices for QI. Recognizing this, PSP-*One* adapted QI tools typically used in the public sector to the needs of private sector providers. The case study "Uganda: Using Self-Assessment to Improve Private Sector RH Service Quality" discusses the impact of PSP-*One*'s QI package on the quality of care provided by private sector midwives in Uganda.

4. Mobilize the public sector's critical role in facilitating private sector participation. PSP-*One* recognized the importance of working with the public sector in order to strengthen and expand the provision of FP and other health services through the private sector. The project's approach included facilitating public-private dialogue and partnerships, building mutual trust, and developing a common understanding of national standards of care. The case study "Guatemala: Creating a Seamless HIV/AIDS Response through Public-Private Dialogue" demonstrates how building a closer working relationship between the public and private sectors can lead to better quality services in the private sector.

5. Pursue optimal market segmentation. Free public sector and heavily subsidized private sector health products and services are often necessary in the lowest-income countries (see case study "Haiti: Social Marketing Condoms, Hormonals and Clean Water"). However, in countries where a sizeable proportion of the population has an ability to pay for FP and other health services, untargeted subsidized products and services can crowd out the commercial sector and undermine opportunities for more sustainable service delivery. In Honduras, where there is a broad array of both subsidized and unsubsidized condom brands available, PSP-*One* developed and implemented a market segmentation strategy that shifted the targeting of subsidized condoms from the general population to underserved and high-risk populations. The goal was to promote a more efficient use of donor resources without compromising condom use. The case study "Honduras: Segmenting the NGO Condom Market" highlights PSP-*One*'s mixed success in this effort and important lessons learned.

PSP-*One* used a broad range of technical approaches and models to operationalize these principles and implement the project. Core technical areas of expertise included public-private partnerships, social marketing and pharmaceutical partnerships, private provider networks and social franchising, base-of-the-pyramid market-based partnerships, BCC, policy, QI, and health financing.

PORTFOLIO OF ACTIVITIES

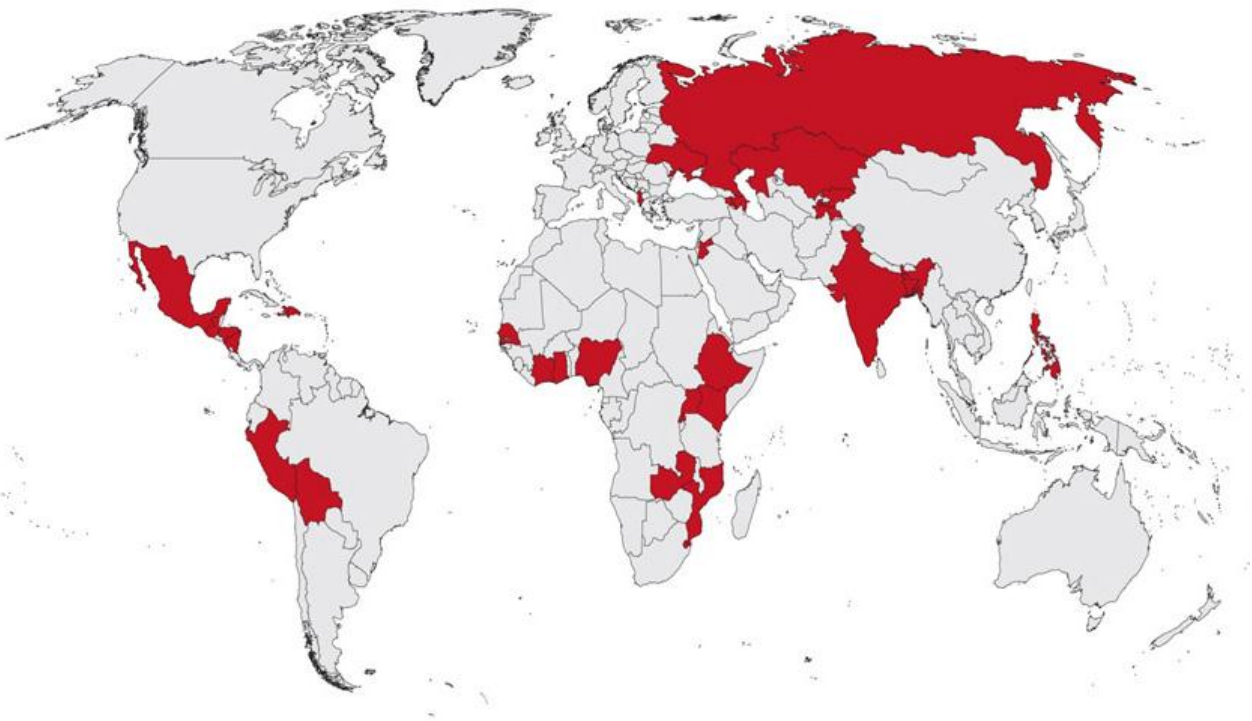
Over the life of the project, PSP-*One* worked in 31 countries implementing country programs, providing technical assistance, and promoting innovation (see Figure 2). The PSP-*One* program portfolio of activities included:

- *Field-Funded Initiatives and Programs.* PSP-*One* received field support to develop private sector initiatives and programs in 17 countries. The project's two largest programs, India and Nigeria, offered platforms for a multi-pronged technical approach, innovation, and scale-up. Smaller programs were generally more narrowly focused on one or two technical areas or private sector health research.
- *Regionally Funded Activities.* The project received regional funds from the Africa Bureau, the Asia/Near East Bureau, and the Europe and Eurasia Bureau. These funds were used primarily for regional private sector assessments and studies.
- *Core-funded Initiatives.* PSP-*One* implemented several core-funded initiatives as part of its mandate to provide technical leadership, foster collaboration, and promote innovation. Examples of core-funded activities included the development of new partnership models (see the case study "India: Leveraging an Innovative Rural Distribution System"), the launch of USAID's first private sector working group, and the annual synthesis of monitoring and evaluation results across USAID's 15 PSP task orders. In addition, the project received "global leadership priority" funding to advance knowledge on priority issues such as equity, long-acting and permanent methods, and FP among young adults.

ORGANIZATION OF THIS REPORT

Following this overview, Chapter 2 presents 14 country case studies that highlight the project's most important innovations, illustrate the breadth of PSP-*One*'s private sector strategies, and discuss key results and lessons learned. Chapter 3 focuses on tools developed by the project to strengthen private sector program design and operations. Chapter 4 highlights key findings from the project's global research agenda, and Chapter 5 presents the project's overarching lessons learned.

Figure 2: Countries where PSP-One worked*



*Countries where PSP-*One* worked with field support are in italics. PSP-*One*'s work in all other countries was supported with core or regional funds. Africa: *Cote d'Ivoire*, *Ethiopia*, *Ghana*, *Kenya*, *Mozambique*, *Nigeria*, *Rwanda*, *Senegal*, Swaziland, Uganda and Zambia. Asia and Near East: Bangladesh, *India*, *Jordan* and the *Philippines.* Europe and Eurasia: Albania, Armenia, *Azerbaijan*, Kyrgystan, Kazakhstan, *Russia*, Tajikistan, and *Ukraine*. Latin America and Caribbean: *Bolivia*, Dominican Republic, *Guatemala*, *Haiti*, *Honduras*, *Mexico*, Nicaragua, and *Peru.*

Over the life of the project, PSP-*One* implemented activities in 31 countries, including large multi-year programs funded by USAID Missions, short-term technical assistance, and core-funded initiatives promoting innovation in the field.

This chapter presents 14 case studies organized by whether the activities contributed primarily to demand-side results (IR 1), supply-side results (IR 2), policy results (IR 3), or scale-up (IR 4). Monitoring and evaluation results (IR 5) and lessons learned are embedded within each of the case studies.

These case studies were chosen to convey the technical breadth of the project, highlight innovations, and show how results informed both program operations and lessons learned.

INCREASING DEMAND

Demand-side considerations such as market size, consumer ability to pay, and unmet need for health products and services are central to private sector decisions about whether to enter new markets or expand participation in existing ones. With this in mind, USAID designed PSP-*One* to achieve the following demand-side results:

IR 1: Knowledge about and use of quality RH/FP and other health products and services from private providers increased.

SR 1.1: Targeted consumer marketing strategies utilized.

SR 1.2: Financial mechanisms to cover RH/FP and other health products and services expanded.

Below, we present case studies for India, Honduras, and Nicaragua that highlight the different technical approaches that PSP-*One* used to stimulate demand for FP and other health services. Specifically, the case studies focus on targeted BCC campaigns in India, market segmentation strategies in Honduras, and the expansion of health insurance to informal workers in Nicaragua.

INDIA: CONDOM, JUST SAY IT! RE-POSITIONING CONDOMS FOR FP

Situation: A steady decline in condom sales between 2002 and 2005 in the commercial and social marketing sectors suggested a decrease in condom use for pregnancy and HIV prevention. PSP-*One*'s formative research suggested that key reasons for this downturn were growing perceptions that condoms are used primarily for non-marital sex and general embarrassment around purchasing and using condoms.

Key interventions and objectives: In response, PSP-*One* together with ICICI Bank, Lowe India, and three of India's largest condom marketers – JK Ansell Limited, Hindustan Latex Limited (HLL), and TTK-LIG Limited – initiated a three-year BCC campaign beginning in June 2004 to reverse the downward trend in condoms sales by repositioning condoms as appropriate for pregnancy prevention and birth spacing among sexually active men. The campaign was called *Yahi Hai Sahi* ("This is the Right Choice" in Hindi). In its BCC approach, PSP-*One* used a combination of mass media, public relations, and on-the-ground retail activities. Retailers were encouraged to serve as agents of behavior change by selling condoms openly and without embarrassment and by ensuring that their customers felt comfortable purchasing condoms. In order to promote total condom market growth, the campaign focused on the entire condom category rather than on any specific brand.

The primary target group was sexually active men from socioeconomic classes A, B, C, or D who were aged 20-45 years and resided in urban areas within one of the following eight North Indian states: Bihar, Delhi, Chattisgarh, Jharkhand, Madhya Pradesh, Rajasthan, Uttar Pradesh, and Uttaranchal. By the third year of the project, the campaign focused increasingly on younger men aged 20–29 as this group had relatively high levels of unmet need for pregnancy prevention and birth spacing.

The campaign was dynamic in its implementation with continuous adjustments and fine-tuning of the communications strategy to ensure maximum responsiveness to consumer needs. In its first year, *Yahi Hai Sahi* mass media communications focused primarily on creating a positive image of couples who used condoms for pregnancy prevention with aspirations imagery. In the second year, the communication messages focused on promoting the idea among men that "if I care for my partner I should always use a condom." In the final year of the campaign, qualitative research suggested a need to directly address the issue of embarrassment around condom purchase and use. Formative research indicated that even saying the word condom was a stumbling block for many men. As a result, PSP-*One* added a new component to the *Yahi Hai Sahi* campaign

called *Condom Bindaas Bol!* ("Condom Just Say It!" in Hindi). Corresponding media messages used humor to demonstrate the difficulties men often have just saying the word condom and to encourage men to "just say it."

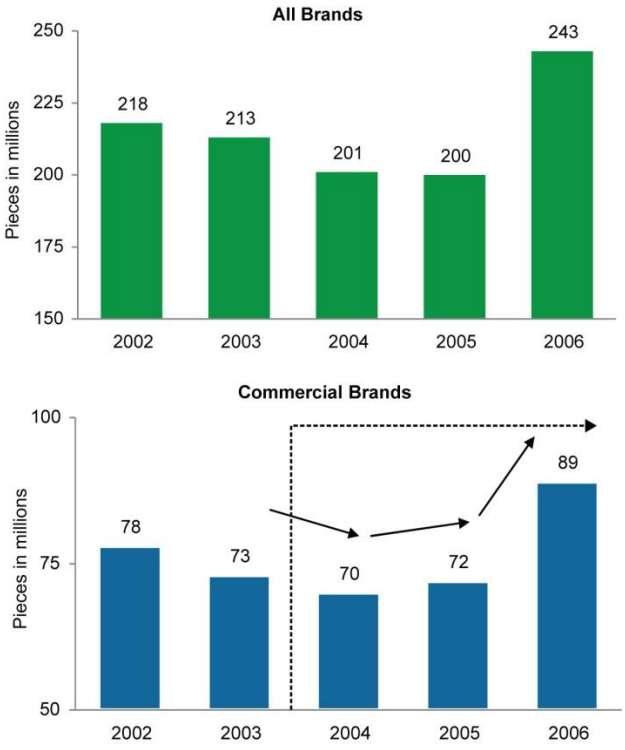
The project also worked closely with condom retailers to enlist their participation in improving the image of condoms. For example, PSP-*One* field teams encouraged retailers to participate in condom display contests, give prominence to condoms through high visibility messages at their outlets, and discuss condoms openly with potential customers.

Results: Trends in condom sales based on retail audits conducted by AC Nielsen ORG MARG Research Limited in urban North India before and after the start of the BCC campaign period are shown in Figure 3. During the first two years of the project (2004–2005) the declining trend in condom sales was arrested and by the third year (2006), growth in condom sales accelerated.

In addition, baseline and end-line knowledge, attitude, and practice (KAP) tracking surveys conducted by PSP-*One* showed significant improvements in attitudes toward and use of condoms among targeted men. For example, current condom use with a spouse grew among married men whose spouse was not surgically sterilized from 38 percent in 2004 to 60 percent in 2007. Consistent condom use with non-regular partners among sexually active men also increased, from 75 percent to 80 percent over the same timeframe. Finally, the percentage of sexually active men who disagreed that condoms need to be used with paid or commercial partners only increased from 54 percent in 2004 to 70 percent in 2007, suggesting an improved image of condoms. Moreover, the strength of these results increased as the level of exposure to the campaign increased (see Table 1).

By the end of the project, the *Condom Bindaas Bol* component of the *Yahi Hai Sahi* campaign had earned significant recognition for its effectiveness and creativity.

Figure 3: Trends in Condom Sales Volume in Urban North India



In total, it won 12 awards including the United Nations Grand Award, the Grand Effie Award, the Population First Special Award, the Golden World Award for Excellence in Public Relations, and the PR Week Asia Pacific Campaign of the Year Award. The project also leveraged a total of $1,638,871 from participating partners.

Table 1: Condom Use and Attitudes by Level of Exposure to the Yahi Hai Sahi Campaign: Urban North India

Indicator	Not Exposed	Low Exposure	High Exposure
Reported current use of condoms with spouse among married men	50%	**64%**	**69%**
Reported consistent use of condoms with non-regular partners among sexually active men	75%	**81%**	**85%**
Disagreed that condoms need to be used with paid or commercial partners only	64%	**73%**	**71%**

Note: Figures in bold are significantly different from "not exposed" values at a statistical significance level of p<.05. *Source:* PSP-*One* (2007).

LESSONS LEARNED

Category campaigns can help overcome plateaus in FP method use

PSP-*One's Yahi Hai Sahi* condom campaign was effective at increasing condom prevalence in its target market in part because its messages were "generic" rather than brand-specific. Generic, or "category," BCC campaigns focus on addressing the underlying causes of non-use and on creating demand for condoms as a whole rather than for a specific brand. When method use has stagnated, as it had for condoms in urban North India, this approach can be effective at generating new users and increasing condom method prevalence. This lesson reinforces and builds on lessons learned from previous projects, including the Commercial Market Strategies (CMS) project's *Goli Ke Hamjoli* oral contraceptive (OC) campaign in India and the Society for Family Health's condom campaign in Nigeria (see Meekers et al. 2004).

Unrolling the Yahi Hai Sahi campaign in stages was important to its success

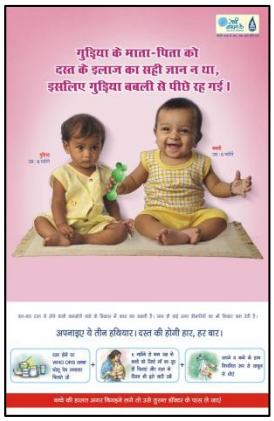
PSP-*One's* formative research revealed at least two key reasons for the stagnation in condom use in urban North India: 1) perceptions that condoms were mainly for high HIV-risk individuals and 2) embarrassment surrounding condom purchase and even saying the word condom. The *Yahi Hai Sahi* campaign addressed these obstacles in stages. The first two years of the campaign were dedicated to changing the image of condom users and associating condom use with birth-spacing, lifestyle aspirations, and caring for *One*'s spouse or partner. These messages helped to reposition condoms as appropriate for all sexually active men and women, not just for those at risk of HIV. After this initial repositioning, the last year focused almost exclusively on reducing embarrassment around just saying the word condom. These two phases of the campaign, which built off of and complemented each other, proved to be effective at shifting attitudes about condoms and increasing condom use.

INDIA: IMPROVING CHILDHOOD DIARRHEA MANAGEMENT PRACTICES

Situation: Although oral rehydration solution (ORS) is highly effective at treating diarrheal disease, its use in India – a country that leads the world in the total number of diarrhea-related childhood deaths – began to stagnate after the late 1990s. Data from the National Family Health Survey 1998–99 suggest that a significant gap existed between ORS awareness and use. Specifically, while awareness registered at 62 percent nationally, use among children under five who had experienced diarrhea within the previous two weeks stood at 27 percent. Moreover, the situation in North India was worse: diarrhea prevalence and childhood mortality rates were higher and the ORS usage rate was lower at just 20 percent. Almost 52 percent of caregivers used inappropriate treatments, such as antibiotics and anti-diarrheals.

Key interventions and objectives: It is against this backdrop that ICICI Bank launched India's diarrhea management program in 2002 under the bilateral Program for Advancement of Commercial Technology – Child and Reproductive Health (PACT-CRH) between the Government of India and USAID. The USAID-funded CMS project supported the program with technical assistance until September 2004 and PSP-*One* provided technical assistance from September 2004 until the PACT-CRH project ended in July 2007.

The program evolved substantially over its five-year lifespan and had two main phases. From approximately 2002 to 2005, CMS and PSP-*One* focused on growing the ORS market, particularly among middle- and upper-income households. Specific objectives included increasing the use of ORS as the first line of treatment for childhood diarrhea, increasing total ORS sales, and increasing the market share of World Health Organization (WHO) formula ORS brands. In the second phase, from 2006 to 2007, PSP-*One*'s focus was on improving overall home diarrhea management practices with a specific focus on lower-income households.



The largest technical component of PSP-*One*'s technical assistance during both phases of the program was BCC, with an emphasis on mass media campaigns such as the *Saathi Bachpan ke* Complete Home Diarrhea Management campaign. However, both phases of the program also relied heavily on provider training, consumer outreach, retail detailing and promotion, and large-scale mobilization around "ORS Day" each year.

Several ORS manufacturing partners also participated in and supported both phases of the program. Six leading pharmaceutical ORS manufacturers – CFL, FDC, Merck, Shreya Life Sciences, TTK Healthcare and Wallace Pharmaceuticals – joined hands from the campaign's inception. PSI, Dr. Reddy's, and Pharmasynth Formulations subsequently contributed to the program in 2005 when they launched their own brands of reduced osmolarity ORS. Taken together,

these nine partners accounted for almost 95 percent of the ORS industry. Each signed a memorandum of understanding aimed at stimulating the growth of the ORS market and expanding ORS distribution and access.

Both phases of the program focused their activities in the urban areas of North India covering Bihar, Chattisgarh, Delhi, Jharkhand, Madhya Pradesh, Rajasthan, Uttarakhand, and Uttar Pradesh, which are jointly characterized by poor health indicators including higher infant and child mortality rates and lower socioeconomic development levels compared with the rest of India. This geographic area also represents over 42 percent of the Indian ORS market.

The program's primary target audience was caregivers with children below the age of five. Health care providers – including doctors, Indian Systems of Medicine Practitioners (ISMPs), pharmacists, and chemists – were an important secondary target audience.

Results: In the first phase of the program, PSP-*One*'s KAP tracking survey results showed that within the urban North India target areas, use of ORS among children who suffered from diarrhea in the last two weeks increased significantly, from 25 percent to 45 percent between 2002 and 2005. Echoing these results, independent retail store audits conducted by ORG-IMS Retail Audit showed that ORS sales increased annually throughout both phases of the project by 10 percent, exceeding an annual growth target of five percent. Spontaneous mention of the use of home fluids among caretakers of children who suffered from diarrhea in the last six months, however, remained steady at roughly 30 percent, indicating that ORS was still not "top of mind" as a treatment for diarrhea.

The results of the second phase of the program, which included the *Saathi Bachpan ke* Complete Home Diarrhea Management campaign, showed significant increases in some key areas of knowledge and practice between 2006 and 2007, including in the area of spontaneous mention of ORS as a treatment for diarrhea. Specifically, the percentage of caregivers who

- had a child less than six months and breastfed their child exclusively increased from 68 to 73;
- agreed with the statement "increasing the quantity of food after an incidence of diarrhea" increased from 51 to 64;
- claimed to wash their hands with soap in the last 24 hours before feeding their child increased from 46 to 57; and
- spontaneously mentioned the use of ORS to treat children suffering from diarrhea in the last two weeks increased from 28 to 48.

LESSONS LEARNED

Category campaigns can enhance the credibility of BCC messages

Although several ORS manufacturers participated in the diarrhea management program, each hoping to increase the sales of their own brand, the campaign opted to promote the reduced osmolarity ORS category as a whole rather than any specific brand. Because the campaign did not have any brand-specific sales objectives, it was able to provide a sense of credibility about the health benefits of ORS use to consumers.

Expectations about potential commercial investment need to be realistic

It is not always possible for commercial partners to dedicate resources at the same level as donors to communications campaigns. For example, in 2006 there was an increase in ORS volume sales of about 2.2 million liters. At an average cost of 30 cents per liter and an estimated margin of 20 percent, the entire ORS industry would have made an additional profit of about $132,000 that year. In comparison, the campaign leveraged about $110,000 from ORS manufacturers that year. While their contribution was in line with market growth and the profits available to them, it was a fraction of the total campaign expenditure for 2006, which was approximately $657,600.

HONDURAS: SEGMENTING THE NGO CONDOM MARKET

Situation: Honduras currently has two social marketing organizations (SMOs) supplying FP and HIV prevention products and services to vulnerable populations. ASHONPLAFA (Honduran Family Planning Association), the SMO with the longest history in the country, is a private, non-profit FP association affiliated with the International Planned Parenthood Federation (IPPF). It has a large clinic infrastructure extending throughout the country, and it provides a variety of general health and FP services. ASHONPLAFA launched its first condom social marketing product, *Guardian*, almost two decades ago and *Guardian* quickly established itself as the low-priced market leader with donor support. Later, ASHONPLAFA introduced a variety of other condom brands designed to target higher socioeconomic segments to help cross-subsidize its program. USAID phased out financial support to ASHONPLAFA's social marketing program in 1998 and commodity support was phased out in 2000

The Pan American Social Marketing Organization (PASMO), a local non-governmental organization (NGO) established by PSI, initiated its condom social marketing initiative at the request of USAID in 2000 as part of a regional HIV/AIDS prevention. PASMO launched the *Vive* condom brand in 2000 with brand-specific marketing and promotion, as well as behavior change interventions targeted at specific behaviors (including partner reduction, delayed sexual debut, abstinence, mutual fidelity, and consistent and correct use of condoms) to high-risk populations. The brand was highly subsidized to ensure that price would not be a barrier to use among those at greatest risk.

In a short time, *Vive* became the market leader in Honduras, contributing to increased total NGO condom sales in the market, but also gradually eroding sales from ASHONPLAFA's established social marketing brands.

Key interventions and objectives: Concerned about unnecessary overlap between the two SMOs and a potentially inefficient use of donor funds, USAID/Honduras requested that PSP-*One* assess market conditions and design a social marketing strategy that would increase total NGO condom sales, minimize direct competition between ASHONPLAFA and PASMO for the same clients, and emphasize their complementary technical strengths and institutional capabilities. The resulting strategy, developed in 2005, recommended:

- Increasing USAID support for demand-side activities (such as category mass media campaigns and BCC) that would benefit both SMOs
- Segmenting the NGO condom market so that USAID resources going to PASMO would focus primarily on supporting condom distribution to non-traditional outlets that serve high-risk and hard-to-reach populations, allowing ASHONPLAFA and commercial condom distributors to be the main suppliers to more traditional channels such as pharmacies

At the request of USAID, PSP-*One* played a coordinating role and was responsible for ensuring that both PASMO and ASHONPLAFA implemented their programs according to the new strategy. Specifically, PASMO would focus on non-traditional outlets, such as bars and dance halls, most likely to serve high-risk groups, while ASHONPLAFA would chiefly supply pharmacies and other traditional outlets. Unfortunately, funds were not available to develop the mass media component of the strategy.

While there have been many market segmentation studies conducted over the last decade, the recommendations – which typically focus on more efficient ways to target donor subsidies – have often proved difficult to implement for political and logistical reasons. The market segmentation strategy adopted by PSP-*One*, PASMO, and ASHONPLAFA represents one of only a handful of examples of putting market segmentation recommendations into practice.

Results: The results reveal a story of mixed success and some important lessons learned for future market segmentation initiatives. Initially, between 2005 and 2006, the intervention went according to plan. PASMO increased the distribution of its subsidized condom brand *Vive* to non-traditional outlets and the organization's total condom sales increased. Also, according to plan, ASHONPLAFA increased its distribution to traditional outlets. As shown in Table 2, not only did sales increase for both SMOs, but also for the condom market as a whole.

Three factors appear to have arrested continued success between 2006 and 2007: 1) PASMO's continued distribution of subsidized condom brands in traditional outlets using funds from other donors; 2) a substantial increase in the distribution of free condoms provided by another donor during 2006 and 2007 in the public sector; and 3) the reduced participation of two ASHONPLAFA distributors.

Table 2: Condom Distribution in Honduras 2005-2007

Distributor	2005	2006	% Growth 2005–2006	2007	% Growth 2005–2007
PASMO	1,314,343	2,217,815	69%	2,661,319	102%
ASHONPLAFA	711,288	1,099,223	54%	878,673	23%
DUREX	552,975	629,802	14%	na	na
Other private distributors	36,540	45,432	24%	na	na
Public sector	2,671,864	5,902,064	121%	6,344.520	137%
Total	5,287,010	8,894,336	68%	9,884,512	87%

"na" signifies "not available."

LESSONS LEARNED

Donor collaboration and coordination is needed to sustain market segmentation gains

Over the last decade, the number of countries with more than one SMO has grown and now includes Honduras, El Salvador, and Nicaragua in Central America; Ghana, Ivory Coast, Tanzania, and Uganda in Sub-Saharan Africa; and Nepal and Pakistan in Southern Asia. In many of these countries, donors have struggled to find ways to encourage SMOs to avoid targeting the same clients and "stealing" one another's market share and to, instead, target different clients and work together to meet the needs of the "total market." PSP-*One*'s work with PASMO and ASHONPLAFA in Honduras suggests that these types of market segmentation approaches can, in fact, be effective at stimulating total market growth and improving donor resource allocation. However, donor collaboration and coordination are needed so that market segmentation gains achieved by one donor are not unintentionally undermined by the service delivery efforts of other donors and key stakeholders.

NICARAGUA: EXTENDING HEALTH INSURANCE TO THE INFORMAL SECTOR

Situation: Nicaragua has about 1.2 million informal sector workers, including street and market vendors, small business owners, and other self-employed workers. For these individuals, facing a family health crisis can put them at risk of impoverishment. They often must divert resources from essential spending, savings, and investment to meet immediate health care needs, and these tradeoffs can negatively impact both current and future household income flows as well as future business growth. Health insurance can serve a vital financial risk protection function for these families, as well as increasing access to priority health services such as RH/FP.

While basic health care is theoretically available for free to all Nicaraguans at Ministry of Health (MOH) clinics, these facilities are typically under-resourced and lack the infrastructure, staff, and medications needed to respond adequately to the population's health needs. Many families go directly to pharmacies for care rather than waiting in long lines at MOH facilities. Health insurance provided through the Nicaraguan government's Social Security Institute (INSS) extends quality care to salaried workers and government employees, but until recently informal sector and unemployed workers were not eligible for INSS coverage.

In January 2007, INSS health insurance was made available for purchase by informal sector workers through a voluntary program known as *Seguro Facultativo de Salud*. Insured individuals and eligible dependents (pregnant spouses and children under 12) could now pay a flat monthly premium for a generous package of covered services. The government initially hoped that increasing access to INSS insurance might reduce some of the burden on the free MOH clinics, while improving the quality of care available to informal workers. In addition, since about one-third of small business owners in Managua have a loan with a microfinance institution (MFI), INSS hypothesized that it would be convenient for many informal sector workers to make health insurance payments at the same time as making payments on their MFI loans.

Key interventions and objectives: With technical assistance from PSP-*One* and the Banking on Health (BoH) project, the government initiated a demonstration project in January 2007 allowing three MFIs in Managua to market the insurance, register subscribers, and collect premiums. PSP-*One*, with co-funding from the Global Development Network, also implemented an evaluation of the pilot. The main goals were to assess the effectiveness of offering government health insurance to informal sector workers both with and without the assistance of MFIs, and to measure the impact of insurance on access to affordable health care, including FP, for this population.

The evaluation employed several data collection methods, including:

- A baseline survey in 2007 with 4,002 market vendors in 7 open-air markets in Managua. The survey gathered information on demographic and socioeconomic characteristics, health care utilization and expenditures, FP knowledge and use, and awareness of available insurance products
- A follow-up survey in 2008 with 2,608 of the same market vendors, to assess insurance enrollment, retention, and changes in baseline characteristics
- Nine focus group discussions and 60 key informant interviews with survey respondents

To reduce bias in measuring the impact of the insurance due to self-selection into the insurance program, the study introduced a randomized component in which individuals were allocated health insurance subsidies of varying amounts by a "lottery." After the baseline survey interview was completed, respondents were randomly awarded different prizes: an informational brochure about the insurance, a two-month subsidy for free insurance, a six-month subsidy, or nothing. Individuals were also randomly assigned to sign up for the insurance at the main INSS office or at *One* of the three participating MFIs; a subset of 175 vendors were given the opportunity to register "on-the-spot" at their market booth.

Implementation challenges: Several external factors affected the rollout and ongoing management of the INSS demonstration project. A political transition occurring simultaneously in Nicaragua delayed the initiation of the demonstration program. Thereafter, the new government substantially de-emphasized working with the private sector, including MFIs. New budget cuts kept the INSS from committing any additional resources to the project – including funds for communications materials to support the MFIs' direct marketing of the voluntary INSS insurance – and the INSS provided only limited administrative support to the MFIs. This discouraged the MFIs from promoting the insurance in any widespread or consistent way, and they stopped prioritizing the insurance product as they became aware that it required additional investment in time and resources. In October 2007, the INSS chose not to renew the contracts with the MFIs for registering subscribers and collecting payments, in essence cutting short the demonstration project by several months, although registered participants were able to remain in the program.

Additionally, while it was thought that enrolling in the insurance program might improve the use of RH/FP and maternal and child health (MCH) services among informal sector workers, the PSP-*One* baseline revealed that utilization of these services among informal workers was already relatively high, although lower than the national average in the case of FP. Specifically, the total contraceptive prevalence rate for informal female workers age 18-49 at baseline was 61 percent, compared with 72 percent for women in the country as a whole. The relatively high use of FP, combined with the limited period of program operation (approximately one year), limited the potential impact of the insurance scheme on FP outcomes.

Results: The evaluation of the insurance roll-out to informal workers revealed several important findings about both program operations and impact:[1]

Insurance enrollment**:** Receiving an informational brochure alone did not cause people to enroll, while receiving six months of free insurance coverage induced about one-third of respondents (34 percent) to sign up. In contrast to expectations, subsidy winners assigned to enroll at the INSS office were more likely to sign up (37 percent) than those assigned to enroll at an MFI (32 percent). "Convenience subsidies" were also a powerful motivator for enrolling in insurance. Among those who were offered the opportunity to register "on-the-spot" without leaving their market booths, 23 percent of those who received only a brochure and 70 percent of those who received a six-month subsidy enrolled. Thus, facilitating the preparation of documents needed to enroll and minimizing the time costs associated with registering at the INSS or an MFI office doubled the impact of a six-month monetary subsidy.

Use of general health services: Enrolling in health insurance did not lead to an overall increase in the probability of seeking health care. Having the insurance, however, did lead to substantial substitution away from use of MOH and private facilities into facilities covered by the INSS insurance. Those who were insured were 38 percentage points more likely to have attended an INSS-contracted clinic in the past year, 11 percentage points less likely to have visited a private clinic, and 9 percentage points less likely to have visited a public health center than the uninsured.

Use of RH/FP and MCH services: Having insurance did not, for the most part, increase the use of MCH, RH, and FP services but did change where people received these services. Pregnant women with insurance were four times more likely to obtain antenatal care from and four times more likely to give birth in an INSS-covered clinic as those without insurance. There was also no significant difference by insurance status in the likelihood of receiving any RH service (Pap smear, mammogram, prostate exam, or HIV test), although insured respondents were significantly more likely to utilize an INSS clinic for these services (12 percent) than those who did not enroll in insurance (2 percent). The only significant impact of the insurance scheme on FP use was with respect to three-month injectables. The endline survey revealed that while only 3 percent of uninsured women used this method, 6 percent of insured women did so.

Out-of-pocket expenditures: Insured respondents' out-of-pocket expenditures at several types of facilities decreased significantly – pharmacy spending by 66 percent, laboratory spending by 94 percent, and spending at private hospitals by 73 percent. There was no impact on expenses at public sector facilities, where care is typically free. Total health expenditures for the respondent and his or her dependents in the past year decreased significantly, by 52 percent, while family expenditures on the most recent illnesses were estimated to have decreased by 73 percent.

Long-term retention: Less than 10 percent of those in our sample who enrolled were still paying for insurance a year later and those receiving the largest subsidies to sign up for health insurance were least likely to be retained over time. There was no difference in retention rates between MFI clients and non-clients. The leading reasons for dis-enrolling were the inconvenience of making payments and the expense of premiums.

[1] The results of this evaluation were published in *Health Economics* (Thornton et al. 2010).

LESSONS LEARNED

For informal sector workers, time and convenience costs matter almost as much as monetary costs

Time is money to informal sector market vendors, whose income relates directly to the amount of time they are present in their market boots. Simply providing information and the ability to enroll on the spot at their market booths in Managua had about two-thirds of the enrollment impact (23 percent enrollment) as did providing a six-month monetary subsidy without on-the-spot enrollment (34 percent enrollment). This implies that streamlined, efficient enrollment, registration, and administrative processes are essential for distribution of insurance to informal workers. There may be scope to test automated registration procedures through handheld personal digital assistants and other remote devices, as well as paperless billing through mechanisms such as text messages on cell phones.

Subsidies can bring informal sector workers into the insurance scheme but may be less effective at yielding long-term retention

The evaluation suggested that subsidies of both price and convenience (in the form of on-the-spot registration) could play an important role in bringing informal sector workers into a voluntary insurance scheme. Subsidies did not, however, increase long-term retention, which was influenced by willingness to pay for insurance, premium pricing, convenience of making payments, and perceived worth of the covered care. Focus group discussions revealed that reasons against participating in the program varied. However two common arguments were that the premium was too high and that the insurance was not worth it because it did not cover children over the age of 12. High premium (relative to income) is a common deterrent to enrollment in any insurance scheme and needs to be addressed when designing insurance schemes to cover the poor.

The main impact of INSS insurance on utilization was to encourage switching away from public and private for-profit providers into INSS-contracted clinics

The likelihood of visiting a health facility at least once in the past year was not affected by insurance enrollment, and there was no significant difference in the total number of health care visits among those who sought care. However, enrolling in insurance clearly induced participants to use less of the possibly lower-quality care available in public facilities, less of the higher-cost care provided by private clinics and more care in INSS-contracted clinics.

MFIs may not be viewed as a credible health insurance intermediary

In this demonstration project, respondents who received a subsidy and were assigned to enroll at an MFI were less likely to enroll in the insurance than those who were assigned to enroll at the central INSS office. Focus group participants indicated a preference for interacting with INSS directly for enrollment and insurance payments, rather than working through intermediary MFIs. Some expressed doubts about the expertise of MFIs in dealing with health-related issues, and others were suspicious that the MFIs would try to profit from the arrangement.

STRENGTHENING SUPPLY

As discussed in the introduction of this report, PSP-*One* was expected not only to implement successful private sector approaches from the past, such as social marketing, but also to pioneer new ones to address long-standing supply-side challenges such as reaching rural areas with FP and other health services sustainably and ensuring consistent quality of care among the many and diverse actors within the private sector health community.

This section highlights a range of innovative models that PSP-*One* developed as well as some more traditional approaches to achieve its second IR and SRs:

IR 2: Supply of quality RH/FP and other health products and services through the private sector increased. This result was supported by three sub-results.

SR 2.1: Distribution networks, partnerships and service delivery points expanded.

SR 2.2: Quality assurance (QA) systems for private providers adopted.

SR 2.3: Strategies for long-term viability identified and implemented.

As an example of some of PSP-*One*'s more pioneering supply-side efforts, we present a case study of the project's work to leverage an innovative commercial distribution system in rural India. We also highlight the role that PSP-*One*'s QI package, the first USAID-funded QI tool to focus specifically on the needs of the private sector, played in improving the quality of MCH and FP services provided by private sector midwives in Uganda. In a third case study, we discuss the project's mixed success in brokering a partnership between a manufacturer of generic FP products in India and a local NGO in Nigeria to distribute the first mid-priced commercial OC in Nigeria. This section also presents more traditional private sector approaches that PSP-*One* employed such as capacity building in Swaziland and social marketing in Haiti.

INDIA: LEVERAGING AN INNOVATIVE RURAL DISTRIBUTION SYSTEM

Situation: The relatively low demand in rural settings for FP, ORS, zinc, and other health products, combined with low purchasing power and high distribution costs typically leads manufacturers to focus on relatively high population density urban markets where distribution costs are relatively low and consumer demand and ability to pay is relatively high.

At the same time, manufacturers of both health and non-health products have long recognized that rural residents – who often make up the majority of developing country populations – represent an important marketing opportunity because of their sheer size in numbers. The key question has been how best to tap into this market in a commercially viable way.

In an effort to addresses this question, Hindustan Unilever Ltd. (HUL). One of India's largest fast-moving consumer goods companies, launched an innovative rural distribution network in 2000 called Project Shakti. To compensate for the lack of a well-developed rural retail distribution network, HUL trained over 40,000 women residing in over 100,000 villages to be direct-to-consumer sales distributors, or "Shakti entrepreneurs" (SEs), for HUL's products. Project Shakti creates a win-win situation by providing SEs with a low-risk microenterprise opportunity on the one hand and by helping HUL reach more than 100 million rural consumers on the other.

With the emergence of Project Shakti, PSP-*One* recognized an opportunity to broker a partnership between HUL, its Shakti distributors, and commercial health product manufacturers to better reach rural residents with health products, including FP.

Key interventions and objectives: PSP-*One* approached HUL in 2006 about adding FP and other health products to its Shakti rural distribution network. HUL was receptive and requested assistance in introducing the concept to the Shakti Council, prioritizing health areas of mutual interest, identifying socially responsible commercial product manufacturers as potential partners, and training SEs on selected health issues.

As an initial step in the partnership, PSP-*One*, USAID, and HUL convened a two-day "Shakti Strategic Rural Health Advisory Board Meeting" in August 2006. The objectives of the meeting were twofold: 1) to present situation analyses for child health, maternal health, RH, HIV/AIDS, and malaria and 2) to prioritize potential health interventions for piloting within the Shakti network. The agreed upon prioritization criteria were as follows:

- Relevance to the community
- Health impact potential
- Commercial and social benefits to SEs
- Potential for HUL product link
- Potential for link to other development programs
- USAID and Government of India priorities

The strategic planning process yielded four target health issues for consideration: childhood diarrhea, anemia, birth spacing, and malaria. Childhood diarrhea ranked the highest against the prioritization criteria for HUL. This was primarily because ORS – the proposed health product that the SEs would sell to address diarrheal disease – provided the closest link to other HUL products, such as Lifebuoy soap which HUL positions as a diarrhea-fighting product. Thus, HUL suggested that the health partnership begin with introducing ORS into the Shakti network. If the initiative proved successful in generating profits for the SEs, HUL was willing to consider introducing FP and potentially other health products into the network.

PSP-*One* and USAID agreed to this phased process and the project subsequently brokered a partnership between HUL and Pharmasynth, a medium-sized pharmaceutical enterprise that manufacturers ORS under the brand Vitalyte, to improve sustainable access to affordable ORS in rural India. In April 2008, PSP-*One*, HUL, and Pharmasynth launched the Shakti Health at the Base of the Pyramid (Shakti h@BOP) initiative in 70 Shakti-serviced villages in Uttar Pradesh to increase rural access to affordable commercial health products.

Results: As the PSP-*One* project was entering its final project year, its Shakti h@BOP work was folded into the Market Based Partnerships for Health (MBPH) project, a new PSP Task Order led by Abt Associates that began in October 2008. The following results regarding ORS sales and SE profit were achieved under MBPH in 2009 building on the foundation laid by PSP-*One*. Specifically, sales of Pharmasynth's ORS product per SE during the diarrheal season (May through July) increased by 164 percent and profits per SE correspondingly increased by 171 percent between 2008 and 2009. The pilot demonstrated that the SE could be a credible source of health products within the community and that health products could generate a small profit for the SE.

Despite the successful partnership around ORS, a change in senior management at HUL led the company to back away from its earlier interest in expanding the partnership to include FP out of concern about potential controversy around FP in India. As a result, by the end of the PSP-*One* project, the partnership had not expanded beyond ORS.

LESSONS LEARNED

There is a business case for commercial ORS distribution in rural India

This pilot demonstrated to both HUL and Pharmasynth that there is a business case for expanding commercial ORS distribution to rural areas in India. In addition, benefit to the community comes with regular supply of this life-saving product from a retailer with knowledge of diarrhea management and correct use of ORS. There are potential implications for community-based distribution (CBD) programs struggling to become more sustainable.

Health products that can be linked to a manufacturing partner's consumer products offer a stronger business case for partnership than those that do not

HUL gave priority to a partnership around ORS instead of FP in part because ORS could be linked to, and potentially support the sales of, its diarrhea-fighting consumer goods products such as Lifebuoy soap. HUL's initial interest in FP was motivated more by corporate social responsibility than by a business interest. As a result, a change in leadership that did not see a strong business case for distributing FP coupled with concerns about potential controversy around FP led HUL to back away from the idea of including FP in the Shakti h@BOP initiative.

UGANDA – USING SELF-ASSESSMENT TO IMPROVE PRIVATE SECTOR RH SERVICE QUALITY

Situation: QA has been a core component of USAID's FP service delivery strategy for more than two decades. However, most of the QA tools and interventions funded by USAID have been tailored to the needs of the public sector and assume a bureaucratic structure that often does not exist in the private sector. Compared with the public sector, for example, private sector health practices tend to be smaller in scale and staffed with only one provider or a provider and an assistant. Private sector practices are also typically more isolated, less integrated into national health plans and strategies, and less likely to be included in government- or donor-supported QA trainings. As a result, the private sector is often less knowledgeable about national standards of care and best QA practices.

This situation prompted the project to develop a private sector QI package tailored to the circumstances of many small-scale private sector providers and to test the extent to which self-assessment could help private providers improve the quality of their services. The effectiveness of the package was tested among midwives associated with the Uganda Private Midwives Association (UPMA).

Key interventions and objectives: As an initial step in developing the private sector QI package, PSP-*One* held a series of panel discussions with experts in QA in domestic, international, and public and private health care service provision. Panelists included representatives from the Kaiser Foundation, Engender Health, University Research Corporation (URC), Initiatives, IntraHealth, Jhpiego, the Institute for Healthcare Improvement, and IPPF/Western Hemisphere. The goal of these discussions was to review leading QA approaches and to build consensus around how best to adapt existing tools to the private health sector in the context of developing countries.

Based on input from the panelists, PSP-*One* developed a QI package that consists of the following elements: a form for reviewing service statistics, a self-assessment tool for providers, a linked action plan for helping to solve issues identified by the self-assessment, and a tool to enable the supervisor to find solutions to problems identified by the provider. The QI package adopted the basic philosophy behind the client-oriented, provider-efficient (COPE) approach of encouraging health facility staff to identify and prioritize their problems. However, one important component of the approach, providing specific trainings where there were weaknesses, was not adopted.

In looking for opportunities to implement and assess the QI package, PSP-*One* selected Uganda where a network of midwives was loosely organized under a local midwifery professional association for midwives in private practice, the UPMA.

Evaluation design: Uganda also offered the opportunity to compare the use of the tool by midwives with and without a supervisory structure through a pretest–posttest quasi-experimental panel study design. The study design comprised three trial arms: two experimental groups and one control group. The first experimental group (Intervention A) consisted of midwives who had received training in the self-assessment tool and in completing an action plan but whose supervisors had not been trained in problem solving or in mobilizing external resources. The second experimental group (Intervention B) included midwives who had received training in self-assessment and action planning and whose supervisors had received training in problem solving and mobilizing external resources. The control group comprised midwives and supervisors who were not trained in the use of the QI package.

According to recent estimates, some 800 midwives are engaged in independent private practice in Uganda, of whom 600 belong to the UPMA (Commercial Market Strategies 2003). A sample of 300 midwives was

considered practical in terms of resources and appropriate in terms of detecting changes over time. Approximately 100 midwives were assigned to each of the two intervention groups and about 100 to the control group, with observations of three client–provider interactions to be conducted per midwife. A systematic random sample of midwives was selected from a list obtained from the UPMA.

The baseline data collection was conducted in October and November 2006, after a week of training provided to interviewers and data-collection supervisors. The interviewers were midwives or nurses working in the Ugandan public sector who were knowledgeable about standards of quality used for RH service delivery in Uganda. The follow-up data collection was conducted by the same interviewers and supervisors in May and June 2007. One week of refresher training was provided to survey staff in May 2007, prior to the follow-up data collection.

Situation: The QI package was effective in improving the quality of care and services when both supervisors and midwives were trained in its use. Results of the evaluation, published in *Studies in Family Planning* (Agha 2010), show nearly 70 percent of the midwives who were trained to use the package reported that it was easy to use. The findings also show that both process and structural attributes of quality significantly increased (at a $p<.05$ level of significance) among clinics in which midwives and their supervisors had received training in the package (Intervention B) compared with clinics in which neither the midwives nor their supervisors had received the training (control group).

The process areas of quality that showed significant improvement in raw rating scores calculated by taking a difference in differences for Intervention B included: interpersonal counseling (20.8 percent increase), technical aspects of FP services delivery (8.2 percent increase), and technical aspects of antenatal care services delivery (17.1 percent increase). Structural areas of quality that showed a significant improvement in raw rating scores for intervention B compared to the control group included: essential equipment and supplies (44.2 percent increase), physical infrastructure (10.5 percent increase), number of days services were provided (6.4 percent increase), and business practices (11.7 percent increase). On the other hand, there was no improvement for Intervention B clinics compared with the control group in the number of FP methods available, the number of other services available, or continuity of care management.

Among clinics in which midwives had been trained in self-assessment and in the development of action plans but whose supervisors had not been trained in the QI package (Intervention A), the only modestly significant improvement (at a $p<.1$ level of significance) relative to the control group was in the summary score for quality of care across the three services (FP, antenatal care, and postnatal care).

LESSONS LEARNED

It will be important to test variants of the QI package that are effective in improving quality of care among providers who do not have regular supervisory support

The QI tool produced only modest improvements among those midwives in clinics where there was not supervisory support based on the QI tool. In other words, in its current form, the self-assessment alone did not yield very significant improvements in quality of care. Given that the majority of private health care providers do not have regular supervisory support, it is important that future private sector programs continue to explore ways to adapt this and other QI tools to private sector providers who are outside of a supervisory structure.

NIGERIA: INTRODUCING AN AFFORDABLE COMMERCIAL ORAL CONTRACEPTIVE THROUGH A SOUTHERN-BASED PARTNERSHIP

Situation: Most contraceptive products used in sub-Saharan countries are subsidized through government or international aid programs. Although many users obtain their supplies — particularly condoms and OCs — from private pharmacies, the most widely sold products in these outlets tend to be subsidized social marketing brands. In Nigeria, PSP-*One* found that commercial, unsubsidized brands represented less than one percent of the total volume of OCs used in 2005. While subsidized commodities are undeniably needed to serve low-income users in developing countries, ensuring the availability of commercially sustainable products will help improve contraceptive security and reduce donor dependence.

Introducing commercial contraceptives in a highly subsidized context in the absence of any phase-out or improved targeting of subsidies is challenging. Social marketing products represent the most significant competition for commercial products because they are sold in the same outlets and have usually built considerable brand loyalty among users over the years.

In 2005, the most widely sold OC in Nigeria was *Confidence,* a brand developed by PSI, and marketed and distributed by the Society for Family Health (SFH), a local social marketing organization. In addition to *Confidence*, pharmacy clients also had a choice between several commercial brands of OCs sold by the German company

Schering AG.[2] The price of *Confidence* was about $0.30, while commercial brand prices started at about $3.00. The market clearly lacked a quality mid-priced OC and as a result, few users could afford to buy anything but the highly subsidized social marketing brand.

In order to successfully launch and sustain sales of a commercial mid-priced OC in Nigeria, PSP-*One* had to identify a reliable and motivated distributor as well as a local agent able to import, warehouse, and distribute a manufacturer's brands. PSP-*One* also needed to help register the product.

Key interventions and objective: The objective of introducing a sustainable mid-priced OC brand in Nigeria was twofold: 1) to provide consumers with greater contraceptive options and 2) to contribute to FP program sustainability. Key components of the initiative included the following:

Rapid assessment: PSP-*One* conducted a rapid assessment of the Nigerian pharmaceutical market, including a review of the countries of origin and prices of popular medicines and determined that a commercial OC priced between $1.00 and $1.50 would likely be affordable for many pharmacy customers.

Partnership formation: In addition, PSP-*One* approached several commercial distributors, as well as SFH, to gauge their interest in adding a new OC to their existing portfolio. The project presented several OC manufacturers – both multinational and Asia-based generic producers – with the results of the assessment and a plan to introduce a "mid-priced" OC in Nigeria at a retail price no higher than $1.25.

As a result of this process, PSP-*One* brokered a legally binding five-year exclusive agreement for the distribution of a new OC formulation between India-based FamyCare and SFH. FamyCare was chosen for its relatively inexpensive, yet quality manufacturing of the Locon formulation, which had been successfully registered and sold in India. PSP-*One* agreed to support FamyCare's brand launch and marketing costs, with the goal of supporting the brand for two years.

SFH was chosen as a distribution partner because of its long track record in distribution and sales of OCs and condoms in Nigeria. It had 50 dedicated wholesalers; 200 retailers; 15 dedicated detailers, and 10 sales representatives spread across 15 locations throughout the country. SFH's detailers were all certified and registered pharmacists responsible for selling quality health products directly to health care providers. The sales representatives' core duties were to offer seamless distribution of SFH's products.

According to the contract, FamyCare would retain ownership of the brand (Locon), to incentivize the company to support its brand, rather than act as a mere commodity supplier. For SFH, this was a significant departure from the classic social marketing approach, which typically involved procuring commodities and creating its own brands. This method of enabling SFH to distribute the Locon brand was expected to give SFH credibility as a commercial distributor, a business opportunity that could improve its long-term financial sustainability.

Revolving fund development: Like most NGOs, SFH was not financially equipped to purchase directly from manufacturers, at least where the initial order was concerned. USAID funds could not be used because FamyCare was not a US Food and Drug Administration (FDA) approved manufacturer. To address this, PSI loaned funds to SFH to place the first order. PSP-*One* signed a memorandum of agreement with SFH, FamyCare, and PSI, describing respective roles and commitments in the partnership. The role of PSI in this partnership was to loan SFH the resources needed to purchase the first product order. Sales of Locon would then be used to establish a revolving fund for subsequent orders.

Registration of Locon: The Locon brand, packaging, and formulation were submitted for registration in June 2007. However, because this formulation of OC had never been sold before in Nigeria, it had to go through a lengthy registration process by Nigeria's National Authority for Food and Drug Administration Control (NAFDAC).

At SFH's request, Famycare modified its original formulation to include a week's supply of iron, calling the new variant Locon-F. The addition of iron was intended to add value to the OC product, while further distinguishing it from the other available OC formulations on the market. The modification of the formulation however contributed to a six-month delay in production registration. Though NAFDAC approved the registration and issued an import license in January 2008, further bureaucratic delays (e.g., shortages of NAFDAC's printed forms) further stalled the product's registration.

Results: Initial sales of Locon-F took place in January 2009 after a series of delays in registration, manufacturing, and importation. The fact that Locon-F was a low-dose OC that women could tolerate more easily than other products enabled SFH to market Locon-F more effectively and justify its higher price over the normally dosed OCs. Indeed, sales of Locon-F achieved significant momentum – sales volumes of Locon-F cycles increased quarterly from 1,400 in the first

[2] Shering AG was subsequently acquired by Bayer and is now referred to as Bayer Schering Pharma AG, Germany* http://www.bayer.com/en/innovative-products-from-schering.aspx [Accessed April 26, 2011].

quarter to 5,400 in the second quarter and 10,800 in the third.

However, this momentum was not sustained after PSP-*One* ended in September 2009; sales dropped to 6,200 in the fourth quarter (Figure 4).

LESSONS LEARNED

Sufficient time and resources need to be invested to successfully introduce non-subsidized mid-priced OCs

Though SFH anticipated that an iron supplement would add further value to the mid-priced pill, the modification led to the initial denial of the product registration, and delayed product registration by six months. Given PSP-*One*'s limited timeframe, the six month delay likely contributed to the product's inability to gain sufficient sales momentum to ensure its viability after the end of the project.

Had the pill not been modified, the Indian manufacturer, FamyCare could have enjoyed a smoother product registration by producing a 'certificate of free sale' demonstrating that it had already manufactured Locon, for successful sale and registration on the Indian market. Though the local regulatory authority, NAFDAC, eventually accepted the certificate, the opportunity cost of that delay was six-months of product promotional support from PSP-*One*.

By the time the product entered the market, the time remaining on the PSP-*One* contract was insufficient to fully promote and distinguish this new product from the existing subsidized brand and higher-priced commercial brands. Customers and retailers alike may not have been fully convinced of the value of the lower hormone-dose pills. SFH sales experts suggest that the full 18 months to two years of promotion originally envisioned would have been more realistic for building a sustainable market for this product.

Locon-F's successful product launch and initial sales volumes reveal that generic manufacturers can be encouraged to market their own brands by partnering with local distributors

Most generic manufacturers in developing countries focus on producing commodities for government- and donor-funded programs. These companies find it difficult to market their own brands because they lack marketing capacity and distribution experience. With capable local partners and marketing support, however, foreign manufacturers can learn to take advantage of opportunities in emerging commercial markets, particularly where a significant price gap exists between subsidized brands and higher-end commercial brands. Lower production costs and flexible pricing structures give generic manufacturers in developing countries a competitive advantage at being suppliers for the developing world, particularly as the demand for mid-priced OCs increases.

Choosing a competing NGO or commercial distributor might have led to greater product sales by reducing a perceived conflict among retailers selling more than one brand of pills at very different price points

PSP-*One* viewed a financially sustainable OC market as desirable for decreasing Nigeria's dependence on donated brands, and it originally envisioned that SFH would enjoy greater profitability from the Locon-F brand. However, the NGO may have been concerned that the new OC would cannibalize the sales of its social marketing brand *Confidence.* This was a particular issue for its detailers and sales representatives, who were incentivized to maintain sales volumes of the subsidized brand. Working with a competing distributor might have been a better option, as external competition may have led to better sales outcomes and greater commitment on the part of detailers and sales representatives.

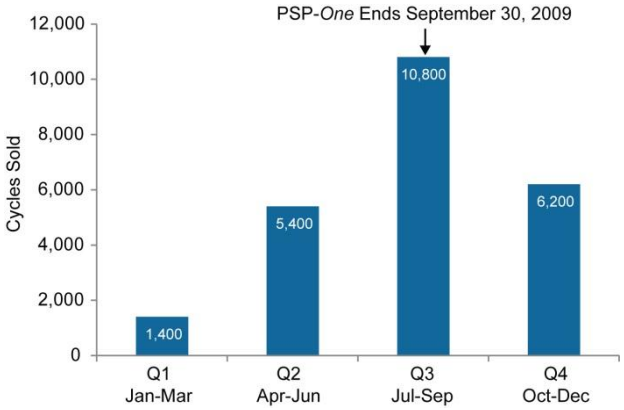
SWAZILAND: BUILDING CAPACITY FOR MALE CIRCUMCISION

Situation: Swaziland has one of the most severe HIV/AIDS epidemics in the world, with an estimated HIV prevalence among pregnant women attending antenatal clinics of 39.2 percent in 2006. The Government of Swaziland has developed a comprehensive HIV/AIDS policy that prioritizes HIV prevention to mitigate the multiple factors that fuel the spread of infection in the country.

As part of its prevention program, the government developed a policy to ensure the provision of safe, accessible, and sustainable male circumcision (MC) services; specifically, the target was to perform 150,000 circumcisions over a five-year period. It was clear that reaching this aggressive target would require the coordinated effort of the public and private health sectors. To guide the roll-out of MC services, the government published a Male Circumcision Implementation Plan.

Key interventions and objectives: In 2008, the Swaziland MOH asked USAID to assist in the roll-out and scale-up of MC for HIV prevention. In turn, USAID asked PSP-*One* to provide technical assistance to the Family Life Association of Swaziland (FLAS), a major provider of MC services, to improve its clinical, financial,

Figure 4: Locon-F Quarterly Sales, 2009



and management capabilities and help prepare it to take a leadership role in MC training and scale-up.

PSP-*One*'s activities began with a thorough assessment of clinical operations that produced a detailed plan for bringing FLAS in line with national and international standards on MC. The project recruited a consulting urologist with significant experience in MC to lead its provider training efforts. An additional clinic was also set up to expand access to MC services, with PSP-*One* providing support in the procurement of needed equipment and medical instruments.

One of FLAS' critical needs was to implement a cost accounting system. Lack of such a system prevented FLAS from rationally pricing its services or responding to requests for proposals from funders. The PSP-*One* team designed a new system to analyze and aggregate costs, and to produce detailed management reports.

PSP-*One* also worked with the FLAS Executive Director and Board to strengthen organizational leadership. Activities for capacity building included financial management training and coaching on roles and responsibilities for financial stewardship. This capacity building dovetailed with the introduction of new accounting procedures and incorporating specific training on interpreting financial reports for decision-making.

Results: Clinical services for MC in Swaziland were significantly improved. Staffing increased with the hiring of additional doctors, nurses, and non-clinical staff. Out-of-date clinical procedures were revamped in the areas of infection prevention, pain management, and post-operative follow-up. Equipment was upgraded and the staff was fully trained in clinical methods. In its June 2009 QA assessment, WHO reported that FLAS had made tremendous improvements in QA, with adherence to WHO standards improving by more than 20 percent over the previous year.

Clinic efficiency also improved, reducing the waiting times for MC services from weeks to 2–3 days on average. Facilities were also redesigned to make better use of underutilized space. Saturday hours were added, and more efficient processes adopted including counseling protocols. The volume of MCs performed by FLAS increased to more than 1,300 cases a year. Of the 900 MC patients treated during the first three quarters of 2009, 898 opted for HIV testing, an increase of 60 percent over all of 2008, demonstrating the benefit of improved HIV prevention counseling.

LESSONS LEARNED

The jointly conducted needs assessment played a critical role in strengthening FLAS's capacity to efficiently expand MC service provision

PSP-*One* partnered with FLAS staff to conduct a thorough organizational development needs assessment to inform subsequent capacity-building interventions. The assessment allowed the project to prioritize critical needs so that it could use limited resources efficiently. The assessment revealed that many of FLAS' systems were actually functioning and serving the organization quite well. For example, the human resources systems and practices resulted in a high level of employee satisfaction and staff retention, despite the fact that salaries and benefits were somewhat lower than in the public sector. Likewise, clinical quality control processes were in good working order, resulting in a high level of patient satisfaction and loyalty. But the needs assessment identified critical areas that could be further strengthened. For example, while overall financial practices were working well, FLAS' service costing improved with the new cost accounting system. Likewise, while the quality of existing services had already put FLAS' MC services in high demand, the recruitment of a consulting urologist resulting from the assessment helped make FLAS MC clinical practices state of the art for the region.

HAITI: SOCIAL MARKETING CONDOMS, HORMONALS, AND CLEAN WATER

Situation: Haiti is characterized by extreme poverty and has some of the worst social and economic indicators in the Western Hemisphere. In 2005, when PSP-*One* began its work in Haiti, the HIV prevalence rate was 3.8 percent. With respect to FP and health, only 32 percent of women used contraception, 40 percent had an unmet need for FP, and approximately half of the population did not have access to clean drinking water.

Key interventions and objectives: PSP-*One*'s objectives in Haiti were to use social marketing to increase consistent condom use to prevent HIV infections,

increase contraceptive use to address unmet need, and introduce a safe water system to help reduce the incidence of diarrheal disease.

Condom social marketing: PSP-*One*'s condom social marketing approach in Haiti used a combination of mass media, peer education, and expanded distribution.

Using mass media, PSP-*One* promoted two low-priced, subsidized condom brands developed by PSI: the *Pante* male condom and the *Reyalite* female condom. The campaign targeted adults aged 25 to 49 as well as high-risk groups such as female sex workers (FSWs) and their clients. The marketing campaign for *Pante* included the slogan "Ou pa paka la" ("You must be there"), emphasizing that HIV status is not visibly apparent and that people often choose not to use condoms with partners they trust. *Reyalite* female condoms were positioned not only as an alternative to male condoms, but also to imbue women with a sense of empowerment through the slogan, "C'est moi qui decide!" ("I'm the one to decide").

To promote consistent condom use among FSWs, PSP-*One* expanded PSI's FSW peer education network in the greater metropolitan areas and revised the FSW curriculum to include the topic of self-esteem.

The project also conducted a Measuring Access and Performance (MAP) study to identify those geographic areas with low product coverage and expanded distribution accordingly.

Hormonal contraceptive social marketing: In 1996, PSI/Haiti introduced the contraceptive injectable *Depo Provera* ® and the OC *Duofem*® under the *Confiance* ® and *Pilplan* ® brand names, respectively, to help alleviate the high number of unwanted or unplanned pregnancies. PSP-*One* focused its efforts on expanding the distribution of these two products to priority FP repositioning zones identified by the MOH and USAID; conducting mass media campaigns through branded radio and television spots, posters, brochures, and stickers; and training NGO staff, women's groups, pharmacists, and vendors in contraceptive technology.

Social Marketing and Safe Water: Building on the success and acceptance of safe water products distributed during the 2005 flood emergencies, PSP-*One* worked with community leaders to launch PSI's local safe water system *Dlo Lavi* in December 2006. *Dlo Lavi* is a dilute sodium hypochlorite solution that is used to treat clear but contaminated drinking water stored in the home.

As part of the product launch, PSP-*One* used mass media (radio, television documentaries, and brochures) and community mobilization activities in schools to educate both adults and children about the importance of clean drinking water, the risks of drinking unclean water, especially among children under five, and the availability of water purification options.

Results: Between the beginning and end of PSP-*One*, sales increased in each of the social marketing product categories, with OCs and female condoms experiencing the most significant sales growth, by 117 percent and 84 percent respectively (Table 3).

LESSONS LEARNED

Engaging community leaders can be an effective way to increase the use of safe water systems

In Haiti, there is little understanding that diarrhea among children under five can lead to death and the belief that diarrhea is just a natural part of growing up is widespread. PSP-*One* found that support of safe water systems from community leaders can help improve community understanding of diarrhea as a serious illness for young children and increase the use of safe water systems.

Table 3: Sales of Condoms, Hormonals, and Safe Water Systems

	Male Condoms	Female Condoms	Oral Contraceptives	Injectables	Safe Water Systems
2005	3,472,202	96,932	283,776	188,195	471,971
2006	4,443,920	66,485	218,452	168,742	387,194
2007	4,795,306	113,091	226,315	143,832	370,147
2008	4,693,514	139,611	287,265	266,910	554,175
2009	4,012,896	178,770	616,330	202,670	819,000
% increase 2005 vs. 2009	13%	84%	117%	8%	74%

IMPROVING THE POLICY ENVIRONMENT

PSP-*One*'s work throughout its country programs demonstrates that the legal and regulatory environment can have a profound effect on the private sector's provision of essential services such as FP and HIV/AIDS. In the absence of a supportive legal and regulatory environment, there is a risk that the private sector will provide fewer services than its potential or operate outside the existing legal framework.

This section demonstrates why policy continues to be an important component of strengthening private sector contributions to public health goals and illustrates some of PSP-*One's* most effective strategies and lessons learned to address the project's third IR and supporting SRs:

IR 3: Conditions for private sector involvement in RH/FP and other health products and services from private providers increased.

This result was supported by two SRs:

SR 3.1: Policy dialogue and collaboration among donors, and public and private providers enhanced.

SR 3.2: Barriers to market entry and expansion by the private sector identified and reduced.

GUATEMALA: CREATING A SEAMLESS HIV/AIDS RESPONSE THROUGH PUBLIC-PRIVATE DIALOGUE

Situation: The HIV prevalence rate in Guatemala is estimated to be around one percent, with most-at-risk-populations (MARPs) such as commercial sex workers and men who have sex with men making up 36 percent of the total number of people living with HIV/AIDS.

While efforts to strengthen and expand HIV/AIDS prevention and treatment services have concentrated on the public and NGO sectors, many people at risk of HIV prefer to go to private sector clinics and labs for testing. A 2007 PSP-*One* rapid assessment, however, revealed a critical lack of counseling accompanying HIV testing in private sector labs and little or no knowledge among private providers about national laws and protocols regarding HIV/AIDS. Overall, the public and private sectors were not engaging each other in their efforts to combat HIV/AIDS, and many in the private sector felt disenfranchised from national HIV/AIDS initiatives.

Key interventions and objectives: At the request of USAID/Guatemala, PSP-*One* designed a program to respond to the above findings. The core component of the resulting program was the establishment of the National Public-Private Sectors' Commission against HIV (COSSEPP-VIH is its acronym in Spanish). COSSEPP-VIH's purpose was to improve public-private dialogue in order to 1) increase private sector compliance with existing national policies and 2) integrate the private sector into HIV/AIDS policy formulation and implementation.

COSSEPP-VIH includes representatives from the National AIDS Program, medical and clinical biochemist associations, registering bodies, and NGOs, who meet monthly to resolve issues related to HIV/AIDS policy and services in the private sector[3].

COSSEPP-VIH's primary focus was on raising awareness in the private health sector about the national HIV/AIDS policy. They distributed over 5,000 copies of the policy as well as counseling and testing guidelines throughout the membership of each of their organizations. They also established a website providing the policy and other country-specific information regarding norms and protocols with respect to HIV/AIDS service provision.

In addition, by the end of PSP-*One*, COSSEP-VIH was working with the Medical Association, the Departamento de Regulation de los Establecimientos de Salud (DRACES) and the Comisión de Asesoria y Control de Estableciementos Quimico-Biologicos (CAYCEQ) to make training in HIV/AIDS mandatory for all health professionals and to revise the certification, licensing, and re-licensing requirements.

Results: When PSP-*One* began its Guatemala activities, there was essentially no formal dialogue between the public and private health sectors on the provision of HIV/AIDS services. The formation of COSSEPP-VIH along with its subsequent legal registration paved the way for a more integrated response to the country's concentrated HIV/AIDS epidemic. Some of the group's most notable achievements include:

Participating in the revision of national HIV/AIDS legislation: This contribution was COSSEPP-VIH's first task after being invited to be an official member of the commission.

Becoming a member of the Guatemala Global Fund Country Coordinating Mechanism: In November 2008, the Country Coordinating Mechanism (CCM) requested that COSSEPP-VIH become a member, demonstrating that the private sector is now viewed as an essential partner in the HIV/AIDS response and will have a voice in key HIV/AIDS forums like the CCM.

[3] COSSEP-VIH's founding members are the National HIV/AIDS Program, the National Board of Physicians, the National Board of Clinical Biochemists, the Guatemala Clinical Biochemists Association, the Internal Medicine Association, the General Physicians Association, the Women Physicians Association, the Coatepeque Physicians Association, the Gynecologist Physicians Association, the Family Physicians Association, and the Marco Antonio Foundation NGO.

Institutionalizing HIV/AIDS continuing education for private physicians: Through COSSEPP-VIH's intervention, ASOMEGUA (the second largest private family physicians association in Guatemala City) has become the first medical association in Guatemala to formally incorporate an HIV/AIDS module into its Continuous Medical Education Program. The association took this initiative due to 1) concern about knowledge gaps among providers; 2) the growing HIV/AIDS case load in private practices, and 3) growing motivation stimulated by PSP-*One* supported trainings.

LESSONS LEARNED

Engaging the private sector in policy dialogue can be an effective way to provide stewardship

In addition to monitoring and regulating the private sector, another important way for the public sector to provide effective stewardship is to actively engage the private sector in policy dialogue. The participation of the private sector in the policy process helps foster compliance by ensuring that policies take private sector circumstances into account and by increasing private sector awareness and knowledge of national health care standards.

ZAMBIA: THE POLICY DIVIDEND OF COMPROMISE AND PATIENCE

Situation: Zambia, one of sub-Saharan Africa's poorest countries, faces the dual challenge of a high disease burden and a serious human resource shortage in the public health system. Although the private health sector is relatively small and fragmented, there are signs that it is beginning to expand and could become an important partner in addressing these challenges. Against this backdrop, in 2006 USAID/Zambia funded PSP-*One* and BoH to conduct a joint assessment of private health sector options in the country. The specific objective of the assessment was to identify priority strategies to expand and strengthen the private sector's role in the delivery of priority health services, including FP.

The assessment found that although the private health sector was small, the increasing demand for health services along with Zambia's improved macro-economic was prompting some private providers to consider expanding their operations and several retired nurses, midwives and clinical officers to consider opening a private practice. However, several factors were compromising these expansion plans. Chief among them was an ambiguous legal and regulatory environment with respect to the private health sector.

While the 1997 Nurses and Midwives Act (signed in 2004), allowed nurses and midwives to open their own outpatient clinics and nursing homes, it did not set out clear, specific clinical guidelines for doing so. Another obstacle was the Medical Council of Zambia's requirement that any private licensed "medical facility" had to be supervised by a physician, despite the fact that physicians were in extremely short supply in Zambia and this was not required in public sector facilities. In addition, the Zambia Allied Professions Act (1977) which governed professional licensing requirements had not been updated in a generation.

Regulatory uncertainty pertaining to the private health sector combined with the required presence of a supervising physician served as important obstacles to retired nurses, midwives, and clinical officers who wanted to open their own practices and whose services were greatly needed. In fact, at the time of the PSP-*One* assessment, the General Nursing Council of Zambia had received few applications to open private facilities, and the Zambia Nurses Association knew of no member who had opened an independent clinic or even sought a license.

Key interventions and objectives: To address these legal and regulatory ambiguities, PSP-*One* facilitated a consultative process in 2006 for legal reform among key public and private sector stakeholders and provided technical assistance through local and international lawyers to draft the New Health Professions Act.

Enactment of the new bill was a multi-year process, and it was not until early 2008 that the President's cabinet approved the bill. Months later, the bill moved to the judiciary committee for review and codification. Competing legislative priorities and shifts in leadership, which included the president's death in August 2008, elections, and political appointments, further delayed the bill. Early in 2009, however, it moved to Parliament for a public questioning period.

This slow pace opened the door to misconceptions that formed around the draft bill. In response, PSP-*One* conducted advocacy visits to review the bill's content and intentions with key stakeholders, especially during the parliamentary public questioning period.

A few months later, Parliament passed the bill without controversy. Figure 5 plots the main milestones in the policy reform process and underscores the patience and persistence needed to produce and sustain national regulatory change.

Results: The New Health Professions Act addressed many of the issues that were important to the MOH and private sector health stakeholders. To create regulatory clarity around the private provision of basic health services and FP, PSP-*One* recognized that it needed to place this goal in the context of the broader legal reform desired by the local policymakers and other stakeholders.

Key results stemming from the New Health Profession Act include the following:

A tiered accreditation system with greater consistency between the public and private sectors: one of the most important achievements resulting from the new law included the establishment of a tiered facility accreditation system that defines facilities by five 'classes' based on the complexity of care offered, irrespective of the facility's public or private ownership. Hospitals were classified as level "A" facilities; facilities offering invasive and complex diagnostic procedures were designated as level "B," and basic outpatient services were ranked as level "E."

The new classification system requires all hospitals and outpatient clinics offering invasive procedures to be supervised by a physician. Facilities offering non-invasive basic primary services do not require physician oversight, regardless of ownership. This tiered facility classification ushered in more efficient accreditation requirements. The most rigorous and costly services and infrastructure are reserved for level A and B facilities; lower-level facilities are allowed to function with simpler, less costly, yet pragmatic equipment, staffing, and infrastructure.

A new licensing authority for the Nursing Council: The new law granted the Nursing Council authority to set its own licensing and continuing nursing education requirements, and gave nurses equal standing with physicians and other allied health professions on the New Health Professions Council. While the law did not explicitly give nurses the right to run their own primary care clinics, the tiered facility classification system may ultimately lead to more nurse-run and nurse-managed private facilities.

A greater voice for patients: The law gave a greater voice for patient rights. Two seats on the new 16-seat Health Professions Council were reserved for consumers, and the law sharpened patient grievance mechanisms. Such patient empowerment is critical to the public sector's ability to serve as a steward of quality in the public and private sectors because consumers are key in calling attention to facilities or professionals needing greater quality oversight.

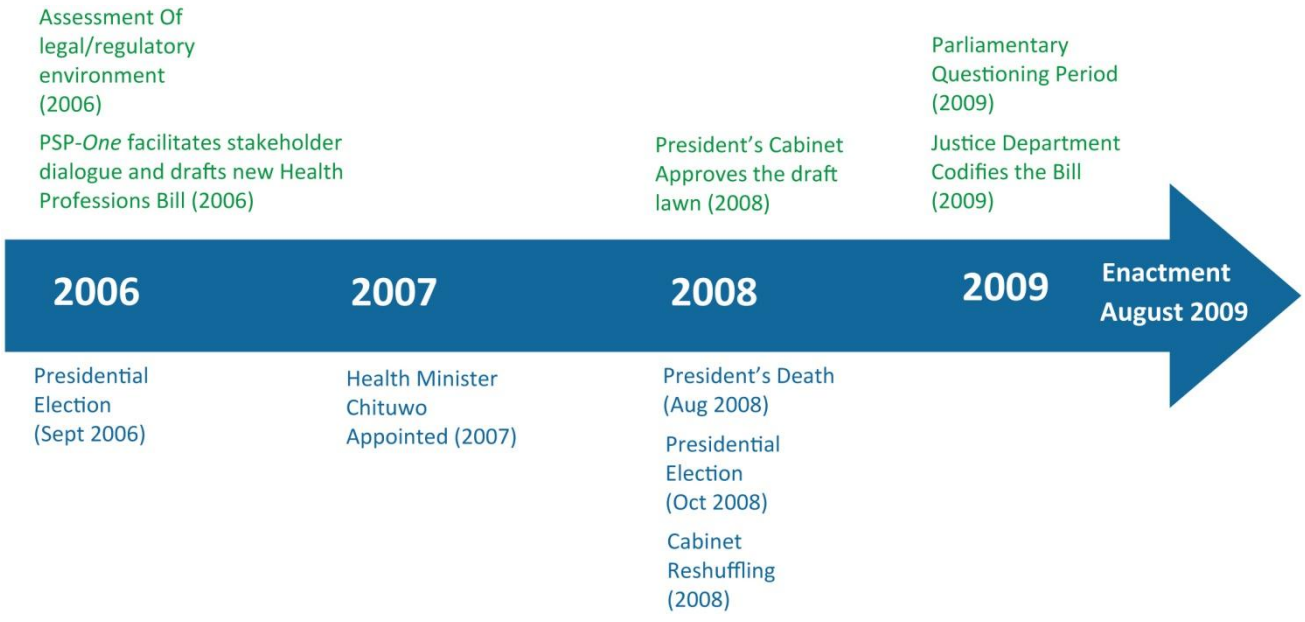
A new emphasis on improving the use of health resources: The law gave the public sector enhanced discretion to deny accreditation to facilities deemed wasteful, redundant, or unnecessary. This authority allows the government to minimize wasteful spending of health resources while basic health and FP needs remain unmet. This bodes well for services like FP, which are sometimes neglected in favor of other more lucrative health services.

LESSONS LEARNED

PSP-*One*'s experience of successfully conceptualizing and shepherding a bill's passage into law within its five-year project cycle revealed several lessons about supporting policy and regulatory reform in the Zambian context: It is important to recognize when to step in and when to step out of the health reform process

While PSP-*One* did shepherd the bill along and facilitated dialogue with key stakeholders at critical moments, the project also recognized that external involvement would have been unwelcome at some key junctures in the policy process. For example, during reviews of the bill by

Figure 5: Legislative Timeline of the New Health Professions Act (2009)



the judicial committee and cabinet, external advocacy would have been inappropriate. Times for public comment were clearly provided, and PSP-*One* seized those opportunities.

Frame private health sector regulatory reform within broader health reform efforts

PSP-*One*'s main objective was to promote an enabling environment for private sector nurses and clinical officers to open and manage health care clinics offering FP services. This objective was not the primary goal of local medical stakeholders, who recognized that the existing professional licensing requirements were not keeping pace with modern health challenges and therefore were more concerned about the overarching accreditation and professional licensing system as well as the lack of accountability within the health system.

PSP-*One* recognized that in order to advocate for greater regulatory clarity for private providers, it would have to work within broader reform efforts. A narrowly focused policy reform initiative aimed only at increasing private provider provision of FP would not have been as successful because it would have attracted a much smaller group of supporters within the public health community. Willingness to work on broader reforms that were important to a wide and influential set of actors was key to the success of the legislative effort.

Local champions for long-term policy reform are key in sustaining momentum for high-level change

Undoubtedly, a long-term presence on the ground is helpful in shepherding any type of meaningful regulatory reform. As the four-year timeline of this bill's passage in Zambia illustrated, a long-term effort was required to sustain momentum of this bill. Local insight about when to reduce and when to increase advocacy efforts was critical to the project's success, as was the local knowledge of competing political priorities and key influential personalities. Through its relationships with local stakeholders, PSP-*One* managed to periodically trace, advocate, and shepherd this bill when needed, while dispelling myths and misconceptions as they arose

SCALING-UP FP SERVICE PROVISION

Many of the case studies highlighted in the previous sections of this chapter are operating at either the regional or national level and have therefore achieved significant scale. For example, the BCC campaigns discussed under the section *Increasing Demand* pertain to all of urban North India. Similarly, the New Health Professions Act in Zambia described in the section *Improving the Policy Environment* applies to the country as a whole.

Scale was achieved in these instances largely because these types of program interventions – BCC, social marketing, and policy – generally operate at a large scale by design. In contrast, this section highlights the project's contributions to its fourth IR – scaling up proven strategies – by focusing on activities that began on a relatively limited scale and were then scaled up (or prepared for scale-up) over the course of the project.

INDIA: SCALING UP ACCESS TO A CONTROVERSIAL PRODUCT THROUGH A PRIVATE PROVIDER NETWORK

Situation: Expanding the basket of contraceptive choices increases overall contraceptive prevalence, as more couples are likely to find a method appropriate for their FP needs. Ensuring the availability of a broad range of FP methods is particularly important in India, where female sterilization has for decades dominated the method mix. It was against this backdrop that USAID decided to launch depot medroxyprogesterone acetate (DMPA), a three-month injectable, under the CMS project in 2003. In light of long-standing constituent concerns about the safety of the product, CMS launched the method on a pilot basis through a private provider network called "DiMPA" that focused on ensuring high-quality DMPA service provision. In addition to launching the network, CMS implemented an advocacy campaign to increase correct knowledge about injectables and neutralize negative media reporting about the product.

Key interventions and objectives: Following the end of the CMS project in 2004, DiMPA program activities continued under the PSP-*One* project. The goals of the program remained the same: to create awareness about DMPA as a safe and effective method of contraception; to increase access to and use of DMPA through the private health sector by establishing a network of clinics; and to promote correct use and compliance with quality of care standards. To accomplish these goals, PSP-*One* 1) trained providers on DMPA provision and counseling; 2) employed field representatives to regularly detail DiMPA network providers with technical updates, job aids, and client materials; 3) monitored quality of care through a series of mystery client observations; and 4) implemented consumer-focused communications promoting DMPA and the network.

Various partners were engaged to accomplish these goals. USAID provided funding and technical assistance through PSP-*One*; the Family Welfare Committee of the Federation of Obstetric and Gynecological Societies of India provided a platform to build consensus and support among ob/gyn providers for DMPA; the Family Planning

Table 4: Attitudes and Practices Related to IC Provision Among DiMPA Network Providers

Indicator	Baseline 2003	Endline 2009
Perception of DMPA		
Overall – good	17%	78%
Prescribing Practices		
Ever prescribed IC	70%	99%
Prescribed IC in last 6 months	54%	94%

Association of India and PSP-*One* conducted provider trainings; Pfizer, initially the sole manufacturer and marketer of DMPA in India, agreed to reduce the price of the product for all DiMPA providers; and DKT was responsible for product distribution.

Results: Over its five-year project cycle, PSP-*One* scaled up the DiMPA network initiated by CMS from 105 clinics across three cities in Uttar Pradesh in 2004 to 1,150 clinics across 45 cities in Uttar Pradesh and Jharkhand in 2009. When the network was first launched, Pfizer was the only marketer of imported DMPA in India. As support for injectables grew, so did their presence on the market. There are now four DMPA marketers in India: Pfizer, DKT International, Hindustan Latex Ltd., and Population & Health Services. In addition, in 2006 an Indian firm, Star Labs, began manufacturing DMPA locally.

PSP-*One* baseline and endline provider surveys showed a significant improvement in DiMPA provider perceptions and an increased percentage of DiMPA providers prescribing injectable contraceptives (ICs) by the end of the project (Table 4). For instance, 78 percent of DiMPA providers reported an overall "good" perception of DMPA in the endline survey, up from just 17 percent in the baseline survey. Additionally, 94 percent of DiMPA providers reported prescribing ICs in the last six months at the end of the project compared with only 54 percent at baseline.

On the consumer side, the baseline (conducted by CMS in 2001) and endline (2009) tracking surveys showed significant increases in knowledge and awareness of

DMPA. Spontaneous knowledge of DMPA was measured at 2.5 percent at baseline and 32.1 percent at the endline, and consumers correctly identifying the duration of effectiveness increased from 5.7 percent to 40.9 percent. Consumers reporting intention to use injectables in the future also increased significantly, from 21.1 percent to 38.8 percent. Though injectable prevalence rates did not grow over the course of the project, the increased levels of knowledge, awareness, and intention to use, combined with the increased availability of injectables from trained private sector providers, sets the stage for increased injectable prevalence in the future.

LESSONS LEARNED

When there is both provider and consumer resistance to a contraceptive method, address provider concerns first

In the absence of resistance to DMPA, scale-up could have involved concurrent promotion to providers and consumers through mass media as well as provider training. This was not possible in the Indian context because consumer attitudes were so negative at the outset that mass media would have simply generated controversy. PSP-*One* used a phased approach focusing on dispelling myths and increasing acceptance among providers initially, which ultimately has set the stage for mass media communications to reach consumers in the future.

Establishing trust with providers is key to overcoming provider resistance to a controversial FP method

Provider training programs have a tendency to focus on technical information, and neglect issues of provider motivation and trust. PSP-*One* improved the results of its training program when it began using in-house PSP-*One* trainers instead of contracted trainers. The in-house trainers were able to establish relationships with providers and to demonstrate the links between training and the other benefits of network membership. Contracted trainers may have conveyed the same information; however, they were not as trusted a source of information and they did little to promote the network. As a result, PSP-*One* trainers achieved much higher rates of enrollment in the network than contracted trainers.

INDIA: MEETING THE FP NEEDS OF YOUNG MARRIED COUPLES THROUGH THE "SAATHIYA" TRUSTED PARTNER CAMPAIGN

Situation: Demand for children immediately after marriage is high in India, yet this is coupled by an

increasingly significant desire to space children more effectively. Currently, short birth intervals of a year are common. The median age at marriage in Lucknow, Uttar Pradesh, is 18 for females and 21 for males, and 66 percent of 15–19-year-old adolescent females have had at least one pregnancy. Globally, youth, including unmarried youth, cite the following reasons for not using contraceptives: not expecting to have intercourse, not knowledgeable about FP, lack of access and lack of decision-making power. Program interventions that enhance self-efficacy and provide contraceptives in a confidential, affordable, and private environment have been associated with increased contraceptive use.

In India, as in other countries, chemist shops (drug stores) are a primary source of contraceptive re-supply methods (condoms and pills) and private outlets such as chemist shops are young people's preferred source of FP information and products. The 1999 National Family

Health Survey (NFHS) found that over 30 percent of youth report obtaining their contraceptives from chemists. Customers are mostly male, however, due to gender and cultural barriers that make many young women uncomfortable seeking FP information and products in crowded shops staffed mostly by men.

Key interventions and objectives: PSP-*One* developed the *Saathiya* ("trusted partner" in Hindi) campaign to meet the FP needs of married couples aged 15 to 24 in lower socioeconomic groups in Lucknow, Uttar Pradesh. The objectives were to prevent unintended pregnancies, reduce sexually transmitted infections, and promote the concept and practice of birth spacing for new mothers.

PSP-*One* adopted a two-pronged youth-friendly approach that aimed to improve both the supply of and demand for contraceptive services and methods. On the supply side, the program focused on expanding the network of service providers, initially targeting chemist shops as the main providers of FP products and information. However, initial qualitative research indicated that young women were reluctant to approach chemists with questions about FP. Through an extensive stakeholder consultation process, PSP-*One* identified Indigenous Systems of Medicine Practitioners (ISMP) (traditional medical doctors) as a viable network to complement the retail outlets. PSP-*One* trained approximately 600 chemists and ISMP doctors as *Saathiya* providers. An additional 250 doctors from the family doctor and ob/gyn communities were engaged as advocates for the *Saathiya* program.

Another supply-side innovation involved promoting a "basket" of short-acting contraceptive methods suitable for young couples. A number of previous social marketing efforts have promoted individual contraceptive methods or categories, such as condoms, but *Saathiya* broadened this concept by promoting four different methods to appeal to the target audience. Four local manufacturers of short-acting contraceptive methods partnered with the *Saathiya* program – JK Ansell, GlaxoSmithKline, Win-Medicare, and Ross Life Cycle Products – to offer youth-friendly products, including condoms, low-dose OCs, emergency contraceptives, and cycle beads respectively. Each of the manufacturers designated *One* of their existing commercial brands as their "*Saathiya*" brand, and these products were jointly promoted through the *Saathiya* communication campaign and training efforts.

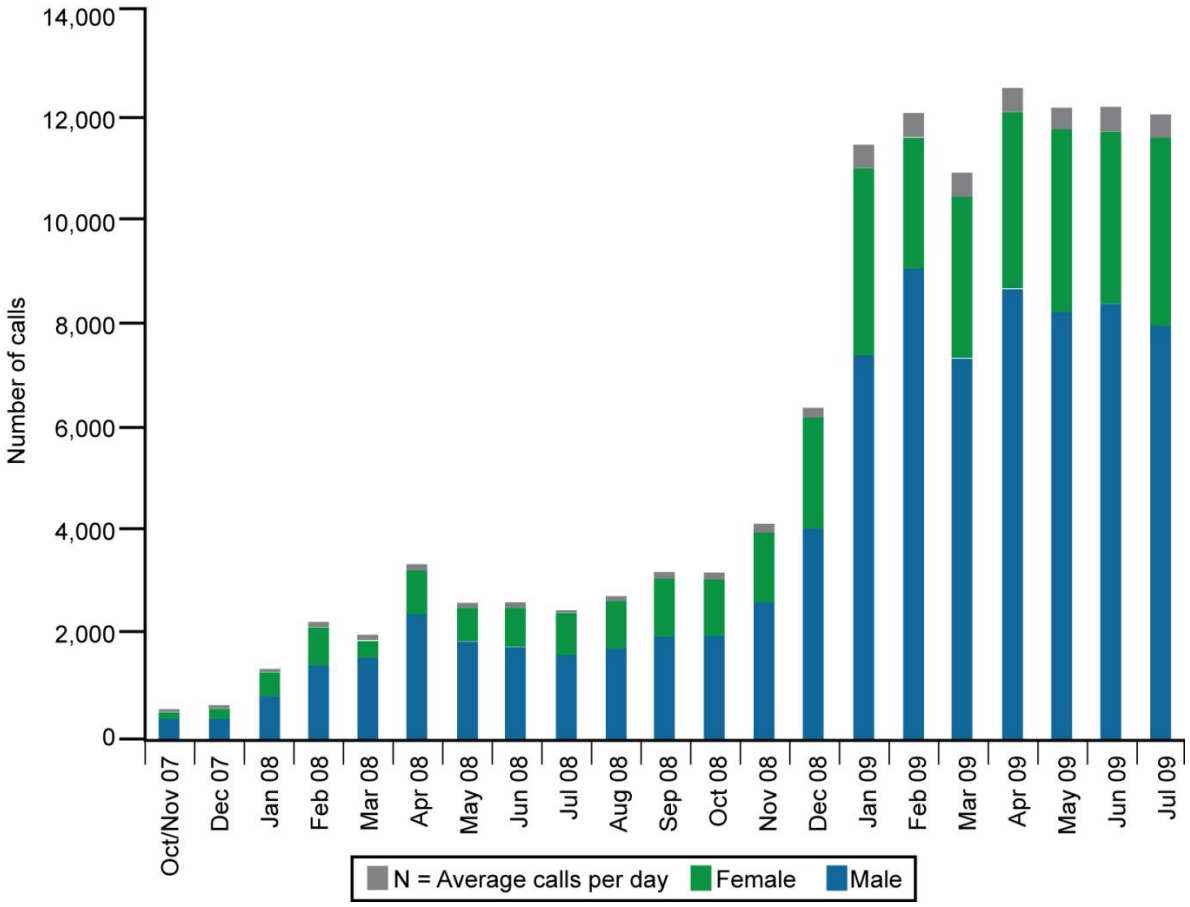
On the demand side, formative research informed the development of campaign messages and materials that appeal to young couples as they start their married life together. An integrated promotional campaign emphasizing youth-friendly channels was implemented to deliver these messages in innovative ways. These communication channels included: glow box signs to identify the *Saathiya*-trained chemist shops and ISMP clinics; billboards, cinema slides, newspaper ads, radio ads, and radio programs; community events using a local theater group and a portable *Saathiya* exhibit; a variety of print materials (leaflets, posters, point-of-sale items); and a new *Saathiya* helpline service.

The helpline provided private and confidential quality information on RH/FP and it referred callers to the *Saathiya* providers for specific services or products. At program launch, the helpline was staffed with four tele-counselors, but it outgrew its capacity fairly quickly due to high call volumes generated by the communication campaign. The helpline extended working hours by 25 percent and by the end of the project operated from 9 am to 12 am seven days a week including major holidays by the team of 10 trained tele-counselors and a manager. To address gender sensitivity in FP issues, the helpline provided separate phone numbers for men and women staffed by same gender counselors. To minimize barriers to information access, the *Saathiya* team negotiated free outgoing service for the helpline callers with major phone connection providers: Tata Indicom, Airtel, Reliance, and BSNL. Overall, the helpline filled an important role in the campaign by counseling and referring clients to the broader network of providers.

Results: A comparison of baseline and endline household surveys showed that awareness of the *Saathiya* campaign was low – only 14 percent of young married adults had heard of *Saathiya* in the endline survey (Arur, El-Khoury, and Banke 2009).[4] However, a strong correlation

[4] The baseline and endline surveys included household surveys with the target audience conducted at baseline with 945 respondents (June–August 2007) and endline with 1,176 respondents (April–May 2009) in Lucknow. Eligible participants included married females (15–24) and currently married men

Figure 6: Saathiya Helpline Calls by Gender



between those who had been exposed to the *Saathiya* campaign and modern FP use suggests that the campaign helped promote modern method use. Married youth in Lucknow who had heard of *Saathiya* were twice as likely to use a modern FP method than their counterparts who had not heard of *Saathiya*. Even after controlling for other determinants of modern FP use, including gender, age, education, religion, and number of living children, youth exposed to the campaign in Lucknow were 71 percent more likely to be current modern FP method users than their unexposed counterparts at endline.

The *Saathiya* helpline analysis also showed a high and growing demand for FP information provided over the helpline among young adults. Between 2007 and 2009, the number of calls received increased 16-fold, from roughly 750 calls per month to nearly 12,000 calls per month (Figure 6). Although open to anybody, the *Saathiya* helpline is successfully reaching young people who are *Saathiya's* target demographic. Interestingly, between 60 percent and 80 percent of calls each month were from male callers.

(20–29 years). Pregnant or expecting parents were excluded from the survey.

LESSONS LEARNED

It takes time for hotline services to demonstrate their value and take root

It took 15 months before the *Saathiya* hotline demonstrated high and consistent demand for its services. *Saathiya's* toll-free helpline received a large and steady increase in calls after the first year of operation. The high call volumes coupled with the high proportion of calls from youth – over 60 percent of calls were from callers under 25 years – strongly suggests the potential of the helpline as a mechanism for providing confidential information on FP.

Expanding the number of phone counselors and phone lines and more heavily publicizing the *Saathiya* helpline may be a cost-effective way of rapidly expanding FP knowledge and use among currently married youth. Given the popularity of the helpline, strengthening referrals between the helpline and participating *Saathiya* providers may be a promising strategy to promote access to youth-friendly FP services and products.

Understanding how the effectiveness of communication channels may vary by gender is important to communication strategy design

Saathiya used a variety of different communication channels to raise awareness about *Saathiya*-trained providers and associated FP products, including radio, print, billboards, drama, theater troops, cinema, mobile messaging, and the *Saathiya* logo to reach out to its target audience. Among these channels, radio had the greatest reported reach among young adults as a whole. However, there was also high variability in the types of communication channels that appealed to men and women. While 15 percent of men reported that newspapers and magazines were important sources for *Saathiya*-related information, virtually no women reported seeing *Saathiya*-related messages through print channels.

FP campaigns seeking to reach lower-income married female youth in Lucknow may be more effective by investing more heavily in radio, billboards, and drama.

Campaigns seeking to reach men may be more successful by focusing on radio and print media.

NIGERIA: SCALING UP FP PROVISION THROUGH HEALTH MAINTENANCE ORGANIZATIONS

Situation: The lack of a formal organizing mechanism for the private health sector makes accessing private providers and scaling up their provision of FP services especially challenging. Unlike their public sector counterparts, private providers typically operate in small independent practices with minimal collegial interaction and no overarching supervisory structure beyond what is sometimes loosely provided by private sector associations. In some countries social franchise networks (see Schlein, Kinlaw and Montagu 2010) provide a vehicle for reaching providers, however most of these networks are not yet financially viable and are therefore constrained in their ability to scale up FP interventions (Chandani, Sulzbach,and Forzley 2006). In response to this situation, One of PSP-*One*'s aims was to identify and leverage more sustainable organizing structures for the private sector and to determine whether they could effectively expand private sector FP service delivery on a large scale.

Nigeria presented an opportunity to address this challenge when, in 2006, the USAID mission asked PSP-*One* to develop a strategy to significantly expand access to FP through Nigeria's extensive private health sector.[5]

To inform the strategy, PSP-*One* conducted a private sector assessment that revealed an opportunity to partner with several large health maintenance organizations (HMOs) contracted under Nigeria's new 2005 National Health Insurance Scheme (NHIS). These HMOs offered several advantages with respect to the project's scale up objective. Not only could they provide an organizing structure that would allow access to a large number of participating private providers, they were also financially sustainable and expanding.

The assessment also revealed that because the demand for FP was low in Nigeria and not very profitable for private providers, successful FP scale up would require 1) bundling FP provision in a package of health services that addressed a broader range of client and provider needs and 2) helping providers better understand how promoting preventative care such as FP was in their financial interest under the NHIS' new capitation scheme.

Key interventions and objectives: The central component of PSP-*One*'s work with HMOs in Nigeria to scale up FP provision in the private sector was the development of a two-day training course called Managed Care and Family Wellness (MCFW) that targeted the participating providers of Nigeria's leading HMOs. The course was developed in partnership with Total Health Trust, one of Nigeria's premier HMOs, and SFH, a local social marketing organization. The first day of the training focused on managed care principles and demonstrated how participating providers could be more profitable under NHIS' capitation scheme by promoting preventive care. The second day concentrated on improving FP counseling skills and provided technical updates in preventive care with an emphasis on FP, malaria, nutrition and immunization. At the end of many of the workshops, SFH presented a range of preventive health products that workshop participants could access through its distribution system, including contraceptives, long lasting mosquito nets, and water treatment solution.

In support of the FP counseling component of the MCFW training, PSP-*One* partnered with SFH to develop a series of FP promotional materials, which included job aids, counseling flip charts, posters and brochures. The materials were designed to prompt providers to initiate FP discussions with their clients and to support and guide them in the counseling process. The posters and brochures informed clients about their FP options and encouraged them to discuss FP with their providers. A total of 53,528 promotional items were distributed to 515 private health facilities over the duration of the project.

To scale up the MCFW training and ensure its sustainability, PSP-*One* worked with the HMO

[5] Nigeria's contraceptive prevalence rate was only 13 percent and had an unmet need for FP of nearly 20 percent in a population of over 12 million (National Population Commission and ORC Macro 2004).

consortium Health & Managed Care Association iofNigeria (HMCAN) to expand the number of participating HMOs and create a funding mechanism of HMO contributions to the training that would be managed by HMCAN's secretariat to cover training costs. PSP-*One* also partnered with the Association of General and Private Medical Practitioners of Nigeria (AGPMPN) to develop a training of trainers program.

Results: By June 2009, two and a half years after the launch of the MCFW training, PSP-*One* and its partners trained 1,682 private providers and 43 local trainers across 13 states in family wellness and FP. Participating HMOs contributed $14,837 towards the training costs through the HMCAN funding mechanism.

With respect to impact on FP use and unmet need, a comparison of clients intercepted from facilities that participated in the PSP-*One* training at baseline in 2007 (n=660 MWRA) and clients intercepted at endline in 2009 (n=963 MWRA), reveals a substantial increase in the contraceptive prevalence rate (28% to 45%) and an associated decrease in unmet need (51.4% to 42%) among the client population of participating private facilities (Baruwa and Magvanjav 2009). Moreover, women who were exposed to PSP-*One* promotional materials were nearly three times as likely to be using contraception than those who were not.

Though PSP-*One* has ended, the MCFW training continues to be led by AGPMPN, which was accredited by the Medical & Dental Council of Nigeria in July 2010 to offer the training as part of its Continuing Professional Development for Medical Practitioners program. The content of the training remains largely unchanged from that which PSP-*One* and its partners originally developed.

LESSONS LEARNED:

HMOs, with training support from AGPMPN, proved to be an effective and sustainable organizing structure to reach private providers, scale up FP interventions, and increase FP use among clients

Many of the elements of the PSP-*One* FP scale up strategy in Nigeria came together as planned. Demand for the MCFW course was high and allowed PSP-*One* and AGPMPN to expand the training course from 5 to 13 states over two and a half years. The biggest constraint to scaling up further was the NHIS program itself which enrolled many fewer participants than planned. The comparison of baseline and endline surveys at participating provider facilities suggests that the training, and particularly the FP promotional materials, contributed to greater FP use and decreased unmet need among clients.

Integrating FP within a broader package of preventive services was more compelling to providers than promoting FP as a stand-alone intervention

During the PSP-*One* assessment, providers expressed much more interest in being trained to promote a full preventive service package than to promote FP alone, and PSP-*One* tailored the MCFW training accordingly. Given that providers in this program were not paid or given an incentive other than knowledge gains, the attendance of over 1,600 providers suggests that a strong demand exists among private providers for technical support and that there is a high level of willingness to improve their skills and knowledge.

Facility-based training may be more effective over the long term than off-site trainings

One of the challenges that PSP-*One* faced and had to adapt the program to meet, is the difficulty of working through individual providers to achieve facility-level impacts. Ultimately, providers have knowledge and skill gaps that have to be addressed through training and skill building activities. However, at some stage, these activities need to be brought into the facilities where the providers work and institutionalized there so that the knowledge and skills remain in the facility even if the providers choose to move on. In retrospect, the PSP-*One* program would have been strengthened by allocating more time and resources to ensure adequate in-facility follow-up.

3 Tools

PSP-*One* developed a number of tools to guide program decision-makers and implementers and facilitate public-private dialogue. Tools related to sustainability, quality of care and market segmentation are highlighted below.

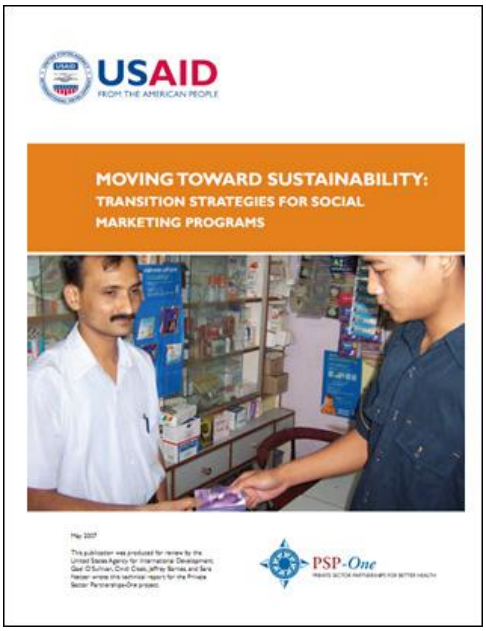
MOVING TOWARD SUSTAINABILITY: A GUIDE TO MOVE SOCIAL MARKETING PROGRAMS ALONG THE SUSTAINABILITY CONTINUUM

Based on an extensive analysis of social marketing programs, PSP-*One* created a guide for moving donor-dependent social marketing programs along the path to sustainability called "Moving Toward Sustainability: Transition Strategies for Social Marketing Programs." Its purpose was to provide donors, program implementers, researchers, and others in the social marketing field with a practical guide to strengthen the long-term viability of SMOs and social marketing programs.

This resource is intended to guide decisions about the four primary dimensions of sustainability: technical sustainability (including the 4 Ps of marketing), financial sustainability, institutional sustainability, and market sustainability. To maximize the utility and application of the guide, a set of accompanying products were developed: five detailed case studies from Africa, Latin America, and Eastern Europe; a summary of sustainability strategies; and a sustainability checklist.

The guide includes indicators for measuring progress related to individual components of a social marketing program. Three phases of sustainability are defined – beginning, intermediate, and advanced – and the four sustainability components are defined within each phase. This structure highlights how social marketing programs and SMOs change over time. The guide also illustrates that an SMO might achieve sustainability in one area, such as technical sustainability, within a shorter timeframe than in another component, such as institutional sustainability. In fact, progress along the continuum is fluid and may include temporary setbacks as well as increases in sustainability.

Building on the issues and indicators defined in the guide, a variety of strategies are described to assist social marketing programs in their decision-making within each of the four sustainability components. Insights are shared in the form of trade-offs and lessons learned, and areas for further research are suggested.



Specific strategies related to technical sustainability include building the capacity of SMOs to conduct international tenders and source products independently, using cross-subsidy pricing strategies, developing partnerships to sustain communication efforts, and moving to commercial distribution models. Examples of financial sustainability strategies include reducing operational costs and introducing product-based commercial accounting procedures. For the institutional sustainability dimension, ideas include establishing an organization with an independent legal status, strong governance, and accountability measures. Finally, strengthening the ability of an SMO to continuously adapt to changing economic, regulatory, and social conditions is one of the most useful strategies related to market sustainability.

This tool has been used in programs in Ghana, Peru, and Senegal to improve the sustainability of SMOs.

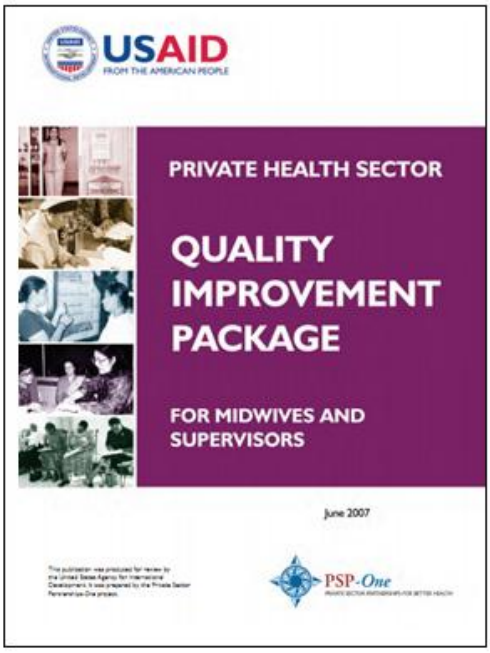
QUALITY IMPROVEMENT PACKAGE FOR MIDWIVES AND SUPERVISORS

Midwives represent an important segment of private sector health care in Uganda as they offer a range of primary health services in some of the poorest and most remote areas of the country. Private practice midwives throughout the African region face challenges to improving their quality of care including lack of training, access to capital, and business skills; inadequate supervision; and weak interaction with the national health systems. At a Congress of Midwives pre-Congress session in 2005, UPMA

invited PSP-*One* to improve standards of care through interventions that leverage existing supervisory and monitoring relationships.

To address the need for problem-solving tools, PSP-*One* developed a QI tool with a self-assessment approach that empowers providers to identify problems and consult with their colleagues to develop solutions. This approach takes into account that the private sector cannot rely on the same types of supervisory models available in the public sector to motivate changes in practice. The tool has the potential to make an important contribution to improving the quality of FP care in the private sector.

The QI tool enables providers to self-assess the quality of services they deliver, become more aware of client needs, and find solutions to problems they encounter through supportive supervision. Elements included questions that enable providers to determine gaps in the quality of care they provide, a linked action plan to help the provider identify and solutions, and a supervisory tool to facilitate support in finding solutions such as mobilizing external resources.

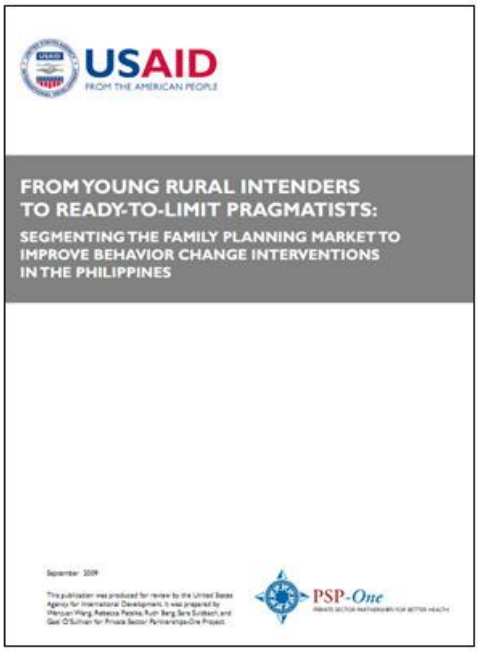


PSP-*One* conducted an evaluation of the effectiveness of the QI tool in Uganda and found that it can significantly improve the quality of FP and antenatal care when both providers and their supervisors receive training on the tool (Agha 2010). The fact that positive results were achieved over a relatively short timeframe suggests that the QI package holds enormous promise.

The tool can be readily adopted for use among small commercial sector providers of RH services who are part of an association, network, or franchise. Future QI packages should test variants that can be effective in improving quality of care among providers who do not have regular supervisory support. In addition to Uganda, the QI tool has been used in Senegal and Nigeria.

CLIENT-CENTERED MARKET SEGMENTATION ANALYSIS

Client-Centered Market Segmentation Analysis draws on classic market research approaches that major commercial companies use to increase product sales and grow market share. PSP-*One* adapted this type of analysis to the international FP context. Using representative survey data, the analysis partitions the FP market into distinct homogeneous sub-groups, or "market segments", that differ in their FP values, beliefs, attitudes, needs, and behaviors. For each segment, the analysis also provides socio-demographic, economic, and media habit information. The goal of the analysis is to help increase contraceptive use by providing FP program managers with information that will help them better tailor their programs to the needs of different FP segments.



The Client Centered Market Segmentation Analysis approach is an example of a multi-dimensional segmentation analysis that highlights not only

demographic and economic variations, but also group differences in values, beliefs, and attitudes. Because these psycho-social dimensions are key drivers of FP demand and use, this approach provides a framework to better understand the issues that impact the demand for contraceptives. A key feature of the Client-Centered Market Segmentation Analysis approach is that it distinguishes those groups that are most likely to be responsive to FP interventions from those who are not.

Although traditional policy-oriented market segmentation analysis can provide strategic information at any stage of FP program design and implementation, it is especially useful to help different sectors determine whether better coordination is needed to reach underserved groups and avoid competing for the same clients. To the extent that marketing is needed to "pull" clients out of the public sector who can afford to pay, a Client-Centered Market Segmentation Analysis can provide stronger guidance on communications campaign development to help reach known groups with special needs – such as young adults – by uncovering barriers and motivation that are unique to these groups. Client-Centered Market Segmentation Analysis can also become an important source of information in negotiations with FP manufacturers by highlighting the size and profile of clients who the manufacturer would be most likely to attract with its brand.

PSP-*One* applied the Client-Centered Market Segmentation Analysis approach in the Philippines and Azerbaijan to inform local FP communications strategies.

In addition to the monitoring and evaluation activities that supported the project's country programs, *PSP-One* developed a global research agenda. Global studies focused on addressing longstanding questions related to sustainability, equity, and the determinants of private sector use among the poor. Key findings from selected studies are presented below.

WHEN DONOR SUPPORT ENDS: THE FATE OF SOCIAL MARKETING PRODUCTS AND THE MARKETS THEY HELP CREATE

While many programs for social marketing of contraceptives in developing countries use the manufacturer's model in which commercial contraceptive brands are selected with the expectation that they will remain commercially available after donor funding has ended, little empirical evidence exists to evaluate the impact of these projects with regard to sustainability. This study addressed this knowledge gap by examining experiences with implementing the manufacturer's model[6] in four middle-income countries where donor support was fully or partially withdrawn: Morocco, the Dominican Republic, Peru, and Turkey.

In Morocco, the commercial sector's market share of OCs began to increase among lower- and middle-income women following the introduction of social marketing. After partial withdrawal of donor support, the commercial sector share continued to increase in these groups, and retail sales of both social marketing and commercial brands increased as well. In the Dominican Republic, after donor support was withdrawn, retail sales of the social marketing brand of OCs fluctuated for a decade before declining, but sales of other commercial brands increased slowly after donor support ended. In Peru, after the withdrawal of donor support, the commercial sector share of condoms declined in all wealth quintiles, possibly due at least in part to a change in government policy mandating the provision of free FP. Finally, in Turkey, where the commercial sector share of condoms among lower- and middle-income women was substantial when donor support was withdrawn, there was a slight decline in the commercial market share. However, more than half of lower- and-middle-income women continued to obtain condoms from the commercial sector.

The evidence across all four countries indicated that the manufacturer's model for implementing contraceptive social marketing interventions can contribute to a higher commercial sector share of a method among lower- and middle-income women, and this share may remain at the same level after donor support is withdrawn. Several factors, however, are required to achieve sustainability objectives: the absence of competition from other sources (such as the public sector), substantial acceptance and use of the contraceptive method, commercial sector involvement in contraceptive provision prior to the introduction of social marketing, and commercial partners' commitment to continue funding promotional activities after donor support is withdrawn.[7]

DOES AN EXPANSION IN PRIVATE SECTOR CONTRACEPTIVE SUPPLY INCREASE INEQUALITY IN MODERN CONTRACEPTIVE USE?

This study addressed concerns about the effects of private sector expansion on access to contraceptive services among the poor. Using data from five countries that had experienced an increase in private sector supply of contraceptives, the study tests the hypothesis that an expansion in private sector contraceptive supply is associated with higher inequality in the modern contraceptive prevalence rate (MCPR).

In Morocco and Indonesia, where substantial expansion in private sector contraceptive supply occurred, socioeconomic inequality in the MCPR declined, as poor women continued to rely heavily on public sector-supplied contraceptives while increasing their use of contraceptives obtained from the private sector. In Bangladesh, where there was a modest increase in private sector supply, there was a marginally significant decline in MCPR inequality. In contrast, the two countries where the private sector had a more limited role, Kenya and Ghana,

[6] The study assessed experiences with implementing the manufacturer's model developed and implemented by the USAID-funded Social Marketing for Change (SOMARC) project, which partnered with commercial manufacturers to market and distribute contraceptive brands priced at commercially profitable levels but affordable to lower- and middle-income consumers.

[7] Findings from this study were published in *Social Marketing Quarterly* (Agha, Do, and Armand 2006).

experienced no significant change in MCPR inequality. However, in rural Kenya, MCPR inequality actually increased as contraceptive use declined among women in the lowest quintile, who were unable to obtain contraceptives from the public and NGO sectors.

Study findings suggested that an expansion in private sector contraceptive supply will not lead to greater inequality in contraceptive use as long as the public sector remains an important source of contraceptives to the poorest women.[8]

DETERMINANTS OF THE CHOICE OF A PRIVATE HEALTH FACILITY FOR FP SERVICES AMONG THE POOR: EVIDENCE FROM THREE COUNTRIES

Despite the recognition of the importance of the private sector in increasing access to contraceptive services in low-income countries, relatively little systematic investigation has been conducted of socioeconomic differentials in preference for private health facilities over public health facilities. This study analyzes data from Kenya, Tanzania, and Ghana to explore what factors influence the choice of a private over a public health facility among poor clients interested in receiving FP services and to determine whether the influence of these factors differ between poor and wealthy clients.

The primary factors that attracted the poor to private sector facilities were the presence of a trained provider at all times, shorter waiting times, and the fact that private providers were more likely to assure clients of confidentiality and to spend more time counseling the clients. Client satisfaction with a range of aspects of service quality was better across all countries for poor clients who visited private facilities rather than public facilities. The primary barrier to choosing a private facility rather than a public facility is cost, for private facilities are more likely to charge routine fees for FP services to the poor than are public facilities. The poor tend to choose private facilities that do not have their fees posted, indicating that the facilities are able to exercise greater flexibility in charging the poor for services.

Non-poor clients also found shorter waiting times and some technical elements of quality of care to be better at private facilities than at public facilities.

Surprisingly, the non-poor clients did not consistently rate their experience at a private facility to be more satisfactory than their experience at a public facility. This finding may reflect the ability of non-poor clients to extract equivalent attention from both public and private providers because of their social status, but further investigation is required to better understand this result. Agha and Keating (2009) concluded that investments in the private sector to improve the structure and process of care are likely to translate into increased delivery of FP services to the poor.

ROLE OF THE PRIVATE HEALTH SECTOR IN HIV PREVENTION AND TREATMENT: FINANCING AND UTILIZATION TRENDS

Recent years have witnessed an unprecedented increase in global financing to combat HIV/AIDS in the developing world. Three major initiatives have been behind this effort: the President's Emergency Program for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, TB and Malaria, and the World Bank Multi-country AIDS Program. This influx of funds – totaling more than $10 billion in 2007 – has played an essential role in expanding access to lifesaving ART. A relatively unexamined aspect of the global response to HIV/AIDS is the role of the private sector, particularly with respect to the extent that it is financing or delivering HIV/AIDS services.

Anecdotal evidence suggests that the private health sector is active in a wide range of HIV/AIDS areas such as CT, sexually transmitted infection and TB treatment and the provision of ART. In many African countries, large private companies were the first providers of ART (via workplace clinics) (Feeley et al. 2007). Prior to the establishment of national ART programs, people living with HIV presumably had to pay out of pocket for treatment. How has this changed as a result of the considerable increase in donor funding? Moreover, what do we know about the provision of HIV/AIDS services through the private health sector? As PEPFAR and other aid programs evolve from emergency relief to sustainable programs, understanding current and potential contributions of the private sector is increasingly important.

To this end, PSP-*One* examined existing data sources – national household surveys and National Health Accounts, which allow for comparable analysis of data relevant to the private sector. The research sought to document the role of the private-for-profit

[8] Findings from this study were published in *Health Policy and Planning* (Agha and Do 2008).

sector in the financing and provision of HIV/AIDS services and to assess trends over time.

To assess utilization of HIV/AIDS services from the private-for-profit sector, data were analyzed from Demographic and Health Surveys and AIDS Indicator Surveys in 12 countries, primarily in Africa. To assess the extent to which private contributions have financed HIV/AIDS services and how these contributions have changed over time, PSP-*One* used times series National Health Accounts data for five African countries: Kenya, Malawi, Rwanda, Tanzania, and Zambia.

With regard to utilization, the study found that the private health sector is active in HIV/AIDS service delivery, although the level of participation varies as a function of overall private sector development, donor funding, availability of government services, and the regulatory environment. The highest reported private sector use for HIV testing was in Haiti (44.5 percent of women and 42.0 percent of men). Among African Countries, Ethiopian women were most likely to have been tested in the private sector (23.6 percent) as were men in Chad (23.7 percent). In Vietnam, public sector providers were the predominant source of HIV testing: only 6.0 percent of women and 6.7 percent of men obtained HIV testing in the private sector. This is likely due to limited availability of HIV test kits outside the public sector.

The choice of provider varied by gender. With the exception of the countries of Benin, Ethiopia, and Haiti, men more frequently reported a private sector source for HIV testing than did women. Wealth was also a predictor of utilization of private sector services. While there was some variation, generally women and men in the richest wealth quintile were more likely to receive an HIV test from the private sector than were respondents in the other four wealth groups. In Haiti, high use of the private sector was reported by women across the wealth groups, possibly signaling a lack of public provision of CT services.

With regard to health financing, on average, absolute spending on HIV/AIDS increased buy a magnitude of four between 2002 and 2006 in the five African counties examined in the study. Expenditures for HIV/AIDS comprised one-quarter to one-third of overall health spending in these countries in 2006. Donors were the largest financial contributors to the national HIV/AIDS responses. The relative private sector share declined significantly, from 27 percent of all HIV/AIDS health expenditures in 2002 to 12 percent in 2006. Whereas private sector companies in Africa played a key role in the provision of HIV/AIDS services early on in the epidemic, in absolute terms the analysis showed that contributions from this sector decreased in all countries except Tanzania.

These findings suggest that donor funds are displacing, rather than complementing, private investment in HIV/AIDS service provision. This possibility runs counter to the intention of several major donors to make the private sector a viable partner in sustaining the HIV/AIDs response. As the characterization of the global HIV response shifts from emergency relief to sustainable programs, continued exploration of the role of the private sector, in financing and delivering HIV/AIDS services, is warranted. Private companies led the HIV treatment effort before the donor response was galvanized, and they can still play an important role in fighting the disease. Private health providers are already delivering essential HIV and related services and are poised to do more. In both cases, partnerships with the government and/or donors may be key to effectively using and leveraging resources for maximum impact.[9]

[9] Findings from this study were published in *Social Science and Medicine* (Wang, Sulzbach, and De 2011) and in *Health policy and Planning* (Sulzbach, De and Wang 2011).

5 Overarching Lessons Learned

With the aim of informing future private sector health initiatives, this report has highlighted some of PSP-*One*'s most important lessons learned for each of the 14 country case studies presented in Chapter 2. This last chapter presents final reflections on some of the project's broader overarching lessons.

INNOVATIVE COLLABORATIONS NEED A MULTI-YEAR HORIZON TO INCUBATE AND GENERATE RESULTS

A primary lesson learned from PSP-*One*'s innovative collaboration with HUL to develop the Shakti h@BOP initiative in India is that that partnerships take time – especially when they involve new concepts (see case study "India: Leveraging an Innovative Rural Distribution System"). From HUL's perspective, the collaboration represented the first time they ventured into working with ethical health products such as ORS and OCs, and the potentially sensitive topic of FP. Extensive education was needed within HUL before the company's board was comfortable with this idea. From the ORS and OC manufacturers' perspective, the rural bottom-of-the-pyramid market that this initiative was trying to reach in a sustainable way represented new territory and time was needed to secure internal support. Concerns about potential regulatory barriers to the distribution of medical products by non-medical personnel also needed time to be resolved. As a result, it took nearly two years before the partnership was fully agreed to and implemented and another year before the initiative began to achieve measureable outputs and results. Although innovations take time, a great deal was learned in the process and the project made important strides in-roads into the challenge of sustainable rural distribution of health products.

TARGETED "CATEGORY" CAMPAIGNS CONTINUE TO BE IMPORTANT DRIVERS OF FP USE

A focus on the continued unmet need for FP throughout the developing world coupled with limited resources has prompted many program managers to focus on the supply-side of FP service delivery and to forgo the expense of mass media promotion and other demand-side activities. As has been found by the CMS project and others, PSP-*One*'s experience suggests that "category" communications campaigns (those that promote a contraceptive method rather than a particular contraceptive brand) can have a strong positive effect on FP method prevalence when combined with supply-side approaches such as broader product distribution, product stock-out reduction, and the introduction of new and more affordable products. PSP-*One* found a strong positive impact on FP method and health product use in the two cases where it supported supply-side approaches with a category communications campaign (*Yahi Hai Sahi* and *Saathi Bachpan ke* in India) and a much weaker impact in the three cases where funding was not available for this type of campaign (segmentation of the social marketing market in Honduras, new product introduction in Nigeria, and *Saathiya* in India). In all three of the latter cases, other important milestones were achieved as outlined in previous sections; however, PSP-*One's* experience suggests that targeted category campaigns continue to be important for driving higher-level impacts.

FP SUPPLY MODELS NEED TO ADAPT TO A CONSTANTLY CHANGING MARKET

The worldwide contraceptive market looks much different today than it did in 2004. Through PSP-*One*, USAID discovered emerging suppliers for FP programs, experimented with new forms of partnerships, and found that its investment in specific partners and brands could substantially impact market dynamics. The social marketing and partnership models developed under the USAID-funded SOMARC and CMS projects gave way to hybrid alliances that can leverage maturing markets in some regions of the world, respond to the changing manufacturers' landscape, and build toward increased market sustainability in the most donor-dependent countries.

PSP-*One*'s lessons learned in creating sustainable markets for contraceptives include:

- *The emergence of generic suppliers has changed the way we work with manufacturers:* The most important contribution of generic manufacturers has been to make lower-priced products available to consumers who obtain contraceptives from commercial outlets. This has been the case in developed countries where insurance policies favor low-cost bioequivalent drugs, and in developing countries with thriving local pharmaceutical industries. Sub-Saharan African markets have continued to rely heavily on donated contraceptives, and it is unclear

whether generic suppliers have had much impact on procurement prices, which were already very low. The erosion of the tender business for research and development (R&D) companies, however, may have caused a major US manufacturer to cease supplying institutional clients, and encouraged another to explore mid-price commercial segments of developing country markets by partnering with local NGOs. These developments have fundamentally changed the way the RH/FP community works with these companies. Generic manufacturers for their part cannot behave like R&D companies because their timeframe is much shorter, and their capacity to invest in training and promotion more limited. As a result, these companies, which have emerged as prime candidates for supplying government tenders, have found the commercial (retail) environment challenging. This new contraceptive world order poses ongoing and future challenges for RH/FP programs. It can no longer be assumed that all contraceptive suppliers are able to invest in market-building efforts, that yesterday's segmentation strategies are still relevant, or that contraceptive manufacturers can successfully complete complex registration processes. Through its contribution to the Reproductive Health Supplies Coalition's Market Development Approaches working group, PSP-*One* also helped frame the challenges of working with generic manufacturers, particularly with regards to ensuring high quality supplies in a less than stringent regulatory environment.

- *Donors have the ability to influence markets through their investment choices:* Donors can have an impact on the delicate supply/demand equilibrium, particularly the number of commercial suppliers on a given market, if they support a single SMO with several contraceptive brands sold through commercial channels. To minimize the negative consequences of working with a single partner (such as unfair competition or decreased market sustainability), donors can reduce their investment in branded advertising or other promotional activities that run the risk of strengthening the market share of one player without having a total market impact. If the current market segmentation (the proportion of users obtaining supplies from the private commercial, NGO, and public sectors) is deemed appropriate, donor resources are best invested in category campaigns that increase the demand for RH/FP products and services as a whole, allowing each supplier to respond to the best of its ability.

A SUPPORTIVE POLICY ENVIRONMENT IS ESSENTIAL TO PRIVATE HEALTH SECTOR GROWTH AND QUALITY OF CARE

Creating an enabling environment through effective policies and regulations is critical to strengthening the private sector role in FP service provision. PSP-*One's* private health sector assessments, along with its legal and regulatory analyses, have helped USAID missions and their country government counterparts better understand the policy barriers to private sector growth and the strategies needed to reform them.

Lessons learned about strengthening private sector participation through a supportive policy environment include:

- *In countries that face human capacity constraints, increasing FP provision through the private health sector may require broad health policy reform:* Although PSP-*One*'s emphasis was on strengthening private sector contributions to FP use, the project's case study for its work in Zambia suggests that addressing policy constraints to private sector participation in health provision more broadly may be necessary to increase private sector participation in the delivery of FP more specifically.

- *Active inclusion of the private sector in policy development helps ensure private sector awareness and compliance:* As is the case in many countries, a significant number of private providers in Guatemala were either unaware of national guidelines around HIV service provision or thought that the guidelines did not apply to them. Once this knowledge gap was identified, the private sector was eager to correct the situation and the public sector welcomed greater public-private policy dialogue around HIV service provision. In fact, the government-led commission on HIV/AIDS for the first time invited the private sector to be involved in policy development around HIV/AIDS by contributing to the revision of current HIV/AIDS legislation.

- *Capacity building around public-private partnerships is needed:* The project found that at least part of the reluctance of some policymakers to engage and support the private health sector is due to a lack of understanding about different partnering options and the pros and cons of each. To help address this situation, PSP-*One* collaborated with WHO to develop a network of public and private sector stakeholders interested in developing partnerships in Africa called Network for Africa. The network, which has over 250 members from the public and private sectors representing 26 countries offers: 1) a membership directory; 2) a virtual library of recommended public-private partnership references and tools; 3) technical exchanges led by recognized technical leaders; and 4) regional workshops. Active participation in the network and growing membership suggest that there is a great interest and need for additional forums that foster capacity building around public-private partnerships.

TURNING SKEPTICS INTO CHAMPIONS: THE IMPORTANCE OF EVIDENCE, COLLABORATION, AND DISSEMINATION

A stakeholder analysis conducted by PSP-*One* during its first year revealed that one of the key barriers to building public-private partnerships was skepticism among both donors and public sector stakeholders about private sector motives, quality of care, and ability to meet the needs of the poor. As a result, PSP-*One* made information generation and dialogue around these core concerns a priority. The project also collaborated with other interested parties to widely disseminate evidence-based recommendations about the most promising ways to work with the private sector.

Lessons learned from this process include the following:

- *Basic descriptive statistics can yield powerful insights:* At the end of its first year, PSP-*One* published a wall chart of basic descriptive statistics pertaining to private health service provision in over 45 developing countries titled *State of the Private Health Sector Wall Chart* (PSP-*One* 2005). The project disseminated the information widely in various conferences and policy forums. Interestingly, the aspect of the wall chart that often drew the most attention was the section revealing that the private health sector already serves many of the world's poorest people. This basic finding challenged the common perception that private health providers are only interested in meeting the needs of the wealthy. It also highlighted the importance of the private sector as a potential partner and ally in the effort to meet global health objectives.

- *Balanced evidence builds credibility:* In an effort to address some of the reluctance to partner with the private sector that PSP-*One*'s stakeholder analysis revealed, the project actively sought to fill information gaps in the areas of greatest concern to policymakers. For example, to address the perception that the expansion of the private health sector creates inequitable FP access and use, PSP-*One* conducted a five-country secondary analysis of Demographic and Health Survey data. Analysis results, reported in *Does an Expansion in Private Sector Contraceptive Supply Increase Inequality in Modern Contraceptive Use?* (Agha and Do 2008), showed that in some countries private sector expansion was actually associated with a *decline* in inequitable use of modern FP and in others it was not. The study also highlighted key factors that produced these different outcomes. The PSP-*One* project found that balanced research around key areas of policy interest – whether conducted by PSP-*One* or other projects and organizations – helped gain credibility among skeptical policymakers and stimulate their interest in working with the private sector.

Global collaboration raises visibility and generates interest: Over the life of the project, PSP-*One* collaborated with multiple influential organizations, including the World Bank, the International Finance Corporation, Kreditanstalt für Wiederaufbau (KfW), WHO, the Brookings Institution, the Karolinska Institute, the Center for Global Development, and the Rockefeller Foundation. These collaborations provided a global stage for dialogue about best practices and lessons learned about working with the private health sector. PSP-*One* and WHO, for example, convened a technical consultation meeting with high-level public and private sector stakeholders from around the world to discuss the strengths and limitations of working with health franchises to meet public health goals. The resulting joint guidance note, "Public Policy and Franchising Reproductive Health: Current Evidence and Future Directions" (Huntington, Sulzbach, and O'Hanlon 2007), generated global interest with over 2,000 copies downloaded from the PSP-*One* website alone.

- *Multiple forums are needed to reach multiple audiences:* PSP-*One* sought opportunities to present the most recent evidence related to private health sector approaches in a variety of forums. The project sponsored several pre-conference private health sector panel discussions at the annual Global Health Council Conference, capitalized on non-traditional venues such as the Corporate Council on Africa, and collaborated with other organizations to sponsor public-private panel discussions and research dissemination at widely attended international conferences such as the International Health Economics Association (IHEA). PSP-*One* also used new technologies such as e-conferences, webinars, and on-line chats to push beyond conventional forums and reach new audiences in the field. The broad dissemination of evidence and program experience coupled with active public-private dialogue in many of these forums helped mainstream private sector approaches and foster new partnerships to help meet some of the developing world's most pressing health needs.

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