Strengthening the Role of the Private Sector in Expanding Health Coverage in Africa

Patrick Osewe, M.D., M.P.H.
Senior Public Health Specialist, World Bank
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BACKGROUND

In the 1960's, when many of the African countries became independent, African policy makers enacted constitutions that committed their governments to providing universal access to quality health care. By definition, this included access to safe and affordable essential medicines. Although this goal is considered overly ambitious by some, many policy makers still believe it is achievable and remain committed to this ideal.

This paper describes the context of health care provision in sub-Saharan Africa (SSA), analyzes current mechanisms for public-private partnerships (PPP), and discusses emerging issues in strengthening partnerships to expand health coverage.

Understanding the Context of Health Care Coverage in Sub-Saharan Africa

After a century of some of the most spectacular health advances in human history, Africa is confronted with unprecedented health crises. The continent faces a disproportionate burden of preventable diseases that not only cause death and unnecessary suffering, but also undermine economic development and the social fabric. This burden exists despite the availability of suitable tools and technology for prevention and treatment, and is largely rooted in poverty and weak health systems.

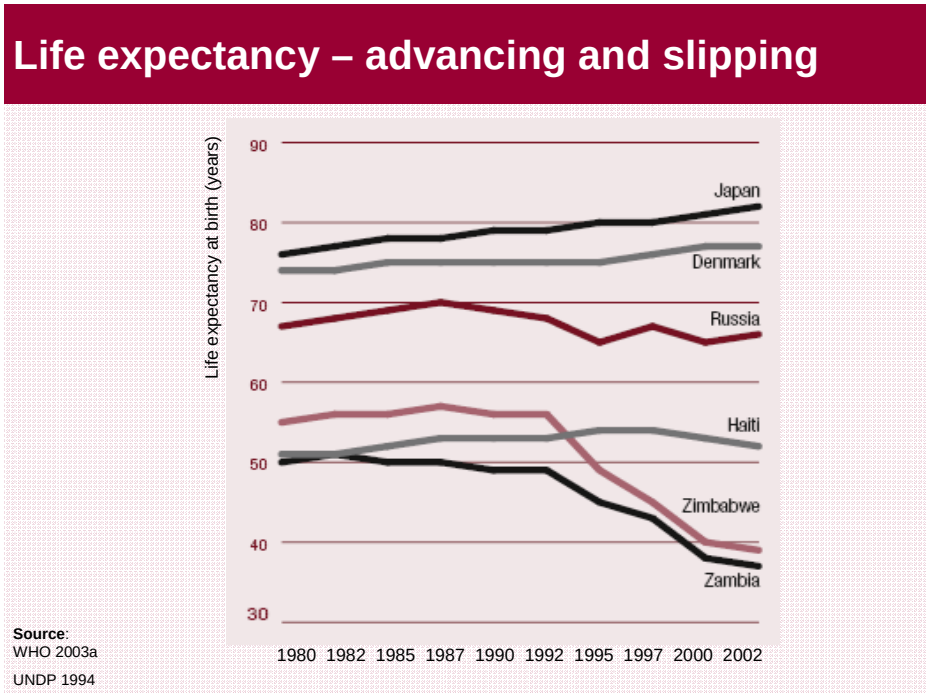
The immediate challenge facing SSA governments is to identify the most effective ways of improving Africa's effort to achieve universal coverage of essential health services, especially to the poorest and most vulnerable. At a technical level, policy makers in SSA have been slow to confront the current reality, capitalize on opportunities, and address a myriad of challenges, such as those highlighted in Table 1 below.

Table 1: The Public Health Sector: Opportunities and Challenges

Opportunities	*Challenges*
✓ Increased political commitment to address HIV/AIDS, TB and Malaria epidemics leading to unprecedented increases in financial resources to both government and development partners (e.g. World Bank, Global Fund to fight AIDS, TB and Malaria; U.S. Government, etc)	✓ High turnover and attrition of health workers due to internal migration to the private sector, external migration to developed countries and the HIV/AIDS epidemic
✓ Increased commitment in the development community to strengthen the human, structural and organizational capacity	✓ Huge burden of disease and too few public facilities compounded by the HIV/AIDS, TB and Malaria epidemics
✓ Increased interest from international organizations and private sector corporations in providing financing, technical assistance, and free drugs (Bill and Melinda Gates Foundation, Merck, Pfizer, etc)	✓ Increase in chronic disease burden
✓ Ongoing health sector reforms designed to address issues of management, financing, and linkages with the private sector to improve efficiency within the health sector and quality of health care	✓ Limited reach of public sector services with limited access by vulnerable populations including women, youth, rural communities, men who have sex with men, intravenous drug users, commercial sex workers, etc.
✓ Governments beginning to play the role of steward in the health sector in addition to, or instead of, direct provision of health services	✓ Limited managerial and technical capacity to provide care at all levels of the health system
✓ Governments implementing new policy instruments to expand the private sector (e.g. regulation, contracting, social marketing and social franchising, training private providers, and vouchers)	✓ Limited domestic budget to finance health care for the majority of the population
	✓ Vertical programs overwhelm overstretched staff
	✓ Multiple action plans developed and supported by different donors

As a result of emerging epidemics, weak management systems, and overburdened and overstretched health workers, some of the poorest countries are facing increasing death rates and plummeting life expectancy. This is eroding previous gains in human survival.

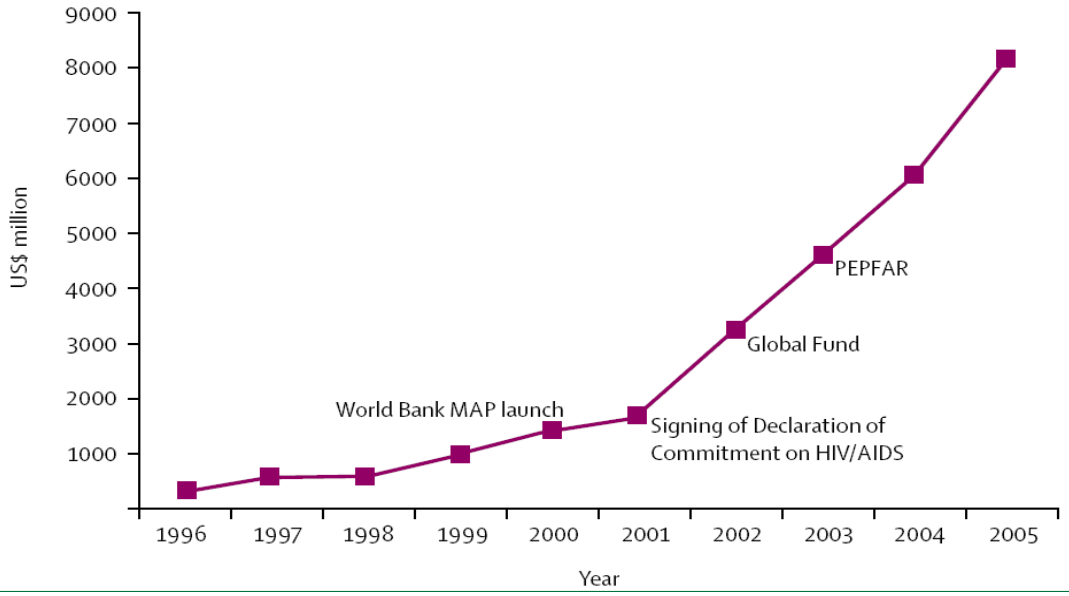
Figure 1: Life Expectancy (1980 – 2002)



By the turn of the millennium the optimism that infectious diseases were a thing of the past was rudely dashed by emerging and resurging health threats, the most notable being the HIV/AIDS and TB epidemics which are plunging sub-Saharan Africa into a profound crisis of survival[i].

Political Commitment and Funding for Expansion of Health Programs
This health crisis has provoked the highest political action. Due to greater public awareness, concerns, and political pressure from advocacy groups, conditions have been created for rapid responses through stronger political commitment; ambitious targets for prevention[ii], treatment and care; and an unprecedented increase in funding for HIV/AIDS interventions.

Figure 2: Estimated Available AIDS Resources (1996 – 2005)



Source: Piot, P. AIDS: From Crisis Management to Sustained Strategic Response. Lancet. 2006; 368:526-30. Data includes international and domestic spending (public and out-of-pocket); International foundations and Global Fund included from 2003 onwards; PEPFAR included from 2004 onwards; MAP= Multicountry AIDS Programme

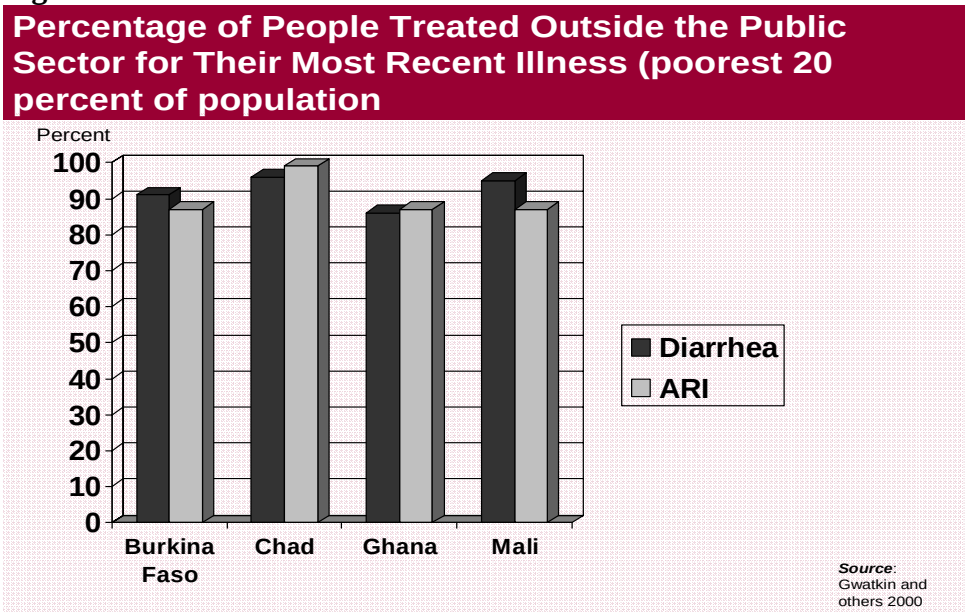
New organizational structures have been created at global, regional and national levels to coordinate the response and facilitate implementation of innovative technical approaches towards scaling up health services in Africa (Figure 2). However, despite the significant inflow of resources from national governments, bilateral and multilateral donors and other international agencies, weak management and the lack of a skilled and motivated workforce has led to low disbursement rates and is preventing the cost-effective use of these funds.

Who uses the private sector?

There is a perception that public health subsidies are well targeted to the poor due to the fact that large portions of SSA health care systems are still financed by public funds from the ministries of finance, which also support large public networks of hospitals and clinics. However, despite the fact that in some countries, up to 80 percent of the population resides in rural, underserved areas[iii], the bulk of funding is allocated to tertiary institutions which are located in urban areas.

A review of household surveys from several countries in SSA indicates that private providers play a significant role in health care delivery to both the rich and the poor (Figure 3).

Figure 3:



Similarly, a review of disease control and child and reproductive health programs have found the private sector to be necessary, though often overlooked or underestimated.[iv,v,vi] An analysis of Demographic and Health Surveys from 26 SSA countries showed that most people in SSA spend their health care money on private services.

Table 2: Use of Private and Public Facilities among the poorest quintile

Country	Among those who sought care outside the home, % who went to:	
	Private Sector	Public Sector
Burkina Faso	35	59
Cameroon	55	45
Ghana	65	25
Madagascar	47	47
Malawi	74	24
Mali	69	24
Mozambique	32	63
Niger	59	36
Nigeria	46	47
Uganda	68	27
Tanzania	29	68
Zambia	24	68

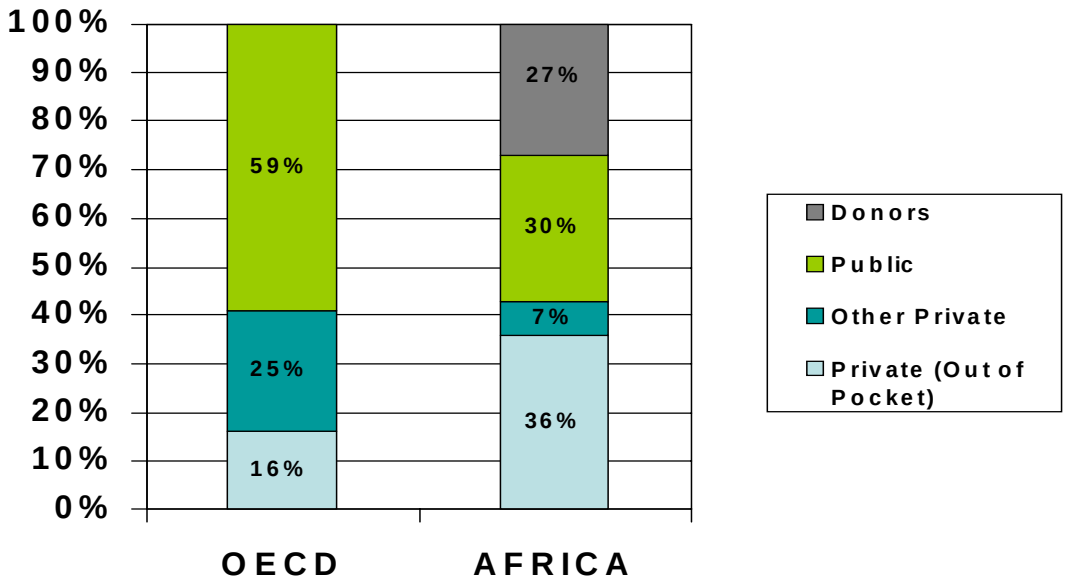
Source: *Trends and Opportunities in Public-Private Partnerships to Improve Health Service Delivery in Africa*. Washington D.C.: World Bank, 2005

Both Figure 3 and Table 2 show that, despite the perception that the private sector caters to the rich and the public sector to the poor, in reality the private sector is used extensively by the poor.

Who Finances Health Care?

As shown in Figure 4, 42% of health expenditure in Africa is private. Out-of-pocket expenses are an important source of health care financing and a major barrier to universal health coverage, especially among the poor in both urban and rural areas. The poor often have four options when facing illness: i) accessing publicly provided health care services; ii) visiting private providers; iii) visiting traditional healers or untrained health workers/drug peddlers; or iv) deciding not to seek medical care at all. Considering that in many countries pharmaceuticals are sold without a prescription, and quality control and self-medication are common issues, the poor and less privileged are more at risk when opting for self-care.

Figure 4: Sources of Total Health Expenditure in 24 OECD and 10 Eastern & Southern African Countries[vii]



Sources: For OECD: WHO. The World Health Report 2002, Annex 5; and World Bank. World Development Indicators 2002. For Africa: National Health Accounts in Eastern and Southern Africa: a comparative analysis.

Who are the private providers in Africa?

Most policy makers agree that ignoring the private sector's critical role in service delivery amounts to a strategic error. However, private providers are quite diverse and consist of a wide range of institutions, organizations, and individuals providing health services (Table 3). Given this diversity, efforts to engage the private sector have often been poorly documented and have not been rigorously evaluated[viii], there is little agreement, and far less knowledge, regarding strategies to engage the private sector effectively.

Table 3: Private Providers in Africa

	Type of Providers		Type of service provided
	Formal	**Informal**	
For-profit – clients generally cover costs on a fee for service basis	• Physicians, nurses, midwives, and dentists operating private practice • Licensed pharmacies	• Traditional healers • Traditional birth attendants • Drug peddlers	• Mainly personal care
Not-for-profit – costs are generally subsidized by the government or donations	• NGOs • Religiously affiliated hospitals and clinics	• Community health workers	• Personal, as well as public health services

Private providers can be grouped into four broad categories: i) formal, for-profit; ii) formal, not-for-profit; iii) informal, for profit; and iv) informal, not-for profit.

Formal for-Profit Providers

In the latter part of 20th century, most governments in Africa initiated health sector reforms as part of structural adjustment programs to receive credits or grants from the World Bank and International Monetary Fund[ix]. As a necessary condition for the reform, most governments put a freeze on employment of health workers to facilitate a review of the skills mix and number of personnel working in the public health sector and to control recurrent costs. This led to a rapid expansion of the private, for-profit sector as many trained health workers, especially in areas with high population density, joined existing private facilities or started their own practices,. This trend is expected to grow exponentially due to rural to urban migration, and as governments contract private providers to increase coverage of health services in peri-urban and rural areas.

Formal Not-for-Profit Providers

In SSA, the formal, not-for-profit providers of health care consist mainly of non-governmental organizations(NGOs) and religiously affiliated hospitals, clinics, and dispensaries--the majority of which are in the rural areas. It is estimated that NGO health facilities provide 64 percent of the formal health care in Uganda and 56 percent in Zimbabwe[x]. In many countries, these private facilities depend on public sector subsidies for personnel, supplies, and maintenance of infrastructure to some degree. These facilities are often located in underserved areas and they tend to compliment the public sector's efforts to reach the poor. Since these facilities are perceived to provide better quality health care and tend to have staff with religious affiliation, they are likely to expand as governments move from health care providers to stewards of the health sector.

Informal for-Profit Providers

Traditional medicine is an important health care resource in Africa and will continue to play a major role in providing health care for decades to come. It is estimated that up to 80% of Africans rely partly or solely on traditional medical practitioners[xi]. They are by far the largest body of private health care providers. These providers are often more accessible because they live in the community, have credibility, and are using centuries-old traditional remedies. Since some of the traditional healers have been quite successful in treating conditions that have symptoms similar to those of people with AIDS (e.g. skin rashes and diarrhea), people living with AIDS tend to seek their services, sometimes while on antiretroviral therapy. Traditional birth attendants also play a major role in health care delivery especially in areas where women do not have access to antenatal care services or if they do would prefer to deliver at home. Therefore, policy makers must take traditional medicine into account and develop policy instruments to engage traditional health care providers.

Informal Not-for-Profit Providers

Community workers are at the frontline of health promotion and disease prevention in most of Africa. For example, they have been quite successful as community distributors of contraceptives and have played a major role in a number of health education programs including those focusing on the importance of insecticide treated bed nets. The importance of this group is heightened because the war against HIV/AIDS will be fought and won at the community level. They are thus playing a critical role in encouraging people to go for HIV testing, and providing home-based care and follow-up for anti-retroviral therapy to promote adherence.

The Growth of the Private Providers

The public sector reform in many SSA countries in favor of privatization in all sectors has led to a rapid expansion of private sector initiatives in many areas, including the health sector. Increased restrictions in the national budgets and high proportions of qualified health workers working in the private sector, especially the for-profit sector[xii] (Giusti et al 1997, World Bank, 2005), have increased pressure for greater privatization. There has also been growing pressure from donor agencies to promote privatization as a strategy for mobilizing resources and utilizing them efficiently for provision of social services.

The majority of SSA governments can no longer adequately support free medical services as enshrined in their constitutions. In Uganda for example, free medical service has led to inadequate salaries for public health workers, insufficient drug stocks at health facilities, and failure to maintain public health infrastructure[xiii]. Various attempts in the past to rehabilitate public health facilities through the introduction of user fees and through donor support did not yield substantial results in terms of better health care delivery and outcome.

The salary of health workers decreased significantly in the 1980s and 1990s due to inflation and economic mismanagement in countries such as Kenya, Zimbabwe, Malawi, and Zambia and internal strife in Uganda, Congo, the Democratic Republic of Congo and many other countries. These salaries were not adequate for health worker's monthly expenses without supplementation from additional income earned inside or outside the public health facility. As a result, a significant number of public health workers joined the private health sector, either by establishing private health facilities or by joining pre-existing facilities. This led to two major developments in the health sector in a number of countries in SSA:

1. An increase in the number of public health workers doing part-time private work to earn additional income;
2. The establishment of a wide range of private health facilities in urban, peri-urban and rural areas, supplementing government facilities.

Over the past decade, it has become increasingly recognized that when appropriately organized and motivated players from the public and private sectors combine their skills in partnership, they can more effectively solve problems that have not so far been adequately addressed by independent action[xiv]. Thus, PPP are being increasingly encouraged as part of the comprehensive development framework. The need to foster such arrangements is supported by a clear understanding of the public sector's inability to provide public goods entirely on its own in an efficient, effective and equitable manner--primarily because of lack of resources and related management issues. These considerations have necessitated the development of different arrangements, which involve the interfacing of organizations that have the mandate to offer public goods on the one hand, and those that could facilitate this goal on the other.

The health system is likely to look very different in the next 20 years. To date, the growth in the number of private providers has been disorganized, uncoordinated, and policy makers have often lacked a clear strategy for how to integrate the private sector into health policy and practice. However, recognizing that the private health sector is growing rapidly--both in urban and rural areas - some governments are implementing strategies to integrate the private health sector into national programs[v]. In addition, there are a number of positive features of the private health sector: i) facilities are more geographically accessible; ii) open for longer hours; iii) offer a range of often required services -- maternity, postnatal, outpatient and inpatient, laboratory services, etc.; and iv) short waiting lines for examination, laboratory, results and drugs.

Thus, rapid growth in the private sector is occurring in many African countries. Consequently, African policy makers are beginning to embrace private health care providers and are exploring different options of working with providers as an integral means of achieving health sector objectives. It is critical, however, that policy makers are provided with available evidence from SSA, and lessons from developed countries that have integrated private providers into their health care system. Policy makers are confronted with major challenges as they try to identify and implement strategies to mobilize private providers toward achieving universal coverage in Africa.

TYPES OF PUBLIC-PRIVATE PARTNERSHIPS

Many definitions of PPP for health have been put forward. Irrespective of the definition, the underlying principles are the same in that they describe arrangements that innovatively combine different skills and resources from institutions in the public and private sector to address critical health problems. Primarily, there are two types of PPP: global and national.

1. Global Public-Private Partnerships Among International Organizations.

A global PPP between governments, international agencies, corporations, and global initiatives addresses specific diseases or supports national programs. Some of the partnerships have been very effective in almost eradicating or controlling debilitating diseases. The partnerships are usually led by the ministry of health (MOH) with the international partners providing funding and technical assistance. Implementation at the country level is managed by a variety of national and local partners.

Figure 5: Examples of Global Public Private Partnerships

Purpose	Partnership
Product development	International Alliance for Vaccine Initiative, Malaria Vaccine Initiative, Medicine for Malaria Venture, Alliance for Microbicide Development
Improving access to healthcare products	Global Alliance to Eliminate Leprosy, Global Alliance to Eliminate River Blindness, Global Alliance to Eliminate Lymphatic Filariasis, Global Polio Eradication Initiative, Diflucan Partnership Program, International Trachoma Initiative
Global coordination mechanisms	Global Alliance for Vaccines and Immunization, Stop TB, Global Alliance for Improved Nutrition
Strengthening health services	Multilateral Initiative on Malaria, African Comprehensive HIV/AIDS Partnerships
Global Financing	Global Fund to Fight, AIDS, TB, and Malaria
Regulation and quality assurance	Anti-Counterfeit Drug Initiatives

Improving Access to Health Products

The Mectizan Donation Program

This is the oldest and most well known donation program still in existence. It started in 1987 when Merck & Co. took the unprecedented step of donating as much Mectizan as necessary, for as long as necessary, to treat river blindness and bring this public health problem under control. Merck discovered and developed Mectizan and the World Health Organization opined that it was safe for mass distribution. To provide duty exemption, Merck also pays for all shipping and handling to countries with those regulations. The program works closely in each country with the ministry of health, which has the final authority. Mectizan was considered a highly appropriate donation because it was the best available drug in existence, was not commercially available, was easily administered, and used existing infrastructure of the long standing Onchocerciasis program established in 1974. Implementation was aided by many NGOs at the country level and the MOH took the lead in training health workers who trained district workers and distributors of the drug using a cascading model (Meredith S).

Improving Access to Health Products and Capacity Building

The Diflucan Partnership Program

This program began in 2000. Pfizer made a decision to donate one of the most expensive life saving drugs for treating opportunistic infections in people living with advanced HIV infections in the countries hardest hit by HIV/AIDS. Diflucan (fluconazole) is effective in treating two of the most common and deadliest opportunistic infections. Through a partnership with Axios International, the International Dispensary Association and the Interchurch Medical Assistance, Pfizer has donated the drug to 44 countries and paid for shipping and handling to recipient countries. At the country level, the program is implemented in collaboration with MOH and health delivery NGOs. The MOH is responsible for the training of health professionals, coordinates with a number of partners for logistical support to ensure a regular supply of drugs, and the collection of data at various facilities within the country. Through the partnership, Pfizer has committed to building strong partnerships with the public sector and civil society to enhance the capacity of recipient countries and provide life saving medication to those who are in need in Africa, Asia, the Caribbean, and Latin America.

Strengthening Health Services

Botswana Comprehensive HIV/AIDS Partnership

Although valuable diamond and minerals deposits and a lucrative mining industry make Botswana one of Africa's wealthiest countries per capita, it has one of the highest prevalence rates of HIV/AIDS in the world, with about 38% of the 15 to 49 year old population infected with the virus. The government, under the President's leadership, has shown an unusual level of commitment to fight the AIDS epidemic, organizing structures at the national and district level to implement national strategies. Together, the Bill and Melinda Gates Foundation and Merck, have committed $100 million over five years to support the government in a comprehensive and sustainable approach – using the national program as a basis and integrating other programs. The Government of Botswana is leading the program and the overall goal is to improve the national response to HIV/AIDS from prevention, to care and treatment. The Government is working with a number of partners: Harvard AIDS Institute is providing training for health care providers, McKinsey on drug delivery, Merck is donating much of its antiretroviral medicines as is needed over the five years of the program, Boehringer-Ingelheim is donating nevirapine for preventing mother to child transmission of HIV and Pfizer is donating Diflucan.

2. Domestic Public-Private Partnerships with Health Care Providers.

A review of well-performing health systems that have substantial private sector involvement reveals a set of institutionalized policy instruments for dealing with the private sector, as well as capable government officials who are comfortable using the instruments. In many African countries, the public sector is extensively involved in the production of health services, even where the financing of services or other critical stewardship is not being addressed. This structure of intervention in the health sector is

often seen as contributing to access and quality problems in health care delivery[xv]. A detailed description of these instruments is provided below.

CURRENT STRATEGIES TO EXPAND PUBLIC-PRIVATE PARTNERSHIPS

As the private sector gets more attention from governments and development partners, policy makers in SSA countries are confronted with two strategic approaches:

- Harness the existing capacity within the private sector and encourage private providers to expand existing services.
- Shift publicly provided services into private control when this is expected to improve services. This approach is used by governments when there is evidence that the publicly run health services are overextended and should focus efforts on core competencies[xvi, xvii]. This strategy is used extensively in rural South Africa to expand health coverage and improve efficiency and quality of care in rural areas.

As noted above, private service delivery is extensive in most of SSA; accessible and widely distributed geographically. A significant number of poor people in both urban and rural areas are seen by private providers. Policy makers should consider a number of instruments to harness the existing capacity within the private sector: i) regulation, ii) contracting, iii) social franchising, iv) training of private providers, v) provision of information to patients, and v) vouchers.

Regulation

This is an instrument that is used to protect the public by:

- improving the quality of care
- reducing inequality and disparities in quality or access
- holding down costs
- improving technical efficiency

The use of this powerful tool is limited in Africa due to weak enforcement of regulatory control, and the unwillingness of health professionals to enforce regulation against their own membership[xviii]. Regulation has been used extensively in South Africa to reduce inequality and disparities in health care created during the apartheid era.

Contracting

This is an instrument where the public sector purchases services, either clinical or non clinical from a private vendor. This is due to the growing evidence of public sector failures to deliver high quality health care. Many low and middle income countries have inherited publicly funded and provided health services that often operate at relatively low levels of technical efficiency[xix]. Ideas are changing about the management of the public sector stemming from new public management theory which says that private sector mechanisms can help to improve efficiency and equity. This instrument has been used in a number of Africa countries. In Zimbabwe for example, 56% of rural health care is provided by church related hospitals through contracts with the ministry of health[x]. The government procures medicines and provides staff salaries and equipment.

Social Franchising

This is a business model in which a firm (the franchiser), licenses independent businesses (franchisees) to operate under its brand name. During the 1990s in the United States, franchising became the most popular method of expanding commercial retail stores quickly with limited capital risk[xx]. Characterized by locally owned outlets which deliver services according to a standardized model, franchises such as McDonalds, Starbucks, and The Body Shop have become ubiquitous in developed and developing countries[xxi]. Franchising has been used extensively in health service delivery by grouping existing providers under a franchised brand, supported by training, advertising and supplies. In Africa, it has been used to increase coverage for treating sexually transmitted disease in Cameron, HIV counseling and testing in Zambia, and family planning usage in Ethiopia.

Training Private Providers

- In many African countries, continued medical education for doctors is not expected or mandatory. Also, many patients go to pharmacies to purchase their medicines without prescriptions, sometimes from untrained pharmacy staff. Training providers important for improving the quality of private providers and a strategic approach to working with private providers. In Kenya for example, shopkeepers were trained in the proper use of drugs to treat childhood fevers. A study showed a substantial improvement in the use of drugs because of the advice from shopkeepers[xxii]. In Tanzania, this instrument is used to train doctors, nurses and pharmacist to increase coverage for antiretroviral therapy for people living with AIDS.

Provision of Information to Patients

Focused education campaigns have been used to expand or alter demand for goods and services. In Ghana, this instrument has been used to educate the community and empower them to demand social services for orphans and vulnerable children from district administrators[xxiii].

Vouchers

Voucher programs deliver health services by subsidizing the provision of particular services to a target group through the use of a token (voucher) that can be redeemed to purchase all or part of a good or service[xxiv]. This mechanism has been used in Tanzania to target pregnant women and children under five for subsidized insecticide-treated bed nets to protect against malaria.

CHALLENGES TO IMPLEMENTATION

Translating policy into implementation is always a challenge, more so in the context of health sector reform that includes changing the roles of key providers and engaging a diverse private sector. Regardless of the strategy or instrument implemented, countries will have to address the following challenges:

- Lack of agreement on strategies to engage the private sector and conflicting views and objectives among stakeholders

- Lack of familiarity with the private sector due to an historical pattern of segmentation between the public and private sectors
- Lack of evidence on successful PPP to assist policy makers in decision making and replication of successful models
- Limited technical skills among government staff to design, plan, and monitor contracts
- Public employees unwilling to support health sector reform for fear of losing their jobs, resulting in more attention paid to reform content or design than to implementation
- Poorly organized private sector – governments are not able to deal with so many players if they are not organized into one entity
- Lack of consultation between public and private sector--limited forums for consultation
- Vertical programs that put a strain on already overstretched health sector staff and may undermine the functioning of existing national programs.

WAY FORWARD

As noted earlier, most African governments still see their primary responsibility within the health system as delivery of health services or direct provision of medical care. This paper highlights several key issues that need to be addressed in order to achieve effective PPP:

- The majority of the poor currently seek care from the private sector, not the public sector as has been generally assumed. Rising health care costs are driving the poor further into poverty.
- The health system, as it is currently structured, is weak and cannot cope with emerging epidemics and the increasing burden of chronic diseases.
- Population is expected to grow significantly and will continue to put a strain on existing public facilities, increasing the sense of urgency for service expansion.
- There are significant opportunities in the private sector to expand service provision in both urban and rural areas, and underserved communities.
- The private sector providers need to coordinate their efforts in order to better engage the public sector.

Few countries in Africa have realized that the main role of the public sector is "stewardship" and have begun to develop relevant policies. Thus, capacity building of both the public and private sector is essential to the success of PPP, and should include:

- Implementing appropriate policy instruments to achieve common health sector objectives.
- Creating an environment that fosters public and private sector dialogue at global and national levels. This environment would also facilitate context-specific partnerships, engaging such partners as such the faith-based sector, which is the largest service provider in SSA.
- Documenting the benefits and challenges of PPP to continue to inform both implementation and policy decisions.

Over the next twenty years, there is likely to be a transition from a Ministry of Health charged with managing hospitals and health centers, and staffed primarily by clinicians, nurses, pharmacists to one charged with overseeing the broader health system. In this new role, the ministries of health will be tasked with ensuring equitable and sustainable financing, regulation, and, staffing, both in the public and private sector. Indeed, the ministries of health are gradually starting to separate service provision from their responsibilities for policy making, planning, financing, monitoring, regulating and informing the public on health matters.

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