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Strengthening Public Private Partnerships for More and Better Health Outcomes in Ethiopia: Expert Reviews and Case Studies



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Purpose and organization of the report

The main purpose of this review paper is to contribute to developing better policies and programs that would enable Public-Private Partnerships (PPPs) to contribute to better outcomes by understanding existing structures, experiences, and practices both globally and in Ethiopia.

The results section of this report has two main sections: one of the sections focuses on findings from the identified “PPP case studies,” and the second section summarizes the findings from key informant interviews. More detailed information on the “PPP case studies” and review of global experience on PPP in health are attached as Annexes.

This is a preliminary report to initiate discussion and planning of concrete activities on PPP within the Ministry of Health (MOH), federal agencies, regions, private providers and their associations for better partnership between government and the private sector moving forward. The report will be updated as more data is available.

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List of Acronyms

ART:	Antiretroviral Therapy
DOTS:	Directly Observed Therapy Short course
FMHACA:	Food, Medicine and Health Care Administration and Control Authority
FMOH:	Federal Ministry of Health
FP:	Family Planning
GoE:	Government of Ethiopia
HEPCAPS:	Developing the Long-Term Capability of Ethiopia's Health Extension Program Platform
HIV:	Human Immunodeficiency Virus
ICL:	International Clinical Laboratories
M&E:	Monitoring and Evaluation
MoFED:	Ministry of Finance and Economic Development
MoH:	Ministry of Health
OIA:	Overseas Infrastructure Alliance
PFSA:	Pharmaceuticals Fund and Supplies Agency
PICT:	Provider Initiated Counseling and Testing
PMTCT:	Prevention of Mother to Child Transmission of HIV
PPM DOTS:	Public-Private Mix for Directly Observed Therapy Short course
PPP:	Public-Private Partnership
RHB:	Regional Health Bureau
SNNP:	Southern Nations, Nationalities and Peoples
TB:	Tuberculosis
VMC:	Vision Maternity Care

I. Executive Summary

According to the World Bank Group, public-private partnership (PPP) is defined as “a long term contract between a private party and a government agency, for providing a public asset or service, in which the private party bears significant risk and management responsibility” (World Bank Institute, 2012). PPP in health is a relatively newly emerging practice. Contracting, leasing, franchising, and social marketing serve as examples of private sector contributions in health that have been practiced globally. Contracting with the private sector to deliver services funded by public money has been undertaken in an increasing number of countries, and has included non-clinical (e.g. catering, security, laundry) as well as clinical service provision. Experiences in contracting with NGOs, particularly mission and religious-based hospitals, have been increasingly utilized in African countries over the last decade. Although rare in developing countries, PPPs have been utilized to provide health facilities, including through lease, concession, and integrative arrangements. Models of such hospital PPPs have been undertaken in Philippines, Brazil, India, and Lesotho. Widely utilized across the developing world, social marketing has made contributions in increasing access to and coverage of targeted health products (e.g. contraceptives). While franchising has been applied in various contexts, successful cases tend to be small, with lack of cost-effectiveness and equity posing challenges for scale up.

Leveraging non-state resources through partnership with the private sector serves as a viable opportunity for the Government of Ethiopia to narrow the gaps caused by resource constraints as well as improve access to quality health services. Taking this into account, Ethiopia’s Ministry of Health proposed conducting a review of existing PPP practices in health both globally and in Ethiopia to better understand existing structures, experiences, and practices and to use the review findings to design policies that will help strengthen PPPs for health in Ethiopia in the future.

Sixteen “PPP case studies”; organizations that have some level of experience implementing PPP interventions for health, were visited, and a total of thirty-five key informant interviews were conducted with representatives from the Federal Ministry of Health, other federal health agencies (FMHACA and PFSA), Ministry of Finance and Economic Development, regional health bureaus, private providers, service users, and private providers associations. Information from the key informant interviews and identified “PPP case studies” were synthesized, compiled, and reported by the team of experts from the Federal Ministry of Health, Resource Mobilization Directorate, and HEPCAPS2 project from June to November, 2014.

With regard to the “PPP case studies,” the majority were contracting-like arrangements between government and private non-profit or private for-profit organizations, summarized as follows.

Contracting partnerships between government and private for profit and nonprofit organizations for the provision of comprehensive primary health care services for the rural population was found to be promising in reaching needy populations with quality health services. In particular, partnerships with health institutions operated under the Ethiopian Catholic Church Development Office, including; Dubo St. Mary Catholic Primary Hospital, St. Luke Catholic Primary Hospital and School of Nursing, and Wasera Health Center, are good examples, which have been detailed under their respective case study sections.

Contracting partnerships between government and private for-profit health institutions for the provision of select health care services, specifically focusing on human immunodeficiency virus (HIV) / Antiretroviral therapy (ART) and Tuberculosis (TB), are contributing their share in expanding access to treatment and care services. Achievements of Bilal Primary Hospital and Jimma Higher Clinic illustrate the value of these partnerships.

Contracting partnerships with private-for-profit institutions for the provision of non-clinical services (e.g. Mizan Aman Hospital’s outsourcing of daily cash collection and patient registration) as well as clinical diagnostic services (Debre Berhan hospital outsourcing of advanced clinical laboratory services), provide promising examples of outsourcing practices by public hospitals beyond the usually outsourced nonclinical services like laundry and security.

Infrastructure-based hospital PPP arrangements, seen in the establishment of specialized medical care services like dialysis (Meles Zenawi Dialysis Center in Mekelle) and eye care (OIC eye care center at Zewditu Memorial Hospital in Addis Ababa) within public hospitals were found to create opportunity for affordable and conveniently located service. The OIA Eye Care Center at Zewditu Memorial Hospital is serving average of 80 - 100 eye patients daily including 10 to 15 minor and major eye surgeries every day being the second advanced eye care facility within a public hospital in the country. The Dialysis Center at Mekelle University Hospital is serving patients in the nearby who would otherwise have been forced to travel more than 700 kilometers all the way to Addis Ababa to get the service.

Social marketing (of family planning and child health commodities by DKT Ethiopia) and franchising (Marie Stopes “Blue-

Star” clinic model for the provision of family planning and abortion care) are contributing their share in increasing access to sexual and reproductive health services. In the year 2013 alone, DKT Ethiopia in partnership with private providers distributed more than 66 million condoms, 4.1 million cycles of oral contraceptives, 2.7 million injectable contraceptives, 1.7 million emergency contraceptive pills, 122,455 Implants, and 195,000 Intrauterine Contraceptive Devices (IUCDs) that translates into 2,442,890 Couple Years Protection (CYPs). On the other hand, in 2013 alone through “BlueStar” Franchising network total of 240,102 Couple Year Protections (CYP) have been generated.

Key informants provided the following recommendations to strengthen partnerships between government and private for-profit and private for-nonprofit sector in health service provision.

- Organize regular consultations between government and private providers and implement effective and agreed up-on mechanisms to strengthen PPP,
- Establish a unit dedicated to coordinating PPP from MoH and regional health bureau (RHB) to woreda health office levels,
- Develop guidelines, standard operating procedures, and tools to standardize implementation of PPPs,
- Support the development of legal framework to provide PPP legal coverage, and
- Build trusting, supportive, and inclusive relationship between government and private providers.

Summary of “PPP case studies” and recommendations

I. Contracting for service delivery

Contracting is a mechanism by which public finances are utilized to procure health care services for public consumers, specified in written and agreed documentation. Generally, contracts exist in the context of delivering specified services (service contracts), or as a means of managing a range of services (management contracts). Under a service contract, the government pays a private entity to perform specific tasks, such as routine laboratory services, or specialized services like radiology, which can be provided within the hospital (contracted in) or operate outside of public facilities (contracted out) (Marek, Yamamoto, Ruster, 2003). Under a management contract, government pays a private entity to manage public facilities, which can include private authority over procurement of labor, supplies, and equipment. Generally this is found to improve access to and quality of health care.

Ideally in contracting government pays private providers to deliver a specific set of services under agreed upon arrangements and procedures. During the review of case studies in Ethiopia, although there are contractual agreements between government and private providers, government’s input is limited to providing technical support and selected drugs and supplies for treatment of HIV/AIDS, TB and Malaria and in some cases vaccines and contraceptive commodities. The only exception is St. Luke Catholic Hospital, which started getting about a quarter of their budget from government.

With regard to management contracting, the only example from the Ethiopia case studies is outsourcing of the management of Gefersa Mental Health Rehabilitation center to the Ethiopian Catholic Church. The table below summarizes local Ethiopian experiences with contracting for provision of services, and recommendations based on these experiences.

Local experience: Contracting with private non-profits	Recommendations
<ul style="list-style-type: none"> • Dubo St. Mary Catholic Primary Hospital provides comprehensive primary hospital level health services except modern family planning to rural population in SNNP region through out-of-pocket fee for service. As there is no other public hospital in the district, St. Mary's serves as the referral hospital for nearby public health centers and health posts, in addition to providing services to the general population. • Wasera Catholic Health Center provides preventive, promotive and basic curative care to the general rural population in SNNP region in addition to serving as the referral health center to nearby health posts. Service is provided based on out-of-pocket fee. • St. Luke Catholic Primary Hospital and School of Nursing provides comprehensive primary hospital level services to the general population in Oromia region in addition to serving as the referral hospital for nearby public health centers and health posts. • The management of Gefersa Mental Health and Rehabilitation Center was transferred to the Catholic Church. The church has taken responsibility of managing and operating the rehabilitation center while government allocates budget annually. 	<p>Designing a standard system that will be used to govern and support health institutions run by nonprofit faith based organizations will help the country utilize the opportunity better. These institutions are mainly run by fees collected from patients and external donors. Government could finance them through contractual agreements to provide defined sets of activities. These facilities need to be engaged in public initiatives designed and implemented to improve service provision and quality at health facilities. Reporting, staffing, supply, review and follow-up are potential areas of collaboration between the government and health institutions run by nonprofit organizations. Lessons in contracting with private nonprofits could be learned from countries like Ghana, Uganda, and others that have experience managing similar health facilities for the benefit of the public.</p>

Local experience: Contracting with private for-profits	Recommendations
<ul style="list-style-type: none"> Bilal Primary Hospital has been contracted by government to provide ART, PMTCT, FP, Malaria and TB related services for patients in Dire Dawa city administration. Patients pay for medical examination and selected laboratory services, while drugs are provided free of charge (as long as they are received from government for distribution free of charge). Gizaw Higher Clinic provides diagnosis and treatment services for TB and Malaria patients, and family planning services to patients in Shashemene, Oromia region, based on contracts from the regional health bureau. Jimma Higher Clinic provides diagnosis and treatment services for TB patients in Jimma town of Oromia region based on the national Public Private Mix DOTS guideline. 	<p>The engagement of private for-profit health institutions is currently expanding access to HIV/AIDS, TB, and Malaria diagnosis and treatment services and the arrangement needs to be institutionalized within the public health care system. There is a need for standard operating procedure (SOP) to guide these practices. The type, depth, and extent of partnerships need to be explicit to avoid confusion. The role and responsibilities, accountability, reporting relationships, service fees, and other operational issues need to be clarified. If these partnerships are guided by SOPs the mechanism will help to reduce the burden on public facilities by providing access to quality services to people who opt to seek these services from private providers.</p>
Local experience: Contracting of selected services to private for-profits by public hospitals	Recommendations
<ul style="list-style-type: none"> Mizan Aman public hospital in SNNP Region outsources daily fee collection, improving efficiency by reducing waiting time for patients and facilitating smooth financial transaction. Debre Berhan Hospital in Amhara Region outsources selected laboratory services to a private laboratory firm, reducing inconvenience for patients who would have otherwise travelled a long distance to get the service. 	<p>Many public hospitals have started outsourcing nonclinical services including; security, laundry, and cafeteria services. The experience of Mizan Aman and Debre Birhan public hospitals could be explored further to provide opportunities to public hospitals to outsource more nonclinical and clinical services as needed to facilitate the delivery of integrated services within the hospital's premises, reducing inconvenience for service users and providers.</p>

II. Contracting for Infrastructure

Another form of public private contracting is for health infrastructure (e.g. facilities). These contracts can take on many forms, including lease contracts, build-operate-transfer (BOT) projects, concession agreements, and divestitures.

In a **lease contract**, a company is given the right to operate and maintain a public utility/facility, but investment remains the responsibility of the public. Lease contracts have been found to be particularly successful in improving equity or increasing services to the poor. For example, in Romania, leasing facilities to private providers for radiology and laboratory service led to lower costs, higher quality services.

With a **concession** agreement, which is similar to a lease contract but differs in the rights of the operator and its remuneration, a private operator is given the right to operate within the government's jurisdiction (e.g. health facility), subject to certain conditions. The operator is generally responsible for the operation and maintenance of the facility, as well as financing and managing all capital investments. The operator pays the government a fee (fixed sum or percentage of revenue) for use of the facility, and ownership remains in the hands of government.

A **Build-Operate-Transfer (BOT) project**, a variation of a concession agreement, is undertaken to build a new facility. Under this arrangement, a private operator is granted access to public land or property, on which the private operator is responsible for designing, financing, building and operating a building, and then transferring ownership to the government at the end of the specified contract term (e.g. 50 years).

Divestitures encompass the selling of publicly owned health care facilities to private entities, with indefinite transfer of ownership to the private sector.

Concession, BOT, and Divestitures are not widely practiced in Ethiopia. Some form of lease contracts are practiced on a small scale. One of the reasons these partnerships are not practiced could be due to lack of a clear modality and procedures that outlines the mechanism. Designing a clear implementation modality with incentive packages and advocacy work to introduce the package would attract private investors to be engaged in these investment opportunities for the construction and operation of facilities.

Local experience: Contracting Health Infrastructure	Recommendation
<ul style="list-style-type: none"> • Mekelle University Hospital: Meles Zenawi Memorial Dialysis Center was established within the Mekelle University Hospital by private investors to provide dialysis services and provide opportunities for teaching medical students. • Zewditu Memorial Hospital: OIA (Overseas Infrastructure Alliance) Eye Care Center was built by private investors within the premises of Zewditu Memorial Hospital to provide specialized eye care services. • Bahir Dar Health Center: Vision Maternity Care was established as part of the health center by a private non-profit to provide comprehensive quality maternal health services including cesarean section delivery. 	<p>There is a need to develop standard implementation guidelines for PPP's contracting health infrastructure, as these partnerships are just emerging. Clarifying roles and responsibilities, transfer and ownerships, accountability, and other operational procedures will be key. The opportunity needs to be open to any one who will be interested in similar investment opportunities and to other facilities all over the country as needed.</p> <p>Conducting a detailed assessment on the feasibility of such models, particularly the OIC Eye care center at Zewditu Memorial Hospital, will be beneficial.</p>

III) Social marketing: Social marketing PPPs look to address supply-side constraints of health systems, such as availability of affordable and quality-assured health goods, by recruiting the private sector in commercial distribution. This mechanism can improve accessibility and affordability of public health products for populations that currently are unable to access or afford these products. Social marketing programs can also be utilized to reach specific target groups that are underserved or neglected by other (public health) delivery mechanisms.

Social marketing in the Ethiopian health sector is usually led by nongovernmental organizations distributing health products like condoms, ORS, and contraceptives to private providers at subsidized cost to be sold at a reduced price, with the main aim of reaching the population in need using as many outlets as possible.

Local Experience: Social Marketing for Health	Recommendations
<p>DKT Ethiopia is an international nongovernmental organization that started operations in Ethiopia in 1990 with the introduction of Hiwot Trust condoms. The organization now socially markets more than 13 different types of health products, mainly sexual and reproductive health and child health commodities. DKT Ethiopia has established partnerships with more than 11,000 private pharmacies and clinics all over the country. In this partnership, DKT delivers selected health commodities to private pharmacies and clinics so that they sell it to the community at a highly discounted price.</p>	<p>The distribution of condoms, contraceptive commodities and other essential products through social marketing has been quite a success, but it is highly reliant on donor funding and DKT's support. The way it is functioning currently is not sustainable if DKT's support is no longer available. Mechanisms have to be designed to make sure this could be continued through the engagement of government, civil society and private sectors utilizing domestic resources.</p>

IV) Social franchises: Social franchises are networks of private health providers that use commercial franchising methods to achieve social rather than financial goals. Building upon existing expertise, social franchises organize multiple, existing, private providers into contractually obligated networks. These franchisees are then trained and supported to provide new, or improved, services.

Social franchising is not a well-developed practice in Ethiopia, though some efforts have been made recently to network private health facilities under the Blue star brand to provide a standardized package of sexual and reproductive health services.

Local Experience: Social Franchising	Recommendations
<p>Blue Star Social Franchising has been initiated by Marie Stopes International to utilize commercial-sector approaches to increase access, method choice, and service quality of family planning services, working through networks of private providers that deliver services under a common “Blue Star” brand, in accordance with franchise standards. Launched in 2008, the goal of the program is to expand and standardize sexual and reproductive health services in the private health sector, in order to improve access to quality reproductive health care services to Ethiopians.</p>	<p>Bluestar’s social franchising is a new practice that needs to be looked at carefully to see its potential for the future. The initiative is currently led by MSI with funding from external sources. Conducting further assessment to understand its benefits and feasible implementation modality including sustainability will be key.</p>

V) Voucher and Insurance Scheme: Vouchers and insurance serve as the main demand-side initiatives used to engage private sector suppliers in the provision of accessible and high-quality care. Voucher schemes work to subsidize or exempt payment of specified services or products for a targeted group (e.g. poor, infants, pregnant women).

As most primary care services in Ethiopia are provided free of charge in public health facilities, particularly those related to maternal and child health and communicable diseases like HIV/AIDS, TB, and Malaria, voucher systems have not be useful for Ethiopia, unlike other countries. Ethiopia is currently developing both social health insurance, as well as community-based health insurance, both of which are anticipated to increase access to and utilization of primary health care services.

II. Background and Review of Global Landscape

The private health sector has grown rapidly over the past decade with the number of private health facilities in the country expanding, particularly in urban areas. In light of this, leveraging non-state resources through partnership with the private sector serves as a viable opportunity for the Government of Ethiopia to further improve access to quality health services.

A reference guide published by the World Bank Institute defines PPP as “a long-term contract between a private party and a government agency, for providing a public asset or service, in which the private party bears significant risk and management responsibility” (World Bank, 2012). Combining the strengths of private actors, such as technical knowledge and skills, managerial efficiency, entrepreneurial innovation, with the strengths of the public sector, including social responsibility, local knowledge, social justice and public accountability through effective public-private partnerships will foster the delivery of high quality health services (Roehrich, Lewis, George 2014).

A range of PPP options exists for governments seeking to mobilize private resources to achieve public health objectives. These options vary widely in practice and are based on separation of risks, responsibilities, and ownership between the public and private sector (Marek, Yamamoto, Ruster, 2003). Financing can come from either the private or the public sector or a combination of both. This section will provide a review of global PPP experiences in the health sector, with particular focus on contracting, infrastructure (e.g. hospital) PPPs, social marketing, franchising, and voucher and insurance schemes.

1. Contracting for service delivery

Contracting with the private sector serves as a mechanism by which public finances are utilized to procure health care services for public consumers, specified in written and agreed upon documentation (IHSD, 2004). These contracts also provide a quantified specification of health services outputs and quality standards expected from financial inputs (England, 2000).

Generally, contracts exist in the context of delivering specified services (service contracts) or as a means of managing a range of services (management contracts). Under a service contract, the government pays a private entity to perform specific tasks, such as routine laboratory services, or specialized services like radiology, which can be provided within the public hospital (contract in) or operate outside of public facilities (contract out) (Marek, Yamamoto, Ruster, 2003). Under a management contract, government pays a private entity to manage public facilities, which can include private authority over procurement of labor, supplies, and equipment. The World Bank's Private Participation in Public Services Group distinguishes management contracts, where the public sector makes human resource employment decisions (contract in model) from those contracts where the private contractor has the responsibility of making these employment decisions (contract out model) (Marek, Yamamoto, Ruster, 2003).

Contracting has been used in an increasing number of countries as a means of improving the performance of health systems ([See Annex III, Table 3.2 for country contracting examples](#)).

Although forms of contracting have been in place in a lot of places, both formally and informally, proper evaluation of these experiences is rather limited, particularly as it relates to serving the poor (England 2004). Various reviews have examined the evidence base behind the effectiveness and impact of contracting out services to private sector providers (Mills and Bloomberg, 1998; England, 2004; Loevinsohn & Harding, 2005; Liu, Hotchkiss & Boss, 2008).

General findings from these reviews are presented below:

- Access – Contracting was generally found to be effective in improving access to health care services
- Equity – Although findings are limited, contracting has the potential to improve equity in access to primary health care for the poor (Liu, Hotchkiss, & Bose, 2008)
- Quality – In general, contracting appears to improve quality of care, but comparison to public provision is not possible as quality has been undefined or inconsistently defined across different projects. When developing a contracting project with the objective of improving quality, implementers and stakeholders must work to operationalize quality through inclusion of quality indicators within monitoring and evaluation (M&E) framework (Liu et al., 2008).

Challenges

Some of the challenges of contracting are:

- *Government capacity* - Often governments that lack the capacity to provide services also often lack the capacity to fulfill contractual obligations. Donor-sponsorship is often necessary to get the initial outsourcing off the ground and to finance the development of expertise in contracting (IHSD 2004). Governments accustomed to top-down bureaucratic governance may also lack skills to properly write and administer contracts.
- *Politically difficult to out-source services traditionally provided by the public sector* - Political buy-in and political will is essential in the implementation of contracting agreements. It is possible that public sector staff may see the contracting scheme as heightening shortage of funds for their own salaries or for public health commodities, which may create tensions between stakeholders (IHSD 2004).
- *Insufficient competition may compromise the contract bidding process and implementation of project* - A lack of suitable providers to contract with may compromise the integrity of the bidding process. Potential monopoly situations can be tackled by sub-dividing contracts into smaller parcels, although this may increase transaction costs (Smith, Brugha, Zwi 2001).
- *Providers could be inflexible* - Providers having flexible cost structures is what permits program efficiency gains. Thus, it is important that providers not have rigid cost structures.

Implementation Considerations

Successful contracting requires the followings to be in place:

- Payment system should be carefully analyzed and chosen for particular context.
- The choice of service provider needs careful consideration.
- It is also important to consider how the responsiveness and acceptability of private providers may change with increase in demand for services (e.g. increased volume, shorter consultation times, longer waiting times, change in attitude of staff and reduction of general attractiveness of facilities).
- The agency responsible for contracting service providers should have the technical knowledge, skills and incentives to underscore the health needs and priorities of the population and contract a suitable provider. This agency must also work to closely monitor performance.
- Quality should be operationally defined and quality-associated indicators well developed.
- If the objective of contracting entails targeting of the poor, there must be a mechanism for identifying these populations, so they may be reached.
- Linking payment or some portion of it to key performance indicators can improve overall performance (Liu et al., 2008).

2. Infrastructure (e.g. hospital) PPPs

Public-private partnerships for developing infrastructures, such as hospitals and health centers, have been undertaken in low and middle-income countries, as these PPPs work to address the failure of the public sector's capital investment capacity (IHSD, 2004). These can take on many forms, including lease contracts, build-operate-transfer (BOT) projects, concession agreements, and divestitures.

Findings

Lease contracts have been found to be particularly successful in improving equity or increasing services to the poor. In Romania, leasing of radiology and laboratory service led to lower costs, higher quality services and a full transfer of financial and demand risk to private providers, including the funding and procurement of new equipment (Marke, Yamamoto, Ruster, 2003). The National Kidney Transplant Institute (NKTI) Hemodialysis Center in Manila Philippines entered a long-term lease agreement with a private provider, resulting in increased numbers of people being treated, with costs seen to be more affordable and overall user satisfaction increasing (CHMI, 2014).

Concession agreements have been found to be effective in various settings as well. For example, the Hospital do Suburbio (HS) concession agreement in Bahia Brazil has been successful in increasing access to healthcare services and has created jobs for health care personnel (IFC, 2011; IFC, 2013). The state of Andhra Pradesh in India utilized a build-operate-transfer (BOT) PPP, a variation of concession contracts, to improve and increase access to dialysis services to its poorest population (UNECE, WHO, ADB, 2012).

Integrative models, which include not only private-sector supply of infrastructure, but also provision of clinical services, have been undertaken in various OECD countries. Most notably, the La Ribera Hospital in Alzira, Spain was successful in improving access, particularly to those services previously not available to patients (e.g. radiology, hemodialysis) (Acerete, Stafford, Stapleton, 2011). An attempt in Victoria, Australia on the other hand failed due to the private operator's limited experience in public service delivery and the underestimation of project cost by implementers (IPA, 2013). Serving as the first in Africa, Lesotho adopted an integrated hospital PPP model, results of which show that access and efficiency have been achieved, with services reaching populations who previously did not have access to quality care (UNECE, WHO, ADB, 2012).

Challenges

Affordability serves as a large challenge in infrastructure-based PPPs in health. Large and ongoing payments from the government are often required. Additionally, operating a hospital or other medical facilities is complex with ongoing expenses. As these projects likely face financial limitations, it is important to assess the government's funding capacity early on. One challenge that has also been noted is that many of the infrastructure-based PPPs in health under International Finance Commission (IFC) support have had very little benefit to the poor. Needing to make sufficient returns to repay loans, health projects financed by the IFC generally target the middle class, which may have little effect on increasing health access to poor populations.

Implementation Considerations

Government commitment to the project and the financial obligations required is crucial. Institutional capacity, availability of capital, and proper execution drive the success of the projects, and government must play a key role in fostering an environment for this success to occur. Sizing and scoping based on financial viability and key priorities will reduce the chances of a failed project (e.g. construction completed, but no funding for hospital operation).

A transparent pre-bid process is essential to carefully determine value for money and risk transfer (IPA, 2013). This process can also be productive in choosing a private operator with extensive experience in public service delivery. The help of international development agencies, such as the IFC, can work to adopting a facilitating role between the private sector and governments.

Additionally, utilizing this model to provide community clinics and district hospitals could serve as one way to target the poor. User fees could also potentially offset costs, with subsidies from donors or low cost development bank loans (IHSD, 2004).

3. Social Marketing

Broadly, two overarching rationales exist for employing social marketing as it relates to increasing coverage:

This mechanism can improve accessibility and affordability of public health products for populations that currently are unable to access or afford these products;

Social marketing programs can also be utilized to reach specific target groups that are underserved or neglected by other (public health) delivery mechanisms (e.g. commercial sex workers) (Smith, Bruha, Zwi 2001).

Findings

Social marketing serves as one of the few private sector interventions with public purpose that have been scaled-up globally, as many cases have demonstrated effectiveness in important health program areas. Social marketing programs have undoubtedly produced great increases in access and coverage of targeted products. For example, reports find that in 2001, over 1.3 billion condoms, 105 million oral contraceptive pills and 8.7 million injectable contraceptives were distributed worldwide (IHSD 2004). In the context of impact on health status, social marketing was found to produce measured health impact in a variety of diseases, such as malaria and onchocerciasis programs.

While evidence has shown that social marketing is effective in increasing product use, having an impact on health status, and increasing access to public health goods, equity benefits may be limited. This is particularly the case for the very poor, who may still need to be reached through public sector supply mechanisms.

Challenges

- Subsidized products may not be directed to those in need: Often social marketing programs procure and import high quality products, standards of which may preclude local production (e.g. condoms). In this way, this mechanism may directly subsidize wealthier groups who could otherwise afford unsubsidized products, which would be an inefficient use of resources.
- The very poor may not be reached through this mechanism: Despite products being subsidized, the cost might still be more than what the very poor could afford.
- Crowding out could become a problem: Increased availability of subsidized public goods may “crowd out” unsubsidized brands and prevent new market entrants, which the intervention is meant to encourage. Additionally, subsidized products may displace demand for any existing unsubsidized commercial products, leading to reduced market share of unsubsidized products and resulting in inefficient use of the public subsidy (IHSD 2004).
- Weakness in distribution systems must be addressed: Constraints such as wholesale coordination, poor access to credit by retailer, low retail margins, dangers of leakage and lack of product, transport and storage facilities should be addressed prior to implementing social marketing programs.

Implementation Considerations

For social marketing to work well, the followings need to be considered:

- Good knowledge of consumer demand is needed to design successful social marketing programs. Products may need to be positioned and marketed differently to be successful and distribution may need to be accompanied by appropriate communications and promotion strategies.
- Strong M&E frameworks to monitoring the economic status of purchasers could more clearly identify who is benefiting from the subsidy and enable policy makers to adjust accordingly.
- Objectives must be clearly defined and target groups agreed upon among decision makers. Specific definitions of target groups and program objectives should be clarified and agreed amongst stakeholders during the project design. Heavy subsidization will be necessary to target the very poor.
- A clear understanding of the existing market is essential when designing a social marketing program so as to minimize the possibility of crowding out (Smith, Bruha, Zwi 2001).
- Pricing of social marketing products must be carefully assessed. Negative impacts of pricing such

socially marketed products close to commercial sector prices have been reported¹.

- A manufacturing model of social marketing may not be appropriate in all contexts. Local manufacturing may be more viable where products are simple to manufacture, economies of scale could be achieved at low volumes and where local business and investment environment is favorable (IHSD, 2004).²
- Addressing potential poor distribution systems is essential for success. Contracting or designing specific programs for wholesale and distribution functions may be necessary to address poor distribution systems (IHSD 2004).

4. Franchising

Social franchises are networks of private health providers that use commercial franchising methods to achieve social rather than financial goals. Building upon existing expertise, social franchises organize multiple, existing, private providers into contractually obligated networks. These franchisees are then trained and supported to provide new, or improved, services in addition to their normal activities. Social franchising focuses on cost effectiveness, equity, health impact, quality, and health market expansion (<http://globalhealthsciences.ucsf.edu>).

Social franchising employs the techniques of commercial franchising to enable wider access and better quality of socially desirable services. Franchising typically emphasizes standardization of products, processes, and pricing; common branding and collaborative marketing; and rigorous supervision of quality standards. In some models, private providers may voluntarily join franchising schemes and even pay for the opportunities provided by participation.

Findings

Studies have examined the impact of social franchising schemes. In general their findings can be summarized as follows:

- Franchising schemes were found to expand access to services, increasing both client and product volume, with benefits experienced by both poor and wealthy households alike (Stephenson et al. 2004; Berk, Adhvaryu, 2012). For example, established in the year 2000 by Pathfinder International as franchiser under “BiruhTesda” brand, a network of 154 private clinics helped to expand access to contraceptives in Ethiopia (Barnes et al., 2008).
- Cost-effectiveness and equity serve as general challenges faced by franchising models relative to other modes of health care delivery (Beyeler et al., 2013).
- Health impact findings are varied, with some studies reporting franchises as outperforming other models of health care, while others found franchises to have the same outcomes (Beyeler et al., 2013).
- Systematic examination and documentation, through thorough monitoring mechanisms is necessary to improve impact findings of this PPP model (Beyeler et al., 2013).

Challenges

While commercial franchising has been applied in many contexts, the highly technical and complex nature of health care provision poses several challenges for franchising in the health sector as described below.

- Unlikely to reach the poor: Franchising may not serve as a viable model for really poor rural areas, unless some sort of exemption for this group is built into the intervention (e.g. subsidy).
- Monitoring is difficult and costly: Constant monitoring and ensuring of quality standards within the franchise is

¹For example, in Nigeria, the socially marketed oral contraceptive brand had 22% of the market of the highest income group and 14% of the lowest. In other countries, such as Indonesia and the Philippines, evidence has shown that where substantially subsidized products are provided, domestic manufacturers or domestic importers are unable to compete, even with added technical support (IHSD 2004).

²ITN manufacturing in Tanzania and hormonal contraceptive manufacturing in Pakistan stand as viable examples of successful manufacturing models (IHSD 2004). Generally, a manufacturing model of social marketing may be more appropriate to middle income countries with more mature markets (IHSD 2004).

imperative, which can be costly and difficult.

Franchising is resource intensive: Sufficient start-up capital and resources are needed for franchising model implementation, as the process involves establishment of a brand, brand maintenance, monitoring of compliance to quality standards, as well as training, record keeping and data reporting on the part of the private sector providers (Ruster, Yamamoto, Rogo 2003).

Lack of evidence on sustainability: The ability of this strategy to sustain itself once external funding ceases has not been assessed, but it may be difficult for social franchises which focus on low income populations or low cost services to be fully independent financially.

Availability of qualified franchisors: Identifying a franchisor able to enforce a franchise contract and impose sanctions of removal from network may be difficult. Additionally, there may be a limited number of private sector providers who qualify for accreditation as franchisor (Ruster, Yamamoto, Rogo 2003).

Implementation Considerations

To reduce potential risk, franchise operations can utilize several strategies including the followings (IHSD, 2004):

- Diversify their sources of funding,
- Extend the range of products,
- Grow additional units in new locations,
- Require franchisees to pay an initial franchise fee or a non-returnable deposit,
- Charge a 'royalty fee' or 'management fee' on gross sales, and
- Allow successful franchisees to have additional licenses for new geographical areas (IHSD, 2004).

Additionally, several features are necessary to support social franchising schemes. These include: access to capital, institutions to uphold contract law, legal protection for brands, and laws that support the franchisors right to terminate a franchisee due to inability to meet well specified performance criteria (IHSD, 2004). The government and public sector must have the capacity to facilitate, regulate, fund, (if necessary) and coordinate policy related to these operations so as to ensure an enabling environment for social franchising schemes to be implemented.

5.Voucher and Insurance Scheme

Vouchers and insurance serve as the main demand side initiatives used to engage private sector suppliers in the provision of accessible and high-quality care. Voucher schemes work to subsidize or exempt payment of specified services or products for a targeted group (e.g. poor, infants, pregnant women). While the priority target group is exempted from paying service fees when visiting facility, the provider is later reimbursed for the cost of the care supplied (by the government or other purchaser).

Findings

Voucher schemes are still in beginning stages in the developing world, with scaled up program examples remaining fairly small. Maternal and Child Health (MCH) vouchers for low-income women in Yunnan China and Sexually Transmitted Infection (STI) treatment vouchers for sex workers in Nicaragua found positive effects on behavior, and a reduction in STI rates in the case of Nicaragua (IHSD, 2004; Borghi, J. et al. 2005). Reproductive and child health care voucher subsidy in Kokata, India worked to increase demand for health services, while insecticide treated net (ITN) voucher subsidy for low-income women in Tanzania found high redemption rates (97% of 8,000 vouchers distributed were used to purchase nets), but low awareness and greater utilization of vouchers among well off households (IHSD, 2004). Most notable form of voucher schemes is the PROGRESA model in Mexico, where voucher schemes have shown positive effects on increasing utilization of services and improving various measures of wellness, including self-reported illness and fitness levels (Gerler, 2000). This positive impact was concentrated in the poorest groups (Coady, 2000). PROGRESA remains one of the few large-scale schemes in the developing world that has been well evaluated (IHSD, 2004).

Challenges

- Service delivery capacity, which is accessible and of good quality must be available for vouchers to be effective. Vouchers can help create supply of services though.
- Private sector providers may have perverse incentive to report ghost patients as a means of maximizing their income.
- Providing free or subsidized services may not guarantee use, as other demand side factors, such as transport costs, can reduce use of voucher.
- Management costs may be high, which raise questions about long-term sustainability and scaling up of projects to the national level (IHSD, 2004).

Implementation Considerations

- Consumer perceptions of costs and benefits should be taken into account through consultation to ensure demand and acceptability.
- Targeted groups should be easy to identify (pregnant women, sex workers as opposed to income group targeting).
- This scheme may be most effective as complementing a social marketing and/or social franchising program, where basic quality assurance systems and provider networks are developed.

Insurance schemes serve as another demand side mechanism for private sector involvement in the health sector and important for Ethiopia to consider as it moves forward in devising its social health insurance model. While vouchers provide a very specific and limited entitlement, for example to a particular service or procedure, insurance typically provides a broader set of entitlements, which can include socially-desirable services. Under social health insurance (SHI) schemes, membership is compulsory and premiums are either flat rate or income-related (IHSD, 2004).

Findings

Private sector involvement in insurance can take two forms – private organizations can provide or administer insurance schemes (with or without government financing) and/or private providers can deliver services paid for by insurance benefits. There is little role of private insurance provision in Ethiopia so at this time this is unlikely to be of much relevance. This approach is being used in several countries with significant private insurance providers such as India and Nigeria.

In terms of service delivery, there is little rigorous evidence of the benefits of private sector involvement in service delivery financed by health insurance schemes, particularly for the poor (IHSD, 2004). Generally, social health insurance models in developing countries only include formal sector employees and middle income populations and may insure access to private providers for some services. Expansion of social health insurance has been undertaken in the Philippines, Ghana, and Kenya in recent years, with both countries focusing on increasing access to the poorer margins of the society (<http://r4d.org/knowledge-center/>).

Challenges

- It is relatively easy to recruit/compel formal sector workers into an SHI system, but far more difficult to reach the informal sector (IHSD, 2004).
- Establishing a social insurance scheme is a large undertaking of national scale, meaning set-up costs will be large.

Implementation Considerations

- Social health insurance is difficult to implement as a universal system within a developing country, where many individuals are unemployed or self-employed. Must consider also adapting a community health insurance scheme to address this.
- Social health insurance is very context specific, requiring economic development and employment structures that can fund the benefits (IHSD, 2004).

A more detailed global review of literature on PPP and country experiences can be found in the Annex.

III. Objectives and Methodology

Objectives

The overall objective of this report is to review global and local practices and experiences related to PPP in health.

The specific objectives of this review and case study are to:

Review the existing platform, practices and learning on PPP in health globally and in the Ethiopian context, and

Explore challenges and come-up with preliminary recommendations to strengthen PPP in health in the Ethiopian context.

Significance

Due to scarcity of national level data on PPPs, findings of this review and case study will play a role in filling the knowledge gap and, as appropriate, will be used to plan and execute concrete actions to strengthen PPPs as means to improve access and utilization of health care.

Methods

This is a descriptive review of PPP in health using key informant interviews, expert observations, and review of records and reports of selected health facilities for case study documentation.

Geographic focus

The review was done in seven regions, namely Amhara, Oromia, Tigray, SNNP, regional states and Addis Ababa, Harari and Dire Dawa city administrations.

Selection process of health facilities

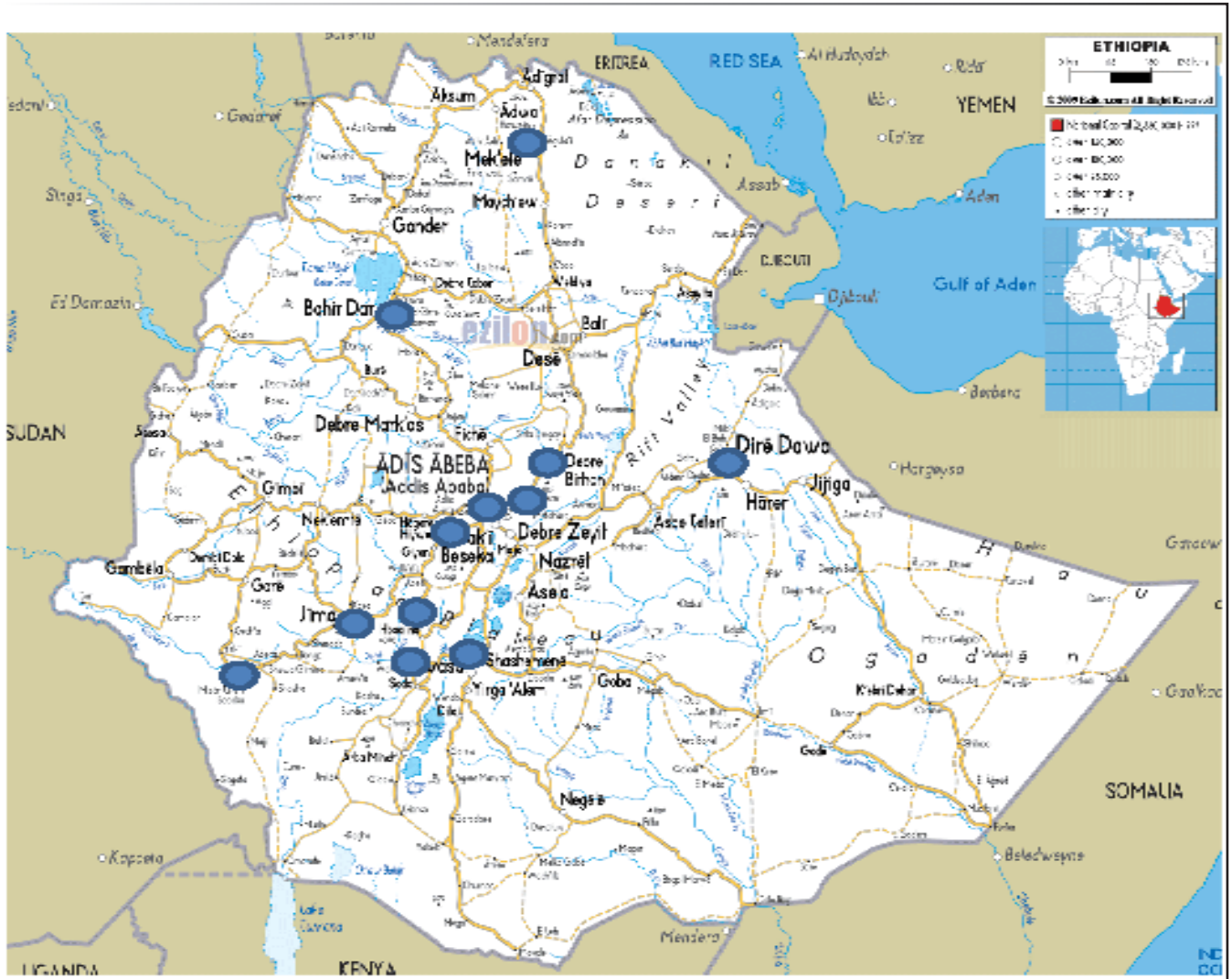
The following steps were followed to identify health facilities that have better experience in implementing health interventions using PPP.

Step 1: Case studies providing health services with some form of PPP were identified in consultations with Ministry of Health, regional health bureaus, private provider associations, and partners.

Step 2: Each case study was reviewed to understand the modality and select those that have better experience for learning. In consultation with the RHB officials of the six regions a total of 26 “PPP case studies” were identified.

Step 3: As some of the “PPP case studies” had similarities with regard to the mechanism and form of the partnerships the list was further filtered to 16. Team of experts drawn from MoH, HEPCAPS, and Ethiopian Catholic Church visited all of the 16 selected “PPP case studies”.

Step 4: Out of the total 16 the report of 14 “PPP case studies” has been included in this review as it has some level of interesting learning and experience. Two of the “PPP case studies” were found not having relevant experience and data to draw learning from.

Figure 3.1. Map showing the location of “PPP case studies”, 2014³

Key informants

Thirty-five key informants selected from Ministry of Health (MoH), Ministry of Finance and Economic Development (MoFED), Pharmaceuticals Fund and Supplies Agency (PFSA), Food, Medicine and Health Care Administration and Control Authority (FMHACA), Regional Health Bureaus, regional private health service provider associations, managers of identified “PPP case studies” including service providers and service users were interviewed (Table 3.2).

³The fully blue shaded circles indicate the location of the “PPP case studies”

Table 3.1. List of “PPP case studies” by type and location, 2014

Region	Name of Health Facility	Type of “PPP Case study”	Type of partnership	Type of service run by PPP	Location
Oromia	Gizaw HC	Private Higher Clinic	Contracting	PPM DOTS, FP, PMTCT, Malaria	Shashemene
	Jimma HC	Private Higher Clinic	Contracting	PPM DOTS, FP, PMTCT, Malaria	Jimma
	St. Lukas Hospital	NGO General Hospital	Contracting	Comprehensive	Wolliso
	Geferesa Mental Hospital	Government/Catholic Hospital	Contracting	Comprehensive	Geferas
Tigray	Mekelle University Hospital	Public Hospital	Hospital PPP	Dialysis Unit	Mekelle/Quiha
DereDawa and Harari	Bilal Hospital	Private Hospital	Contracting	TB and HIV	DereDawa
Amhara	Vision Maternity Health Centre	Centre run by civil society	Contracting	Maternal and child care	Bahir Dar
	Debrebirhan Hospital	Public Hospital	Hospital PPP	Outsourcing	Debrebirhan
SNNP	Mizan-Aman Hospital	Public Hospital	Contracting	Outsourcing	Mizan
	Wasera Health Center	Catholic health center	Contracting	Comprehensive	Doyogena
	Dubo St. Mary Hospital	Catholic health center	Contracting	Comprehensive	Areka
Addis Ababa	Zewditu Hospital/OIC	Public Hospital	Hospital PPP	Eye Care	Addis Ababa
National	DKT Ethiopia	Work with private providers	Social Marketing	Reproductive Health and Child Health Commodities	Multiple places
	Marie Stopes International	Network of private-for-profit	Social Franchising	Family Planning	Multiple places

Table 3.2. List of key informants by type, 2014

Key Informants	Officials from MoH, RHB Officials, Directors or Deputy Directors of Agencies	Managers of “PPP case studies” including service providers, service users, and private providers associations
MoH	2	
MoFED	1	
FMHACA	1	
PFSA	1	
Amhara Region	1	2
TigrayRegion	2	
OromiaRegion	1	6
Dire DawaCity Administration	3	3
Harari Region	1	
Addis Ababa City Administration	1	1
SNNP Region	1	8
Total	15	20

Data collection

Experts who work at Ministry of Health, Resource Mobilization Directorate, Partnership Coordination Case Team, and HEP-CAPS project collected data using the following instruments:

- 1) Key informant interview guide for interviewing service providers: this guide was used to interview head nurses, medical directors, or other technical lead persons in the selected facilities.
- 2) Key informant interview guide for interviewing higher officials: this guide was used to interview higher-level officials at regional health bureaus, private service providers associations, and prominent private service providers.
- 3) Data extraction checklist: this template was used to extract data from records.

On top of this, data collectors documented their observations and collected any documentation like reports, fliers, announcements, training materials and any other materials that have relevant information for the assessment.

Half of the key informant interviews were audio recorded and transcribed for analysis but in other cases interviewees didn't want to be recoded and information was captured on notebook.

Organizing data and report write-up

All of the key informant interviews that were audio recorded and taken on notebook were transcribed and organized for analysis. The 6 member expert groups who did the data collection reviewed the transcriptions and jointly identified the key themes.

Quantitative Data extracted from reports and other documents was presented in tables and graphs as appropriate. Data extracted from studies, reports, and other relevant sources is used to make comparisons as needed.

IV. Result

Finding are presented in two major sections:

- Section 4.1: Summary of findings from the “PPP case studies” and
- Section 4.2: Summary of findings from Key Informant Interviews

Section 4.1: Summary of findings from the “PPP case studies”

A total of 14 “PPP case studies” were explored, organized and presented according to the typology detailed in the literature review. Ten of the 14 “case studies” represent more or less contracting-like arrangements, two could serve as Infrastructure based (hospital) PPP arrangements, and one each on social marketing and social franchising models presented as follows.

4.1.1. Contracting partnerships between government and private non-profit health facilities operated by the Ethiopian Catholic Church development office

This is partnership between the Ethiopian government, represented by the Ministry of Health, Regional Health Bureaus, or Regional Finance and Economic Development Offices with the Ethiopian Catholic Church to provide comprehensive primary care services through health facilities operated by the Church. The Ethiopian Catholic Church currently provides primary care services through its more than 80 health facilities in different parts of the country.

The following health facilities utilizing this model of partnership were contacted to further explore how they function and understand their contributions to primary health care provision:

- Dubo St. Mary Catholic Primary Hospital, SNNP Region,
- Wasera Catholic Health Center, SNNP Region,
- St. Luke Catholic Primary Hospital and School of Nursing, Oromia Region, and
- Gefersa Mental Health and Rehabilitation Center, Oromia Region.

What are the outputs of these partnerships?

These partnerships are having significant contributions in improving access to comprehensive primary care services in the rural context. The following key findings demonstrate their contribution in quantitative terms with regard to delivery of key primary care services that have public health importance.

From the year 2008 to 2013, Dubo St. Mary Catholic Primary Hospital provided outpatient care to 177,997 (average of 29,666 per year) patients, inpatient care to 43,962 (average of 7,327 per year) patients, major operations to 5,044 patients, ART to 517 HIV infected persons, minor operations to 2,855 patients, antenatal care to 38,589 pregnant women, delivery services to 9,625 pregnant women, and Cesarean Operation to 1,040 pregnant mothers with complications. The average number of patients received outpatient care per public hospital (any hospital) is about 55,618 with an average of 4,288 inpatient care per hospital in the year 2013/14. As majority of these public hospitals are general hospitals they are expected to provide care to large volume of patients. The average number of deliveries attended per public hospital in the year 2013/14 was about 1,295, which is lower than the average number of deliveries attended from the year 2008 to 2013 by Dubo Primary Hospital per year (1,604 per year).

In the year 2012 alone, Wasera Catholic Health Center provided outpatient care to 12,335 adults and 1,558 children below the age of 5 years, inpatient care to 199 patients, minor surgeries to 27 patients, delivery service to 469 pregnant mothers, and HIV Counseling and Testing to 2,140 people. On average a public health center provides outpatient care to nearly 7,044 patients per year and delivery service to about 316 per year.

In the last five years (from 2009 to 2013), a total of 53,141 (average of 10,628 per year) patients received inpatient care and

13,350 (average of 2,670 per year) pregnant mothers delivered at St. Luke Catholic Hospital and School of Nursing. Both the inpatient care and delivery services are much higher than services provided by an average public hospital (average of 1,295 deliveries and 4,288 inpatient care per year as described above).

With 200 beds and 96 staff Gefersa Mental Health Hospital and Rehabilitation Center has been providing care to 140 patients (36 females and 104 males) at the time of data collection in June 2014.

How is the quality of service?

Services provided through these Catholic health facilities are generally of good quality. Experts who visited these facilities for this assessment appreciated the cleanliness of the compound and service delivery units, the receptiveness of service providers, and the accessibility of service delivery units to people with disabilities. Additionally, 2012 data from St. Luke Catholic Hospital and School of Nursing reported; general mortality rate (4.1%), pediatric mortality rate (4.17%) and infection rate from wound due to caesarian operation (1.3%) below 5%. Moreover, in that same year, the bed occupancy rate of the hospital was also high (86.6%), indicating high level of utilization for a rural primary hospital compared to an average of 56% bed occupancy rate in public hospitals in the year 2013 (*KPI report, 2013/14*). The average infection rate from surgical operations and inpatient mortality rate in public hospitals for the year 2013 are estimated at 13% and 3.8% respectively (*KPI report, 2013/14*).

What is the role of government?

Except St. Luke Catholic Primary Hospital and School of Nursing neither Wasere Health Center nor Dubo Primary Hospital are getting direct financial support from government. But all of the health facilities get technical support from government in the form of training, mentoring and supervisions, logistics and supplies support occasionally, and facilitation of the environment for smooth operations.

How are these facilities financed and how much is their budget?

These health facilities cover their cost through raising funds from local and external donors and through user fees. Thus far, St. Luke Catholic Primary Hospital and School of Nursing is the only health facility that receives direct budgetary support from the government. These health facilities provide services at affordable prices, with mechanisms in place to provide free service for those who cannot afford to pay. The medical examination fee these health facilities charge is less than \$0.5, which is more or less similar to the average fee in public health facilities (Pearson et al., 2011).

Between 2008 and 2013, Dubo St. Mary Catholic Hospital spent nearly 52.3 million Birr, which is an average of about 8.7 million Birr per year. Average annual spending is similar to that of a public primary hospital, whose annual spending usually ranges from 6 to 13 million Birr. Revenue collected through service fees covered more than 60% of hospital costs, reducing dependence on donor funding. Anecdotal evidence from different unpublished reports indicate most public health facilities covering less than 40% of their budget through revenue collection. Similarly, Wasera Health Center's spending, recorded at nearly 1 million Birr in 2012, was comparable to annual spending for an average rural public health center. Having a School of Nursing, St. Luke Catholic Hospital's budget was relatively high (29.6 million Birr for 2013).

These findings indicate that these hospitals are providing comprehensive and good quality primary health care services, while spending about the same of an average public primary hospital. Important to note, though, is a significant proportion of their budget still comes from external donor funding, which is not a reliable source over the long term.

How expensive are their service?

These health facilities charge service fees that are much lower than private for-profit health facilities, but are still more expensive than public health facilities. They do provide free treatment for patients who cannot afford to pay, using different mechanisms to confirm their financial status.

How much are they connected with the community they provide services to?

In terms of connections with the general communities they serve, these facilities have varying degree of linkages. Wasera Catholic Health Center serves as a rare example of engaging the community, making use of health extension workers (HEWs) in its catchment area and organizing regular public forums to get community feedback. Generally, though, relationships with the community need to be improved through various mechanisms. Community representation in hospital governing boards, organizing of regular public forums, working closely with religious leaders, administrators, opinion leaders, and other influential community can serve as possible means of ensuring community participation.

How is their relationship with government?

They have some level of relationships with government health offices at zonal and woreda levels, through supervisions, trainings, and participation in review meetings, but this need further improvement. Greater support and attention from government officials at different levels is essential to foster a meaningful and sustainable relationship with these facilities, and ultimately reach effective levels of service deployment.

What should be done in the future?

Designing a standard system that will be used to govern and support health institutions run by non for-profit faith based organizations will help the country utilize the opportunity better. These institutions are mainly run by fee collected from patients and external donors. Government could finance them with contractual agreement to provide defined set of activities. These facilities need to be engaged in initiatives designed and implemented to improve service provision and quality at health facilities. Reporting, staffing, supply, review and follow-ups are potential areas of collaboration between the public and health institutions run by non for-profit organizations. Lessons could be learned from countries like Ghana, Uganda, and others that have experience managing similar health facilities for the benefit of the public.

4.1.2. Contracting partnerships between government and private for-profit health facilities

This is partnership between the Ethiopian government, mainly represented by regional health bureaus and private for-profit health facilities for the provision of key public health services. Under these PPPs, the private sector is contracted to deliver specific health services, particularly HIV/ART, prevention of mother-to-child transmission (PMTCT) of HIV, TB, Malaria, Family Planning and other related services. This is intended to expand access to selected primary care services that have significant public health importance through private service providers. Private providers dedicate space, manpower, and other necessary materials to make sure services are delivered properly as per the agreed guideline. In exchange, the government's role is to provide technical support in the form of refresher trainings, on the job mentoring, provision of drugs and supplies and overall regulatory role to ensure delivery of quality services as per the standard.

The health facilities contacted to learn more about this form of partnership are:

- Bilal Primary Hospital, Dire Dawa City Administration,
- Gizaw Higher Clinic, Shashemene Town, Oromia Region, and
- Jimma Higher Clinic, Jimma Town, Oromia Region.

What is the effect of these partnerships in improving access to selected primary health care services?

The contribution of these partnerships in expanding access to selected primary care services is appreciable. Some of these contributions are:

- Partnership with Bilal Hospital began in 2005 with the introduction of ART services. As of the year 2013, a total of 829 HIV infected persons are on follow-up care, out of which 456 are currently receiving ART from the hospital. Additionally, an average of 23 clients get Provider Initiated Counseling and Testing (PCT) for HIV, 6 new patients start TB DOTS, 7 new clients take contraceptives, and 10 – 15 Malaria patients get diagnosis and treatment services every month.
- Despite beginning in just 2012, the partnership with Gizaw Higher Clinic has resulted in a total of 162 Malaria

patients receiving treatment, 128 new contraceptive acceptors receiving family planning services, 84 TB patients receiving DOTS, 110 pregnant women receiving PMTCT services, and 420 clients receiving HIV Counseling and Testing Service since the launch of the collaboration.

- In the past 7 years Jimma higher clinic provided DOTS to 800 TB patients through the Public Private Mix DOTS program.

Jimma Higher Clinic reported 93% treatment completion rate for TB, all of the 84 TB patients who started treatment at Gizaw Higher Clinic successfully completed their treatment, and 95% of the 209 TB patients who took treatment from Bilal Hospital completed their treatment successfully. The successful treatment completion rate observed in the three health facilities is higher than the 91.4% national level TB treatment completion rate for the year 2012/13 (MOH, 2014).

How much does it cost to get these services from private for-profit providers?

Services provided under this partnership are subject to medical examination fee, which in most rural and regional towns ranges from 20 to 30 Birr. This fee could range from 5 to 10 Birr at public health facility. Additional laboratory investigations or other diagnostic services could incur additional fees. Drugs and routine clinic visits to collect medication are free of charge.

How much are private for-profit health facilities connected with the community they provide services to?

In terms of relationships with communities, private for-profit service providers generally have weak connections. Their relationship is limited to interactions with service users when they come to their facilities. Otherwise, there is no outreach or public forum to interact and form a linkage with the community as a means of addressing community concerns and improving services accordingly.

How is their relationship with government?

These services are provided to the public under formal contractual agreement between government and private providers. Government's role is to provide training to service providers, supply drugs and laboratory reagents, and ensure quality of service while the private provider will dedicate fulltime Nurse professional, service delivery room, and provide service as per the standard. There is some level of relationship with government, particularly on technical capacity building through refresher trainings, on the job mentoring, and providing job aids and provision of supplies for services provided in partnership.

One of the challenges expressed by private providers in this partnership is the unreliable supply of drugs and necessary products in a timely manner.

What should be done in the future?

The engagement of private for-profit health institutions for expanding access to HIV/AIDS, TB, and Malaria diagnosis and treatment services need to be institutionalized with the public health care system. There is need to have standard operating procedure to guide these practices. The type, depth, and extent of partnerships need to be explicit to avoid confusions. The role and responsibilities, accountability, reporting relationships, service fee, and other operational issues need to be clarified. If these partnerships are guided by standard procedures the mechanism will help to reduce the burden on public facilities providing access to quality services to the population group who opt to seek these services from private providers.

4.1.3. Contracting partnerships between government and private for-profit institutions for provision of selected non-clinical and clinical services

Outsourcing services to the private sector has been commonly practiced by many public hospitals since the launching of Ethiopia's Health Care and Financing Strategy in 1998, but has been limited to outsourcing of non-clinical services (i.e. food/cafeteria, laundry, cleaning and related services). Yet, some public hospitals have gone beyond this to outsource laboratory services, patient registration, and daily cash collection. This breakthrough practice could have significant learning value for other public hospitals.

Two public hospitals undertaking this form of PPP were identified and visited for further learning:

- Mizan Aman Hospital, SNNP Region, and
- Debre Berhan Hospital, Amhara Region.

Although the Health Care and Financing Strategy provided public hospitals an opportunity to outsource non-clinical services in order to improve quality and efficiency, implementation of this practice varies across health facilities. These two hospitals were identified as having better experience with regard to outsourcing of some services outside of the commonly outsourced services like laundry, cleaning, and security.

Mizan Aman Hospital's outsourcing of daily cash collection and patient registration to local civil society organization (youth association) has been found to improve efficiency by greatly reducing management burden from the hospital and giving hospital management the opportunity to focus on other important tasks. The private cooperative that took the contract achieved this through increasing the number of cash collection sites. Close follow-up and support by hospital management helped to achieve positive results.

On the other hand, Debre Birhan Hospital contracted with US-based International Clinical Laboratory (ICL) to provide advanced quality laboratory services. Not all types of laboratory tests are done in public hospitals and health centers and even those tests commonly done at public facilities are fraught with service interruptions due to equipment malfunctioning or reagent stock outs among other problems. To address this and other challenges related to the hospital's laboratory services, the hospital designed a formal agreement with the private provider, ICL.

Through this collaboration, ICL is responsible for opening a site within the hospital's premises to collect specimen based on orders from the hospital's service providers, transport the specimen to their main laboratory, conduct the test and deliver the results back to the hospital. In addition, ICL is also expected to build the technical capacity of the hospital's staff. The practice has helped the hospital to provide comprehensive and uninterrupted laboratory services at discounted price by about 30% to service users, who are able to now avoid traveling to Addis Ababa to get these services.

What should be done in the future?

Many public hospitals have started out sourcing nonclinical services commonly; security, laundry, and cafeteria services. The experience of Mizan Aman and Debre Birhan public hospitals could be explored further to provide opportunities to public hospitals to outsource more nonclinical and clinical services as needed to facilitate the delivery of integrated services within the hospital's premises reducing inconvenience for service users and providers.

4.1.4. Infrastructure-based Partnerships between public hospitals and private for-profit companies to provide specialized health care services

The other type of partnership identified through case reviews was infrastructure-based partnerships, which taps into private financing and efficiency to deliver selected specialized services. This has been found to be another interesting area of collaboration, with great potential benefit in ensuring specialized care services are provided sustainably within public hospitals at an affordable cost and without pressure on the government and hospitals to establish and operate them.

Three public hospitals undertaking this type of PPP model have been identified and visited for further learning:

- Mekelle University Hospital: Meles Zenawi Memorial Dialysis Center,
- Zewditu Memorial Hospital: OIA Eye Care Center, and
- Bahir Dar Health Center: Vision Maternity Care.

What did these partnerships achieve so far?

These partnerships helped to deliver specialized care that were limited in a very few places to hundreds of patients with subsidized cost. To mention some of the achievements:

- The OIA Eye Care Center at Zewditu Memorial Hospital is serving 80-100 eye patients daily and 10 to 15 minor and major eye surgeries every day.

- Since its establishment in 2012, the Dialysis Center at Mekelle University Hospital has served 49 patients, all individuals who would otherwise have no other option for treatment in the region.
- After its introduction, the contracting between nongovernmental organization and Bahir Dar public health center helped to increase the number of births attended at the health center from an average of about 30 deliveries per month to an average of 160 deliveries per month. Establishment of Cesarean delivery service helped to reduce the burden on the only hospital in the town.

As these partnerships are new and due to scarcity of data, it is difficult to comment on the quality of services provided, but experts who did the data collection generally appreciated the cleanliness and organization of services as well as the receptiveness of the staff.

Mekelle University Hospital: Meles Zenawi Memorial Dialysis Center

Being the only Dialysis Center in Tigray region, Mekelle University Hospital's MelesZenawi Memorial Dialysis center provides a tremendous opportunity in avoiding referrals to Addis Ababa and creating an educational opportunity for the staff and medical students of Mekelle University.

Zewditu Memorial Hospital: OIA Eye Care Center

Menilik Public Hospital served as the main facility in providing higher-level specialized eye care services to communities, with high demand for services overburdening the hospital. The opening of OIA Eye Care Center at Zewditu Memorial Hospital in Addis Ababa addressed this problem, giving patients seeking eye services an alternative. Currently, the facility provides service to nearly 100 patients daily.

Bahir Dar Health Center: Vision Maternity Care

Felege Hiwot Hospital served as the only public hospital in Bahir Dar town providing advanced care to laboring mothers with complications until the establishment of VMC at Bahir Dar Health Center. Under this partnership, maternity services of Bahir Dar Health Center has been outsourced to a nonprofit making private organization that helped to introduce advanced services including Caesarian Delivery to help laboring mothers with complications and enhance the quality of antenatal care and delivery services, boosting the number of service users exponentially. Before this partnership about 30 women delivered at the health center per month. With the establishment of the VMC maternity center, this number increased to an average of 160 deliveries per month. In the year 2013/2014 alone, 1,619 women delivered at the center.

What should be done in the future?

There is a need to develop standard implementation guideline as these partnerships are just emerging. Clarifying roles and responsibilities, transfer and ownerships, accountability, and other operational procedures will be key. The opportunity need to be open to any one who will be interested in similar investment opportunities and to other hospitals all over the country as needed.

Conducting detailed assessment on the feasibility of such models, particularly the OIC Eye care center at Zewditu Memorial Hospital, will be beneficial.

4.1.5. Social marketing and franchising

Social marketing and social franchising are being practiced in Ethiopia mainly through the support of DKT Ethiopia and Marie Stopes International (MSI) in partnership with private providers. Their experience is briefly presented in this section.

Social Marketing – DKT Ethiopia

DKT Ethiopia is an international nongovernmental organization that started operations in Ethiopia in 1990 with the introduction of *Hiwot Trust* condoms. The organization now socially markets more than 13 different types of health products mainly sexual and reproductive health and child health commodities.

Health Product Distribution Mechanism

DKT Ethiopia has established partnerships with more than 11,000 private pharmacies and clinics all over the country. In this partnership DKT delivers selected health commodities to the private pharmacies and clinics so that they sell it to the community at a highly discounted price. In addition to this, DKT provides training to collaborating private providers based on need assessment and during the introduction of new products. DKT does the promotion, branding and demand creation work too.

The private providers benefit from the capacity building trainings and they also get controlled profits through the provision of social service to the community they serve.

DKT uses a database of nearly 20,000 sales points (including shops, hotels, and informal business outlets) to generate real-time data for monitoring products and services.

Government's role

Government mainly facilitates tax exemption, product registration, demand creation, and control quality of products distributed in country.

Achievement

In the year 2013 alone, DKT Ethiopia in partnership with private providers distributed more than 66 million condoms, 4.1 million cycles of oral contraceptives, 2.7 million injectable contraceptives, 1.7 million emergency contraceptive pills, 122, 455 Implants, and 195,000 Intrauterine Contraceptive Devices (IUCDs) that translates into 2,442,890 Couple Years Protection (-CYPs). On top of the contraceptive commodities more than 2.5 million Oral Rehydration Salts were distributed during the same year. <http://www.dktinternational.org/country-programs/ethiopia/> & <http://www.dktethiopia.org/>

Added value of the program

The modality created thousands of private outlets to contraceptive choices and selected child survival commodities all over the country. The outlets ranged from private clinics and pharmacies to hotels, shops, and informal business increasing availability of these commodities off office hours at discounted prices.

Challenges

DKT Ethiopia distributes the commodities door-to-door, which is demanding, expensive, and difficult to sustain. The price of commodities is heavily subsidized through external funding the organization raise making the program donor dependent. The other challenge is lack of distribution outlets in the rural areas limiting its reach.

What should be done in the future?

The distribution of condoms, contraceptive commodities and other essential products through social marketing has been quite a success but it is highly reliant on donor funding and DKT's support. The way it is functioning currently is not sustainable if DKT's support is no longer available. Mechanism has to be designed to make sure this could be continued with the engagement of government, civil society and private sectors utilizing domestic resources.

Marie Stopes International (MSI) – “BlueStar” Social Franchising

“BlueStar” Social Franchising has been initiated by MSI to utilize commercial-sector approaches to increase access, method choice, and service quality of Family Planning as well as Safe Abortion services, working through network of private providers that deliver services under a common “BlueStar” brand, in accordance with franchise standards. Launched in 2008, the goal of the program is to expand and standardize sexual and reproductive health services in the private sector, in order to improve access to quality reproductive health services in Ethiopians.

Services provided through the “BlueStar” network

A range of sexual and reproductive health services are provided with a particular focus to long-term family planning methods and safe abortion services, but also including HIV testing, STI screening and treatment, Antenatal Care, and most recently

cervical cancer testing and screening. Quality of service is assured through competency based trainings and regular site inspections (each service provider inspected at least every two months), internal and external clinic audits (once in a year), and through client exit interviews (once in a year).

Benefit for the private providers and added value

The participating private providers receive free training, onsite technical assistance, and subsidized or free equipment. Other incentives include the creation of a brand identity, mass marketing campaigns for the brand or on behalf of members, and access to medical commodities at cost or below market rates. In return, members agree to comply with standards and client fee restrictions set by the franchise, report on performance across certain parameters, and to pay fees to maintain their membership. Privately delivered care makes up a large portion of health services particularly in urban areas. They can offer a range of health services, with some level of quality oversight from an independent body.

Achievement

As of the year 2013, a total of 586 private providers (527 urban and 59 rural) have been networked under the “BlueStar” brand to provide standardized and quality comprehensive family planning, HIV/AIDS, and abortion care services.

To date over a million service users visited private providers networked under “BlueStar” for family planning, abortion care, and HIV/AIDS related services. In 2014 alone through this network total of 458,200 Couple Year Protections (CYP) (about 6% to 8% of the total CYP generated in the country) have been generated <http://healthmarketinnovations.org/program/blue-star-ethiopia/>.

Financing

Currently MSI is running the “BlueStar” by generating external funding from donors. Members pay a minimal membership fee, but this is not enough to run the program for the time being. Out-of-pocket payment is the main mechanism by which service users utilize to get service from the providers. Generally “BlueStar” member clinics provide sexual and reproductive health services at a lower price compared to non-member private providers. For example member clinics provide abortion care at less than 300 Birr (US\$15) while others charge as high as 800 Birr (US\$40).

Recommendation

“BlueStar” social franchising is a new practice that need to be looked at carefully to see its potential for the future. The initiative is currently led by MSI with funding from external sources. In the long term MSI need to transition the responsibility to local institution like professional associations, association of private providers, or other indigenous institutions for sustained outcome.

Another approach would be to increase the membership fee and sell franchise services like training and quality control to “BlueStar” members to increase the income from social franchise and become less dependent on external funding.

Conducting further assessment to understand its benefits and feasible implementation modality including sustainability will be key.

Detailed review of the case studies except the Social Marketing and Social Franchising can be found in

Annex I.

Section 4.2. Summary of key findings from the key informant interviews

Key informants forwarded the following recommendations for strengthened PPPs.

Organize regular consultations with private providers and implement effective and agreed up-on mechanisms to strengthen PPP

The importance of having regular consultations among private providers, government, community and other important stakeholder has been mentioned as key to addressing challenges and properly guiding the partnership between the private and public sector.

Strengthening the private providers' associations will be key in facilitating consultations and providing a platform to serve as bridge for the partnership. Through regular consultation and by establishing supportive and inclusive support system it will be possible to establish effective PPP.

“Private Service Providers Association has to be strengthened, which will have value in addressing the concerns of private providers and the government related to standards or other issues. It will serve as key in mediating relationships between the public and private sector. There has to be regular forums between the government and private providers. Additionally, we need to have the participation of private facilities in the planning process and when we plan to train health professionals, private providers have to be included. Unless we include them in every activity that we plan to accomplish, the partnership will not be realized. Just having directions and standards can't help.” KI 6, Regional Health Bureau Official.

According to information from key informant within FMHACA government is having meetings with the private health service providers and their associations every two months to discuss on challenges and strengthen partnerships at national level. This practice could be expanded to regions to engage many more private providers in these conversations.

Establish a unit dedicated to coordinating PPP at different levels

As a means of facilitating PPP on the part of the government, recommendations were made to create PPP units to be housed at different levels, from Federal Ministry of Health to region and below. One of the key informants expressed this as follows:

“My general recommendation for the future is the creation of a unit dedicated to PPP at all levels, from the district to federal level. This unit should serve as a liaison/mediator between private providers and government.” KI 5, Head of Regional Private Health Service Providers Association.

Develop guidelines, standard operating procedures, and tools

The need for developing standardized PPP guidelines, operating procedures, and tools, with the involvement of private service providers, has been emphasized. It is important to not only put forth effort in the development of these standards and guidelines, but to also provide orientation for policy implementers at all levels so that they are aware of the manuals and guidelines. Lack of this created problem with regard to decision-making around issues, such as what level of support government could provide to private facilities and how this could be provided. Despite the Health Policy and Health Sector Development Program documents outline the key contribution of the private sector, lack of subsequent guidelines has been reported as a major gap to operationalizing PPPs. A key informant describes this follows:

“We need standard operating procedures, guidelines, and other guiding document, as there is confusion about what to do and how to do it. For example, we are currently not providing Coartem (Anti-Malaria treatment) for the treatment of malaria to private providers while we are providing drugs for TB and PMTCT, this kind of decisions need to be guided by standards. Standard manuals need to be prepared and existing best practices need to be expanded.” KI 3, Regional Health Bureau Official.

Overall, lack of clear and consistent guidelines were brought forth as an issue in PPP implementation.

Develop legal framework to provide PPP legal coverage

Another key challenge mentioned throughout many key informant interviews was the lack of legal framework.

A public health official describes the lack of a legal PPP framework in the country as follows:

“Currently there is no consistent PPP legal framework to enable the partnership be based on legal framework. We are simply working based on informal understanding and contractual agreements but there is no legal framework. “KI 15, Regional Health Bureau Official.

Discussion held with government official from Ministry of Finance and Economic Development (MoFED) identified this as a gap for PPP in every sector. MoFED is the responsible authority to develop the legal framework and they are under preparation to draft it. This is expected to take time, as it needs to pass through rigorous consultations with different sector offices including Ministry of Health, it also needs approval of the cabinet and need to be endorsed by the parliament too. Pending the legal framework the official advised to use existing commercial and contracting laws as basis to establish PPPs and have close consultations with lawyers based on specific cases and types of partnerships needed to be established.

Build trusting, supportive, and inclusive relationship between government and private providers

The importance of establishing a trusting, supportive, and inclusive relationship between government and private providers has been mentioned as a key step forward to establish stronger PPP. Key informants stressed the importance of joint supportive supervisions, in which private providers and professional associations serve as member of a team responsible for regulating service providers.

Introducing self-assessment schemes where private providers evaluate their own services based on a predesigned checklist was mentioned as important in quality service provision.

“The support relationship between government and private sector has to be strengthened further, private providers need to be involved in the supervision process, and importantly, there has to be self-monitoring by the private providers as well” KI 5, Head of Regional Private Health Service Providers Association.

A key informant from FMHACA complemented the need for self-monitoring by the private health service providers and importance of effective communication between government including the regulatory body and the private health providers particularly through their associations. In addition there is big forum organized biannually with the large majority of private health service providers, the public and other stockholders to discuss progress, challenges, and way forward.

Although the Health Policy and Ethiopia's Health Sector Development Program documents express the value of the private sector, some key informants expressed that there is very limited tangible engagement. Highlighting the contribution of the private sector in the health sector plan and designing mechanism to effectively engage them in the implementation process has been emphasized.

V. Preliminary Recommendations

Public-Private Partnership (PPPs) in Health is an emerging and growing area providing tremendous opportunities to enhance investments in the health sector by reducing burden on government and offering alternative for affordable health service to the community.

Review of global experiences on contracting of specific health services has been found to improve access to quality services. Contracting of specific services like laboratory and radiology were found to improve access for the poor, addressing equity concerns. Likewise partnerships in the form of Franchising and Social Marketing were found to improve access to affordable services and products, particularly to specific neglected and marginalized communities.

In the Ethiopian context, different types of PPP practices are being implemented at different levels of intensity. Thus far, government gives great attention to public service provision, particularly on primary health care service delivery. Understandably, this is because of limited private sector involvement in the provision of primary care services, particularly in rural areas where about 85% of the population reside. Nevertheless, with increased urbanization, and as disease pattern and the needs of the population change, it is important to consider the engagement of the private sector both for primary care services and tertiary level of care.

Lack of a standardized PPP operating procedure was reported as a major limitation in the implementation of PPPs. The work on strengthening PPP must begin by addressing this challenge. The Federal Ministry of Health, in partnership with regions, private sector, health professional associations and other stakeholders must *devise a clear standard operating procedure to guide PPPs in health*. This guideline should address the potential types of partnerships, their scopes, extent and types of support expected from government, expected level of participation and contribution from the private sector and government, monitoring mechanisms, accountability systems and potential consequences of breaking these partnerships, among other important concerns. On top of this working with Ministry of Finance and Economic Development in the *preparation and approval of national PPP legal framework* will be essential.

With regard to strengthening existing public-private partnerships case studies documented in this report illustrated that facilities operated by Church-based non-profit making organizations are contributing in the provision of quality primary care services to rural communities. Strengthening of these partnerships by *establishing a standard collaborative agreement* along with exploring the potential for *government cost sharing* to address unreliable donor funding will have great contribution.

Likewise *partnerships between government and private-for-profit facilities on specific programs, particularly HIV/ART and TB need to be structured, systematized, and fully led by government* for sustained impact.

Private provision of select advanced diagnostics and treatment services within public facilities can serve as promising mechanisms moving forward. Still, these partnerships have to be guided by standard procedures and carefully followed-up to avoid undesired consequences.

The experiences of DebreBirhan and MizanAman public hospitals in *outsourcing clinical and non-clinical services need to be considered for scale-up*. If guided in structured manner these types of practices could larger impact in enhancing quality of care and efficiency of public hospitals.

Building a respectful, trustworthy, and inclusive relationship between public and private sectors will be key for effective partner-

ships. Organizing regular forums, facilitating the working environment for the private sector to grow, strengthening private providers association and using them as mediators, establishing a supportive and joint regulatory system, and appropriately identifying private providers that work against the standard and taking corrective actions timely will benefit the partnership.

For government to be well positioned to guide partnerships with the private sector, it is important to *build strong structures from Ministry of Health to Woreda Health office levels*. Establishing a *unit dedicated to PPP at national, regional and possibly at woreda levels* will have significant contribution in guiding PPP in systematized and organized way.

Government and stakeholders need to invest in *building capacity of the private sector and government sector offices on PPP with particular attention to the design, management, monitoring, evaluation and review of contractual agreements and other types of public-private modalities*.

Finally a thorough investigation on PPP with detailed economic analysis is recommended to identify modalities that could work best at larger scale in Ethiopia.

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⁴This is comprehensive list of references, some are used in the main document, others are used in the annex, the remaining are kept for general reference

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VII. Annexes

Annex I: Case Studies

7.1.1. Case of Dubo St. Mary Catholic Primary Hospital

Partnership description: The partnership is with SNNP regional government to delivery hospital based curative, health promotion and rehabilitative care to rural community in Wolayita Zone of SNNP region. The partnership was formalized with project based official agreement signed between Ethiopian Catholic Church, Catholic Church Vicariate of Sodo and Finance and Economic Development Office of SNNPR.

Background information

Dubo St. Mary primary hospital was established in Boloso Sore Woreda, Wolita Zone, SNNP region by the Ethiopian Catholic Church, Apostolic Vicariate of Sodo in 2002. The hospital is providing services to an estimated 253,698 populations residing in Boloso Sore woreda. Patients from Kembatta, Hadiya, Dawro, Gamogofa, Halaba, Konso of SNNPR and Bale and Arsi Zones of Oromia region use the services provided by this hospital.

Although the hospital mainly provides hospital based curative and preventive services it also provides outreach support for the health promotion and disease prevention work done by health centers and health posts within the hospital's catchment area. The overall objective of the hospital is to provide comprehensive services to the public at affordable prices, with a particular attention to mothers and children. The hospital has 103 beds and with regard to staffing there is one general surgeon, five general practitioner medical doctors, one emergency surgical officer, one health officer, 47 different types of nurses, 6 pharmacy and 5 laboratory professionals, one radiographer and 153 administrative support staff.

A board consisting of members from the Ethiopian Catholic secretariat, including the Bishop, who is the chair of the board, hospital general manager, and medical director manage the hospital. This board meets three times in a year to review performance of the hospitals, address challenges, approve budget, review expenses and check compliance to standards and other activities. In addition, the hospital has management committee led by the general manager where the medical director, merton, finance manager, and human resource manager are members. This committee meets monthly to direct day-to-day activities.

Description of the partnership

The hospital functions under formal partnership between the Ethiopian Catholic secretariat and SNNP regional government with primary aim of delivering hospital based curative, health promotion and rehabilitative care to rural community in Wolayita Zone of SNNP region. The partnership was formalized with a project based official agreement signed between Ethiopian Catholic Church, Catholic Church Vicariate of Sodo and Finance and Economic Development Office of SNNPR. This project agreement is renewable every five years with the current extending from July 1, 2013 to June 30, 2017.

Responsibility of government: The government is providing mainly technical support through supportive supervisions, regular mentoring visits to enhance quality of HIV, TB, and PMTCT services, provision of limited supplies for maternal health services, and provision of drugs for TB, HIV, and Malaria. Recently government assigned general practitioner medical doctors to the hospital but salary will be paid by the hospitals. As the education opportunity for residency is granted by government this helped to retain them in the hospital.

Responsibility of the Ethiopian Catholic Church, Apostolic Vicariate of Sodo: The Ethiopian Catholic Church, Apostolic Vicariate of Sodo is responsible for overall establishment and management of the hospital including but not limited to expansion, upgrading, or maintenance, procurement of supplies, recruitment and management of staff, raising and managing fund, assure quality of services and others.

Major achievement

Through the partnership the following major activities has been accomplished between the years 2008 and 2013:

- 177,997 patients received outpatient care (average of 29,666 per year)
- 38,589 pregnant women received at least one antenatal care (average of 6,431 per year)
- 43,962 patients received inpatient medical care (average of 7,327 per year)
- 5,044 major operations (average of 841 per year) and 2,855 minor operations (average of 476 per year) were done
- 9,625 pregnant women delivered at the hospital assisted by skilled attendant (average of 1,604 per year)
- 1,040 pregnant mother delivered through cesarean section (average of 173 per year)
- 517 HIV infected patients are receiving treatment
- A total of 52,320,102.37 Birr generated to provide the above mentioned and other services (8,720,017.06 birr per year)

Although the hospital is labeled as primary and supposed to serve the community in Boloso Sore Woreda, it is providing much more services to other communities coming from other woredas in SNNPR and Oromia regions.

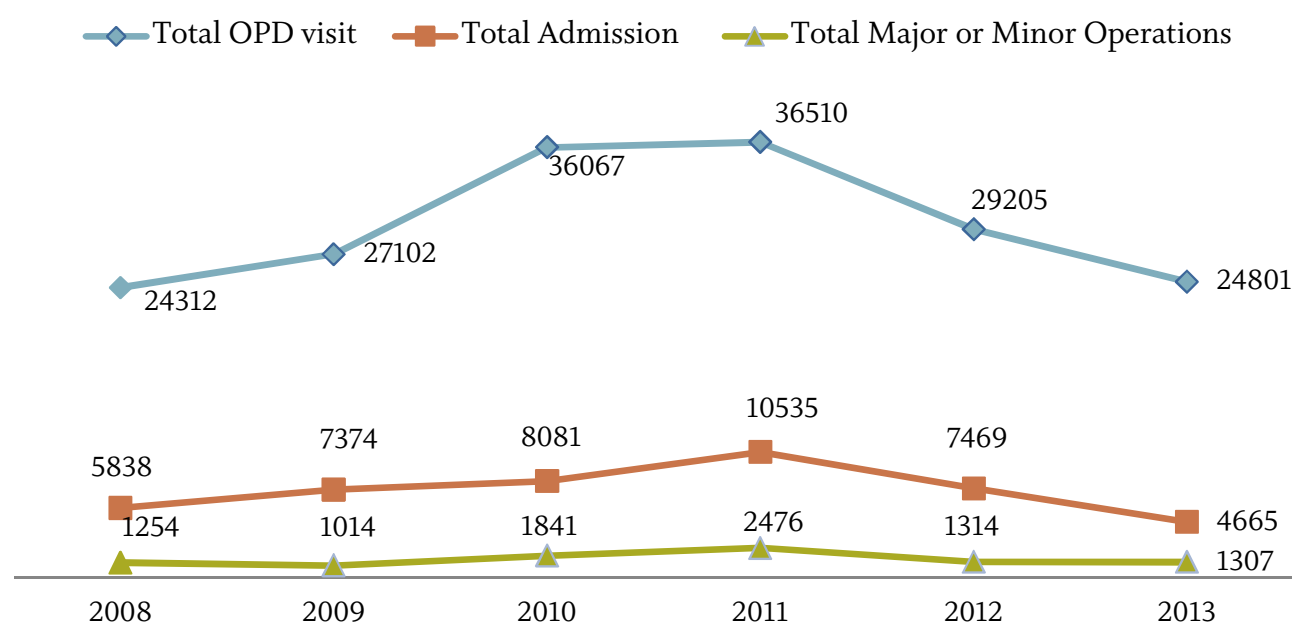
“This Hospital is benefiting the community very well, previously patients were travelling long distance in rough road to Arbamench Hospital. Now thousands of patients from Boloso sore and other nearby woredas are utilizing the service conveniently, patients appreciate our service and that is why they come from far areas passing other hospitals on their way”
General manager of the hospital.

Outpatient and Inpatient Care: As presented in Figure 1, between the years 2008 and 2013 a total of 177,997 patients visited Dubo Catholic Hospital’s outpatient department, of this 43,962 patients were admitted for inpatient care, and 9,206 major and minor operations were done.

Number of OPD visits increased from 24,312 in 2008 to 36,510 in 2011 and 29,205 in 2012 but showed sharp decrease in 2013 to 24,801. Similarly patients who received inpatient care increased from 5,838 in 2008 to 10,535 in 2011 and showed reduction to 7,469 in 2012 and sharp decrease to 4,665 in 2013.

From 2008 to 2013 a total of 226,211 patients visited the hospital for outpatient care, antenatal care and delivery services.

Figure 1. Total number of OPD visits, Inpatient Care, and Major and Minor Surgeries, Dubo Catholic Hospital, From The Year 2008 to 2013, Ethiopia



Maternal Newborn and Child Health: From the year 2008 to 2013 total of 38,589 pregnant women received at least one ANC from Bubo Catholic Hospital, although the number of pregnant women visiting the hospital for ANC greatly decreased during the years 2012 and 2013 (Table 2).

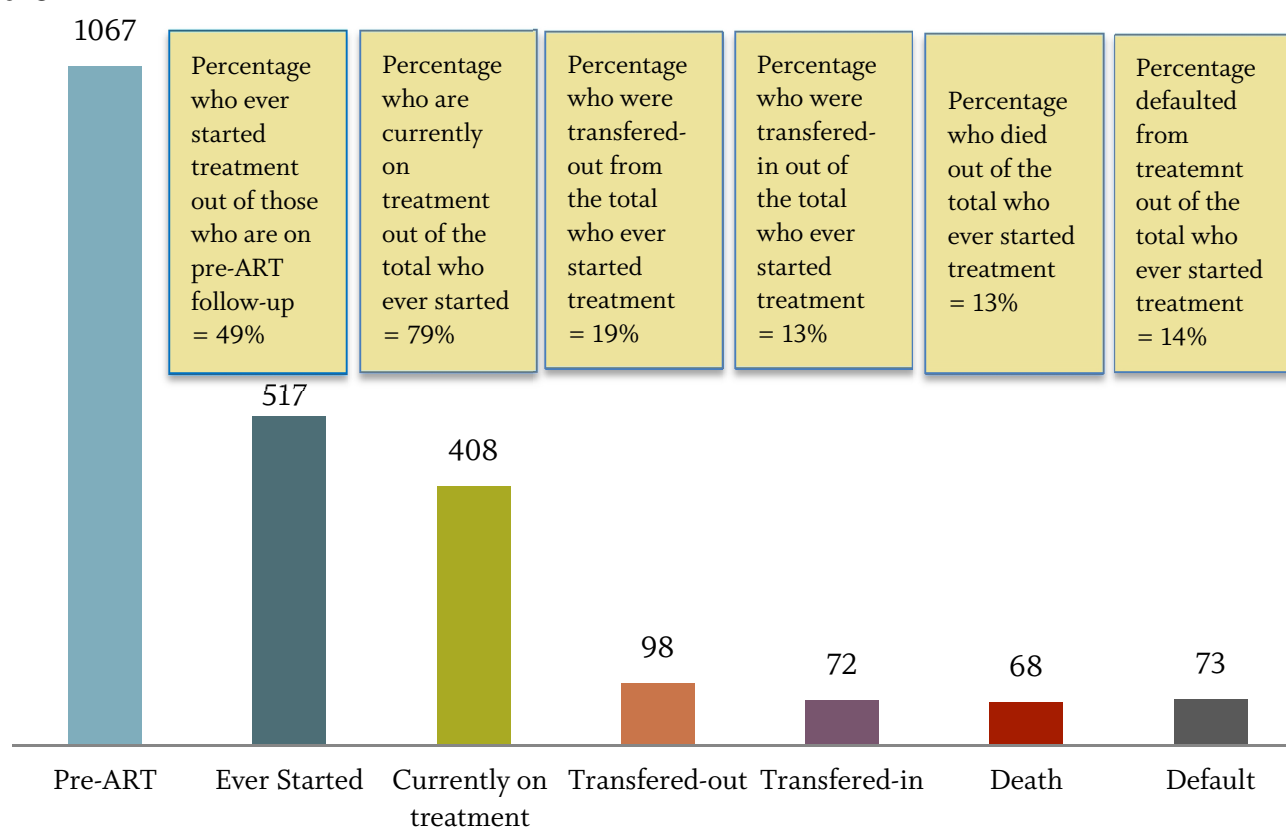
A total of 9,625 women delivered at the hospital within the six years period from 2008 to 2013, average of 1,604 pregnant women delivering at the hospital every year. Similarly the number of women who gave birth at the hospital decreased from 1,843 in 2008 to 1,108 in 2013. For the years from 2008 to 2011 the proportion of stillbirth remained 3% or below but it was as high as 8% in 2012 and 7% in 2013. Out of the total births happened at the hospitals from the year 2008 to 2013 21% were births with some complication, Proportion of cesarean section delivery was 11%.

Table 2. Maternal Health Services Dubo Catholic Hospital, Boloso Sore Woreda, SNNPR, 2008 to 2013

Year	2008	2009	2010	2011	2012	2013	Total
Antenatal Care	7833	6212	10366	8451	3999	1728	38,589
Total Number of Birth Attended	1843	2049	1516	1903	1206	1108	9625
Percentage of still births	2%	<1%	3%	3%	8%	7%	3%
Total Caesarian Delivery	123	122	156	213	191	235	1040
Percentage of deliveries with Cesarean Section	6.7	6.0	10.3	11.2	15.8	21%	11%
Assisted Deliveries (C/S, Vacuum, and others)	12%	8%	20%	26%	40%	30%	21%

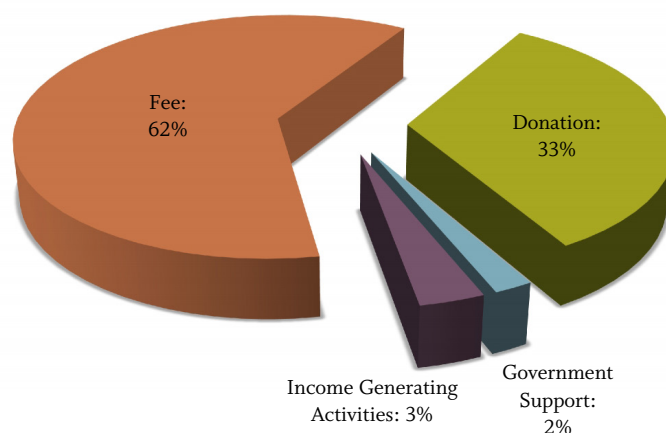
Antiretroviral Therapy: From the year 2008 to 2013 a total of 517 persons infected with HIV are receiving Antiretroviral Therapy at the Hospital. Out of the total that started treatment 13% died and 14% defaulted with 27% attrition rate both due to death and discontinuation of treatment within five years period.

Figure 2: Characteristics of Persons Infected with HIV who are on Care and Treatment at Dubo Catholic Hospital, Bolososore Woreda, 2008 - 2013



Affordability of services and cost implications: Out of the total budget utilized from 2008 to 2013, 62% was generated from service fee, 33% from donors, and 3% from income generating activities like cafeteria and other related sources. Government's contribution accounted 2% of the total spending (Figure 3).

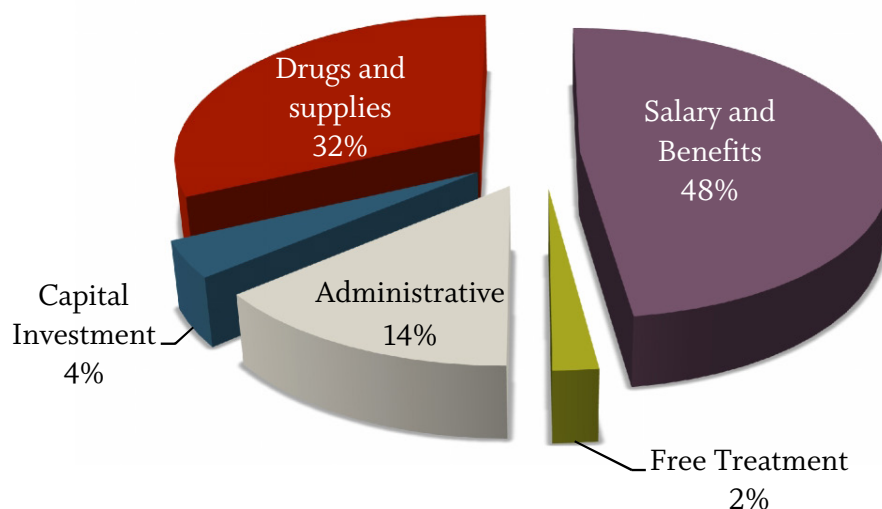
Figure 3: Percentage of Budget Share from Fee, Donation, Government and Income Generating Activities, Dubo Catholic Hospital, 2008 - 2013



Out of the total 52,320,102.37 birr spent from 2008 to 2013, 48% was spent for salary and benefits, 32% for Drugs and Supplies, 14% for administrative expenses, 4% for capital investment, and 2% to provide free treatment for those who don't afford to pay (Figure 4).

Considering the 226,211 patients who visited the hospitals for outpatient care, antenatal care, and delivery services in the six years period, the per capita spending is 231.29 Birr.

Figure 4: Bubo Catholic Hospital's Expenses By Category, 2008 - 2013



Out of the two patients interviewed one was concerned about cost of service;

“we brought her (patient) over the weekend, she was critically sick but now she is fine, so far we have paid more than 1,000 birr already, this is very expensive...I don't know how we will manage the remaining expenses” Caretaker of 55 years old female patient.

Another caretaker of chronically sick patient said the cost is reasonable compared to the service the hospital is providing. According to the general manager, free service is provided for patients who cannot afford to pay, which is verified through a screening and review process the hospital follows. Maternal and child health services are also provided free of charge for everyone, although, according to the general manager, this is weakening the amount of revenue collected from service fee as no one is refunding.

Main reasons for success

Some of the main reasons for success are:

Leadership: the board, led by the Bishop of the Ethiopian Catholic Church, is providing active management support. This has helped the hospitals expand services and generate more funding.

Commitment of staff: commitment of the administrative and technical staff has helped the hospital to maintain its track record of providing quality services.

Government support: although government could do better to strengthen service provision and minimize financial dependence on unreliable donor funding, the ongoing technical and material support particularly on TB and HIV and support provided to address shortage of medical doctors is recognizable.

Gaps and challenges encountered and ways to address them

Although the hospital is providing many appreciable services the following needs particular attention:

Weak link between the hospital and the public/community: The hospital does not have strong linkage with the community. The only way by which feedback is obtained is through suggestion boxes, but is insufficient, particularly in the rural context, as many patients are illiterate. It is important to organize regular community forums to review performance of the hospital and have community represented in the hospital management board.

Increasing trend in still birth rate: one of the indicators of quality maternal and newborn care services is percentage of stillbirth, which is increasing from time to time. The hospital might not have control over all factors that contribute to this, but it is essential to understand why this is happening and work closely with responsible government officials at different levels to address the problem.

Performance of the hospital showed decreasing trend: starting from 2011, significant reduction has been observed in services provision, which must be understood and a solution sought.

Electricity Power Problem: To combat the unreliable and low electricity supply, the hospital utilizes a high power generator, which is costing the hospitals thousands of birr each day for fuel and maintenance. Responsible government authorities need to solve this problem for better quality service.

Weak linkage with catchment health centers and health posts: The hospital has no substantial linkage with nearby public health centers and health posts. This needs to be improved for better referral linkage and teamwork.

General feedback and recommendations

In summary, the collaboration between the government and Dubo St Mary Primary Hospital is playing significant role in making hospital-based services accessible to the rural community without much financial and management burden on the government.

There is a need to design mechanism by which the hospitals could be reimbursed for the free services provided for mothers and children, otherwise it will be difficult for it to continue functioning as the revenue collected from fee is gradually decreasing over time.

7.1.2. Case of Wassera Catholic Health Center

Partnership description: The partnership agreement is between the government and a health center run by Ethiopian Catholic Church. The purpose of this partnership is to provide primary health care services for the rural community of the Doyenga Woreda in the SNNP Region.

Background information

Wassera Catholic health center was established as clinic in 1977 and it was upgraded to full functional health center starting from 2011. Currently the facility provides comprehensive preventive, promotive and curative health care to the rural community with reasonable price. It is being run by 6 volunteer Catholic Christian health professionals and 16 salaried health workers and 10 administrative supportive staff. The health center has more than 30 clean, fully equipped and well-maintained service delivery units. The Health center provides comprehensive services expected from a fully functional health center including ultrasound and dental care services except family planning.

Description of the partnership

This is a partnership between a health center run by the Ethiopian Catholic Church and government to provide primary health care services for rural community in DoyogenaWoreda, Southern Nations Nationalities and Peoples Region. While the Catholic Church cover majority of the expenses for building the facility, equipment, staffing, and other operation cost, the Woreda health office is providing drugs and supplies particularly for immunization, TB, and HIV; training for health workers and provide ongoing technical support through regular supportive supervisions, mentoring and review meetings.

Wassera health center is functioning under a formal partnership between SNNPR regional government and Ethiopian Catholic Church, Hossana Catholic Secretariat Office to provide primary health care services for the four kebeles of Doyogenaworeda namely Utuge, BagadamoGatame, HawaoraArrara, and MurasaWeramo. The health center is financed by funding from Catholic Christian private donors and by collecting free from service users.

The formal project agreement signed with the regional government lasts from July 2012 to June 2017. Based on this agreement the health center is working in partnership with Doyo-genaworeda health office even if there is no formal binding memorandum of understanding signed to formalize the partnership. Lack of such formal agreement with the Woreda health office has been limiting factor with regard to establishing effective mutual accountable and transparent partnership.

“we don’t have agreement with the woreda health office. We do things with common understanding; there is no written agreement on role and responsibilities. As non-profit making health center we want to be supported financially by the government, I have requested this but there is no response so far. There is no standardized relationship between us and the woreda health office, we need to have formal memorandum of understanding to avoid confusion on what to do and not to do” head of Wassera Health Center

Currently the health center is providing service to 25,610 population covering four kebeles in Doyo-genaworeda. It is one of the four health centers needed in the Woreda, three of the health centers are owned by government.

“This health center is viewed as key service delivery unit in this woreda, we participate in the planning and execution of activities like Immunization, TB, and other services. We get supplies for immunization, TB, and HIV from the Woreda based on our request. We have regular meetings with them, we attend training even if it is not adequate, we receive supportive supervision from the woreda and zone” Head of Wassera health center.

Major achievements

The delivery of quality primary health care services equitably at an affordable price in a rural area is one of the achievements. The health center is responsible for supporting the four health posts under their catchment. With regard to this training has been provided by the health center to health extension workers on; on how to establish and train health development army, on Maternal and Child health, Immunization, Tuberculosis, Malaria, and HIV.

“the support we provided for the establishment of HDA, support for health promotion and disease prevention work, the availability of better diagnostic services at the facility like ultrasound, effective referral system, immunization, free delivery

service even if this is not public facility, these all will have major impact in forming healthy community” head of Wassera Catholic health center.

In the year 2012 alone the health center provided outpatient care for 12,335 adults and 1,558 children below the age of 5 years, 469 mothers gave birth at the health center attended by skilled attendant, 2,140 persons got provider initiated HIV Counseling and Testing, 9,399 different types of laboratory investigations were done. In addition to this 199 patients were admitted for inpatient care, 27 minor surgeries were conducted.

To strengthen the linkage between the health center and health posts 16 supportive supervision visits were carried out to the four health posts. In collaboration with the health extension workers assigned in the four health posts and with the woreda health office it was possible to fully vaccinate 632 children, antenatal care has been provided to 1,211 pregnant mothers, post-natal care was provided for 798 mothers, and 2,074 women received family planning services. Four of the kebeles are open defecation free. Health education was provided to 31,105 people.

The per capita outpatient visit for the year 2012 considering all types of visits (care for sickness, antenatal care, family planning, vaccination) is calculated at 1.07 visit per person per year, when it is limited to care for sick adults and children it is calculated at 0.56 visit per person per year. As presented in Figure 5, delivery (57%), postnatal care (PNC) (96%), and fully vaccinated children (84%) coverage rates for the year 2012 were encouraging.

Figure 5: Delivery, Postnatal care, and Fully Vaccinated Coverage, WasseraHealth Center and Catchment Health Posts, 2012



The services being provided are of good quality as observed and described by the head of the health center as follows:

“We recently organized community forum to get feedback on our service, community liked the cleanliness of the facility, cleanliness of the toilets, they appreciated the respectful care and attentiveness of health workers. We give priority to our patient, we provide very good service, as you can see the facility is very clean, we provide timely and ethical service, we don’t look for the compensation we get rather we give attention to helping the community” head of Wassera Catholic health center.

Two service users were interviewed, 60 years old man and 30 years old woman, both appreciated the way services are orga-

nized, respectful and ethical way of service provision, cleanliness of the health center and bathrooms, availability of drugs and laboratory services consistently which made them travel long distance passing other health facilities on their way.

“when I arrived at this health facility I was nervous but in the process every one comforted me with care and got what I needed, now I am happy my problem is fixed and am going home” 30 years old woman.

Main reasons for success

The main reason for success is the commitment of technical staff, which mainly is because of appropriate handling, supportive management procedure followed in the health center and the fact that volunteers dedicate their time for good work to get blessing from God. The support received from donors helped to construct good quality infrastructure and equip it with quality medical equipment.

The other reason for the success is the support provided from government in facilitating the project agreement, supply of drugs and supplies for specific programs, and provision of ongoing technical support through supportive supervision, mentoring and review meetings.

Challenges encountered and ways to address them

The first major challenge is inadequate budget to run the health center due to unreliability of donor funding and scarcity of fee collected from service users as most maternal and child health services are provided for free and many more poor patients are also treated for free. So far there is no one reimbursing the health center for the free services provided.

The second challenge is lack of standardized partnership agreement with local government, Woreda health office, to guide the work relationship effectively.

The third challenge is the health center is not well involved in the planning, budgeting, trainings, review forums and supply of supplies and drugs is limited to specific programs.

Financial Implications

The 2012 annual budget of the health center was 1,409,718.49 Birr. Out of this 683,317.25 (48.4%) was revenue collected through fee for service while the remaining (51.6%) was received from donors. From the annual budget the health center utilized 1,046,729.41 Birr (74.25). Out of this 249,191.89 Birr (24%) was spent for salary and benefits of administrative support staffs, utilities, and other administrative expenses, 63,643.11 Birr (6%) has been spent for construction and maintenance and other capital investment and the remaining 733,894.91 Birr (70%) has been spent for drugs, supplies, salary and benefit of health professionals, free treatment and related direct program expenses.

The per capita health expenditure by this health center for the year 2012 was about 42 Birr, this doesn't include the spending through government for running health posts and cost of supplies coming from the public sector.

The cost of services provided by Wassera Catholic health center has been described as “very cheap” both by the head of the health center and interviewed service users. Maternal and Child Health, TB, HIV, and related services are provided free of charge for every one. Fee is collected from adult patients medical examination, laboratory services, ultrasound, and minor procedures. The health center provides free service for poor patients who can't afford to pay.

“all patients are treated fairly, if there are poor patients they get free service, we evaluate their income status or they bring letter from their kebeles” head of Wassera Catholic health center

Both service users interviewed reported affordability of the service by majority of the community who live in the area, they said it is cheap compared to the service provided as quoted below:

“The cost is not bad, it is cheaper than other facilities. We can afford to pay and get services as it is not expensive. Even if the community is poor still we can afford to pay as it is not expensive” 60 years old man

“I paid 115 Birrr for everything: examination, laboratory, and procedure. The cost of service is reasonable, I take it as normal, it is cheap” 30 years old woman

Key Lessons

The partnership can easily be scaled-up to other areas where there are similar health facilities being run by the Catholic Church or other non-for-profit organizations. Some of the key points of interest could be the following:

- i. The health center is very well maintained with regard to the infrastructure, availability of supplies and equipment, staffing, and relationship with the community, health extension workers, and the woreda health office. The cleanliness of service delivery rooms, maternity ward and delivery room and delivery beds, the compound, and toilets is appreciable. In summary it is clear the health center is providing quality services to the rural community under the woreda health office.
- ii. The support relationship the health center established with the health extension workers is encouraging and need to be strengthened further.
- iii. The regular community forums the health center is having with community is helping to strengthen the relationship between the health center and the community, get feedback to improve service provision and address community's concern.
- iv. Woreda health office is providing drugs and supplies particularly for immunization, TB, and HIV. In addition to this they are conducting regular supportive supervision and mentoring. The health center is participating in regular woreda level review meetings and trainings. But the support provided is far behind what is needed. The woreda could assign health workers to be based at this health center to address the shortage of health professionals, they can allocate budget for certain activities particularly to compensate services provided for free and to cover expenses for providing technical support to health posts.
- v. The cost of running such big health center can generally be assessed as reasonable compared to the services provided. The annual per capita spending per person is about 42 Birr. Six of the 18 technical staffs are providing free volunteer service. Out of their total budget about 70% is also spent for direct program implementation.
- vi. Community residing in the catchment area and neighboring woredas is using the service in fairly equitable way, there is free treatment scheme for those who can't afford to pay and services like maternal and child health, TB, HIV are being provided free for every one.
- vii. Lack of standardized memorandum of understanding between woreda health office and health center has been cited as a major problem for effective and transparent partnership.
- viii. As the health center is providing many services for free the revenue being collected is far behind from covering their running cost, this need long-term solution.

Recommendations

Recommendations in moving forward are as follows:

- i. Developing standardized template to be used as memorandum of understanding between the woreda health office and health center is critically important. This MOU need to list the roles and responsibilities of each party and implementation steps including monitoring mechanism.

- ii. The woreda health office could formally outsource primary health care services to the health center including financing of these services.
- iii. As the health center is providing some services not provided by other public health centers it can be used as referral center.
- iv. With regard to expanding the good practices of Wassera Catholic health center it will be good to create support network with nearby public health center or explore possibilities of outsourcing their management.
- v. The health center has serious shortage of health professionals, to address this problem 1) the woreda could assign health professionals covering their salary 2) the woreda could assign health professionals retaining their benefit for further education but salary could still be paid by the health center.
- vi. Although the health center has one of the best delivery rooms it is not being utilized well as the ambulances are taking laboring mother to other public health centers for unknown reason. This needs immediate attention.

7.1.3. Case of St. Luke Hospital and college of Nursing and Midwifery

Partnership agreement description: Under this agreement between Oromia Regional Health Bureau (ORHB) and Ethiopian Catholic Church, ORHB committed to support 24% of the annual running cost in the form of a grant. The grant contribution is to cover part of St. Luke hospital's local employee salaries, pharmaceuticals expenses and tuition fees for ORHB candidate students to attend St. Luke College of Nursing and Midwifery (30% of the admission quota of the nursing college is reserved for students coming from ORHB). In return the hospital is expected to render affordable services to the community.

Background

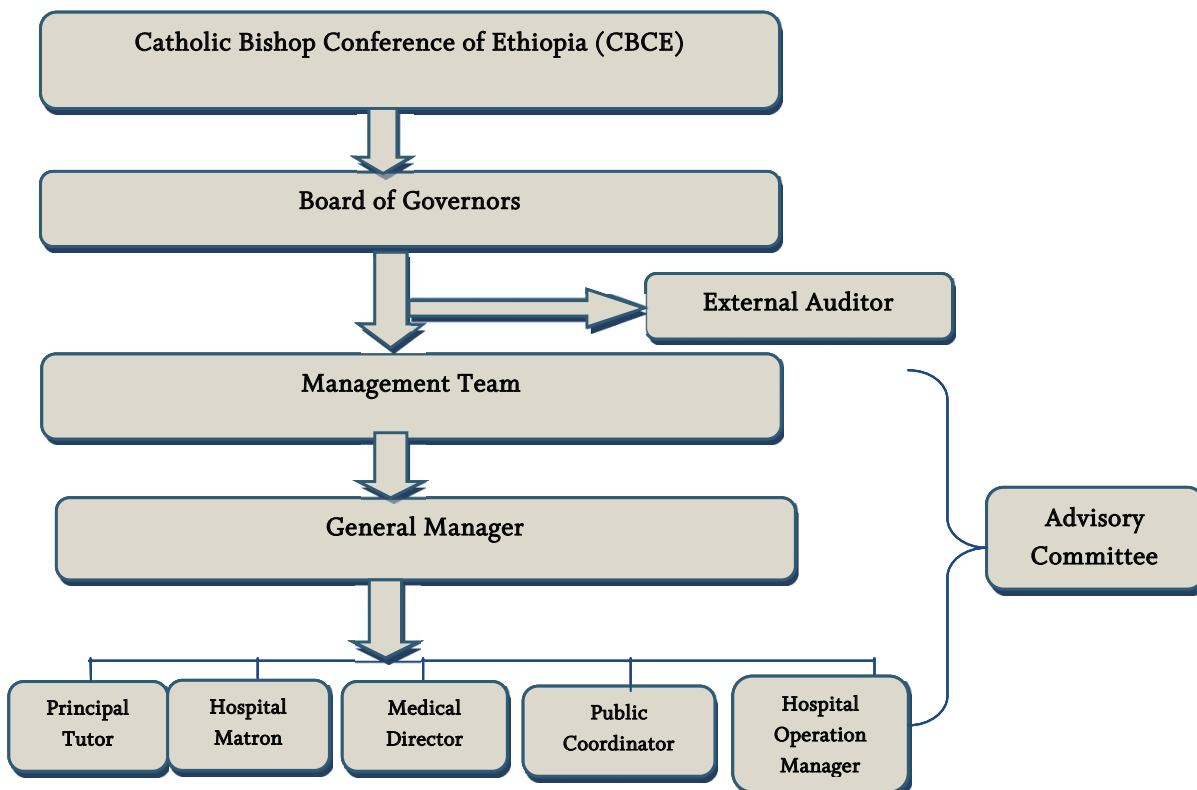
St. Luke Catholic Hospital and College of Nursing and Midwifery was established in 2001 in Wolisso town, Southwest Shoa Zone in Oromia region. With 397 staff (both technical and administrative) and 200 beds it provides outpatient and inpatient services with 24hr emergency access. The hospital serves a total of 764,337 people (female: 401,659 and male: 362,678). According to the HMIS data 75% reside in Wolisso and surrounding Woredas in Goro and Wonchi and 25% of patients come from other zones. The hospital provides the following list of services:

- Internal medicine, surgery, pediatrics, orthopedics, ophthalmology, TB clinic
- Delivery, neonatal, gynecology
- Maternal and child health services
- Voluntary counseling and testing and PMTC/ART
- Preventive care including outreach services
- Neonatal Intensive Care Unit and therapeutic feeding for malnourished children
- Other services including dental and mental health

The College of Nursing and Midwifery begun training in 2010 and was accredited in 2012. In the year 2013 the college graduated 16 clinical nurses.

The Board of Governors oversees operations of the hospital and college of nursing. The board has 13 members composed of representatives from zone administration, elders, representatives from different religions, women and youth, Red Cross, and regional police. The board is responsible for the overall organization and functioning of the institution and appoints and delegates the management team. The management team's task is to follow work progress, quality of care, decides on personnel recruitment and material availability and provides advice to the general manager. The management team is composed of 9 people and is accountable to the board. In addition, there is an advisory committee, which assists in resolving grievances originating either from the hospital and/or the public.

Figure 6: Organizational Management Structure of St. Luke Catholic Hospital and College of Nursing, Wolliso, Ethiopia, 2013



Description of the partnership

St. Luke Catholic Hospital and College of Nursing is operating under a formal agreement signed between the Ethiopian Catholic Church Social and Development Coordination Office/Doctors with Africa Cuamm/ and the Oromia Bureau of Finance and Economic Development (OBoFED) and Oromia Regional Health Bureau (ORHB). The project aims to decrease morbidity and mortality through the provision of primary health care services for the target population along with the provision of formal trainings to alleviate the shortage of health professionals, working in close collaboration with the ORHB. The project agreement is renewable every five years.

Under this agreement ORHB committed to finance 24% of the annual budget every year to cover part of St. Luke Hospital's local employee salaries, pharmaceutical expenses and tuition fees for ORHB candidate students to attend the nursing college. In return, the hospital is expected to render affordable quality health services to the community, including comprehensive curative and preventive care, outreach services, community based maternal and child care, screening and management of malnourished children, safe and clean drinking water, and diploma level pre-service training on nursing and midwifery.

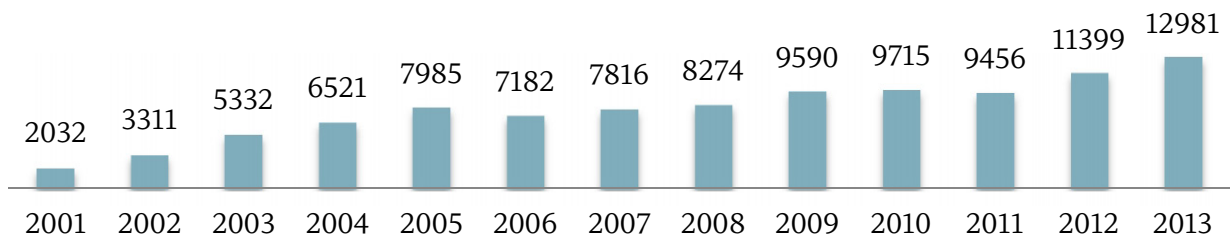
Major achievements

This partnership resulted in key significant achievements as listed below:

Enhanced access: access to affordable hospital-based primary care service created in a rural woreda.

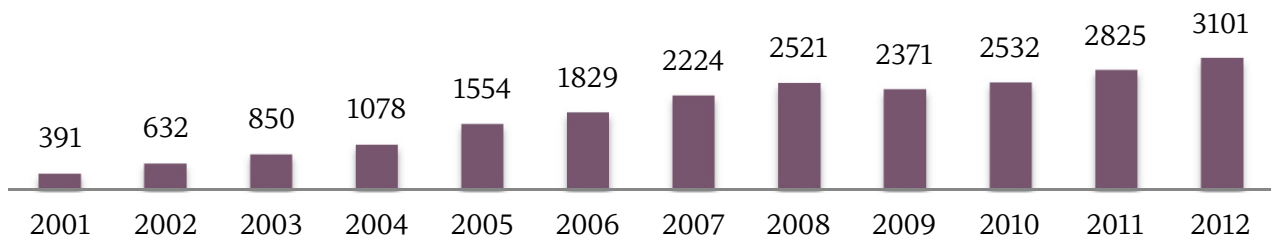
Boost in Service Utilization: since the hospital become operational in 2001, health service utilization in both inpatient and outpatient care showed significant increase. For example total number of patients who received inpatient care increased from 2,032 in the year 2001 to 12,981 in the year 2013 (Figure 7).

Figure 7: Total Number of Inpatient Care Services From 2001 to 2013, St. Luke Catholic Hospital and College of Nursing, Wolliso



Pregnant women who delivered at the hospital showed significant increase: As presented in Figure 8 the total number of women who delivered at St. Luke Catholic Hospital increased from 391 in the year 2001 to 3,101 in the year 2012.

Figure 8: Total Number of Births Attended at St. Luke Hospital from 2001 to 2012, Wolliso



Good quality care: As presented in Table 3 the proportion of general mortality (4.1%) and pediatric mortality (4.17%) rates were low for the year 2012. Caesarian Delivery Rate was 16.5% in 2012, which is acceptable, and infection rate from caesarian operation was 1.3%. In general, the bed occupancy rate was also high (86.6%) which indicates a high level of utilization for a rural hospital.

Committed staff: The hospital has very disciplined and religious oriented staffs providing better nursing and delivery care.

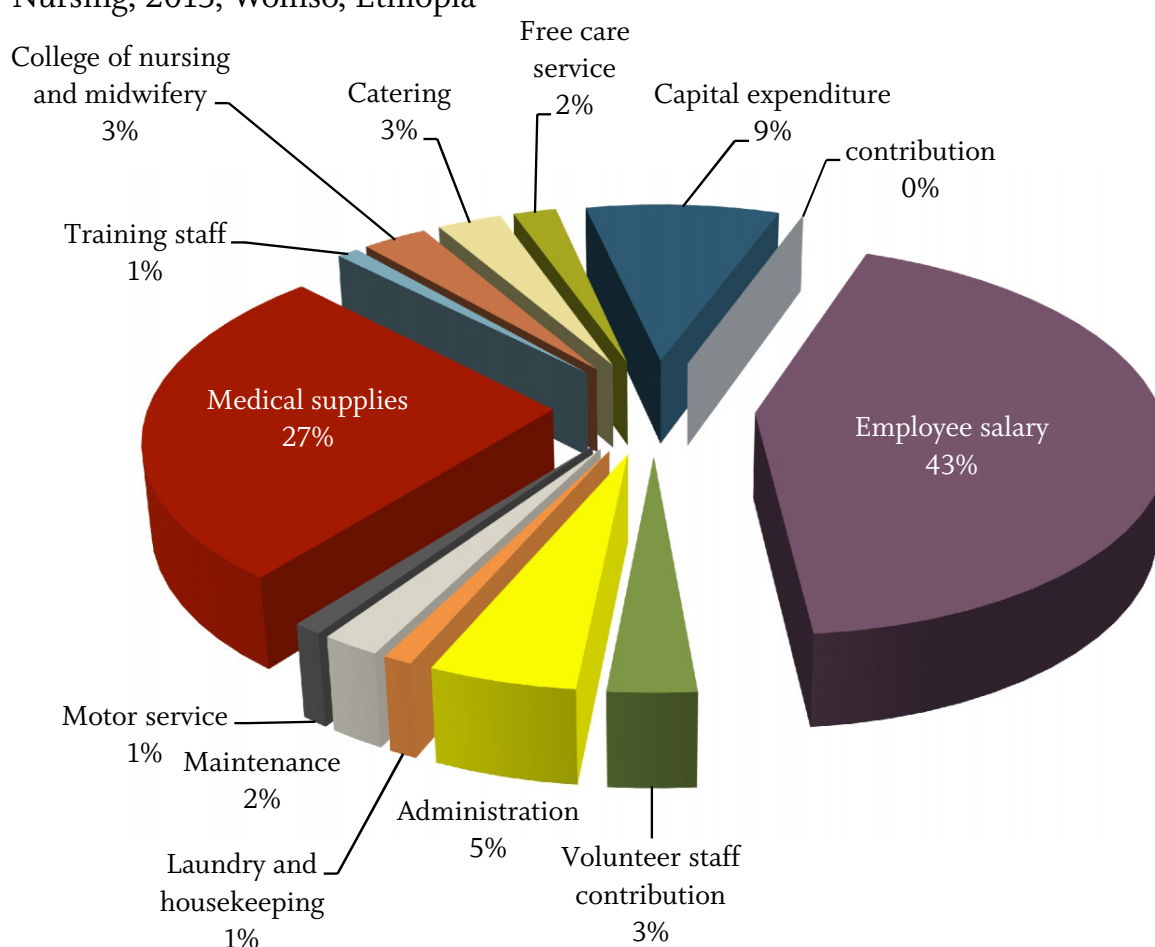
Table 3: Quality of Care at st. Luke Hospital, 2012, Wolliso

Indicator	Target	2012
General Mortality Rate	< 6%	4.1%
Pediatric Mortality Rate	< 6%	4.17%
Caesarian Delivery Rate	< 20%	16.5%
Caesarian Section Delivery Wound Infection Rate	< 3%	1.3%
Bed Occupancy Rate	85 % – 95%	86.6%

Financial implications and cost of services

The annual income of the hospital for the year 2013 was 29.6 million ETB. The breakdown of income by source was as follows: service fee (30%), donation (47%), Oromia Health Bureau (13%), the hospital emergency fund (6%), volunteer staff contribution (3%) and other sources (1%). Out of the total income, 28.8 million ETB (97%) has been spent in the same year, with the majority being spent on staff salary (43%) and medical equipment and supplies (27%) Figure 9.

Figure 9: Annual Expenditure by Type, St. Luke Hospital and College of Nursing, 2013, Wolliso, Ethiopia



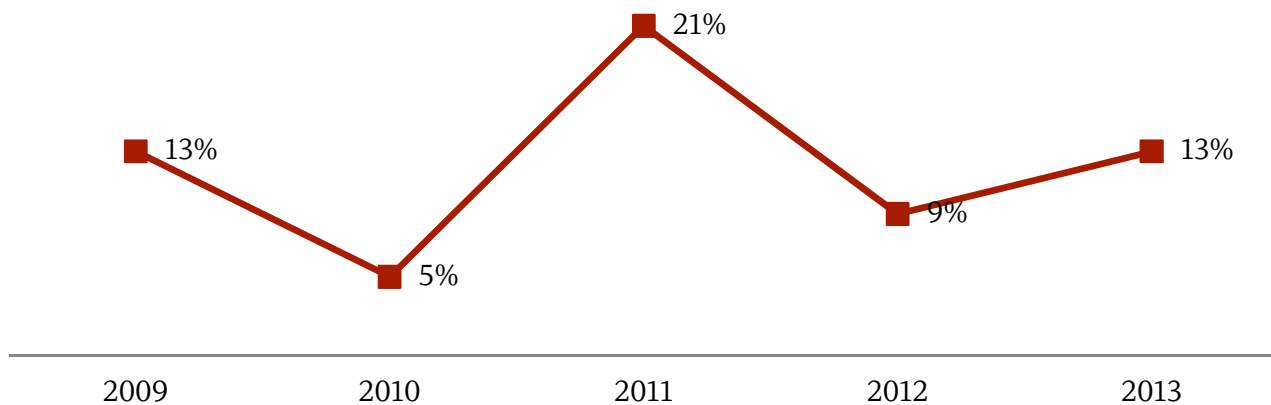
The hospital provides health services free of charge for poor patient and the cost of services is way below what private-for-profit health facilities charge but somewhat higher than public hospitals.

Challenges

Some of the challenges this partnership is facing are listed below:

- i. Finance: According to the Civil Society Agency's regulation the hospital need to generate 75% of the revenue from user fee and 25% from other sources. This will demand the hospital to increase cost of services which will create burden on the community and services will be limited to those who afford to pay. On top of this the financial support from ORHB has been less than what has been agreed (24%, Figure 10).
- ii. Medical Supplies and Equipment: shortages of medical supplies and equipment limited the hospital from providing optimal service to communities.
- iii. Standard for PPP: Lack of standardized modality to guide PPP created challenge with regard to guiding the collaboration in a transparent and mutually accountable way.

Figure 10: Financial Contribution to St. Luke Hospital from ORHB, 2009 to 2013, Wolliso



7.1.4. Case Study I: Case of Bilal Primary Hospital

Partnership description: The partnership agreement is between Dire Dawa Regional Health Bureau (RHB) and Bilal Primary Hospital to provide Antiretroviral Therapy (ART), Directly Observed Therapy of Short Course (DOTS) for Tuberculosis (TB), Malaria diagnosis and treatment, Prevention of Mother to Child Transmission of HIV (PMTCT), Immunization and Family Planning (FP) services.

Background information

Bilal Primary Hospital was established as a private-for-profit health facility in Dire Dawa in 2004 to provide comprehensive services to the community living in the town of Dire Dawa and nearby woredas. The Hospital has a fully functional operating room, delivery room, 42 beds, X-ray and other advanced diagnostic facilities. Currently the hospital has 2 general practitioners, 1 internist, 2 X-ray technicians, 1 pharmacist, 4 druggists, and 24 nurses (including four midwives) and other types of health professionals, with a total of 51 technical staff and 61 administrative support staffs.

Description of the partnership

The Dire Dawa RHB partnered with Bilal Primary Hospital in order to enhance access to key public health services and address fragmentation of services by avoiding unnecessary referrals. The partnership was established to provide the following services: Antiretroviral Therapy (ART), Directly Observed Therapy Short Course (DOTS) for TB, Malaria diagnosis and

treatment, Prevention of Mother to Child Transmission of HIV (PMTCT), Immunization and Family Planning (FP). The collaboration on HIV/AIDS was initiated in 2005 and DOTS treatment in 2006. The collaboration on Malaria was initiated in August 2013.

Responsibility of government: Dire Dawa RHB provides the following support:

- In-service training and on-the-job technical mentoring for service providers at Bilal Primary Hospital on ART, TB, FP, PMTCT, Vaccination and Malaria treatment services
- Drugs and supplies needed for the provision of services related to ART, TB, FP, PMTCT, Vaccination and Malaria treatment services
- Regular supportive supervision and quality assurance monitoring.

Responsibility of Bilal Primary Hospital: As the primary service provider, Bilal Primary Hospital is responsible for the following:

- Assigning fulltime health professionals dedicated to providing ART, TB, FP, PMTCT, Vaccination and Malaria treatment services
- Dedicating service delivery rooms for ART, TB, FP, PMTCT, Vaccination and Malaria treatment services
- Making sure high quality ART, TB, FP, PMTCT, Vaccination and Malaria treatment services are provided
- Ensuring responsible use of drugs and supplies intended for the provision of ART, TB, FP, PMTCT, Vaccination and Malaria treatment services
- Organizing regular performance reports to share with Dire Dawa RHB
- Making sure services are provided at an affordable price

In general, there is a close work relationship between the two parties, resulting in more than a decade-long successful partnership.

“The support we got from the RHB is mainly related to training, supplies, drugs and necessary logistics essential to run the program. From our side the hospital dedicated health professionals, assigned room, and complied with all the requirements. We are also getting ongoing technical support from start to date. ICAP has been with us from the start-up of the program until it is fully functional” Head nurse of Bilal Hospital.

Major achievements

The major achievements of this partnership are summarized as follows:

- i. 829 HIV infected persons are on follow-up and care out of which 456 are taking ART
- ii. On average 23 patients every month are getting Provider Initiated Counseling and Testing (PICT) for HIV
- iii. On average 6 new patients start TB DOTS every month
- iv. On average 7 new clients take contraceptives every month
- v. On average 10 – 15 Malaria patients get diagnosis and treatment services every month, and
- vi. On average 41 pregnant women and 49 children receive vaccination every month.

The head nurse of the hospital emphasized the benefit of the partnership as follows:

“This [partnership] helped us to deliver comprehensive service and avoided unnecessary referral and discontinuation of services. For example patients could be admitted in our hospital for any medical reason. Because of the existence of PICT [Provider Initiated Counseling and Testing] we will screen them for HIV, if they are found positive we will immediately link them to the ART services. A mother who delivers in this hospital will get PMTCT, immunization, and family planning services without additional payment ensuring comprehensive services provided to service users in the same health facility” Head nurse of Bilal Hospital.

Immunization: The hospital provides vaccination services to both children and pregnant women using supplies delivered to them from the RHB. From July 20, 2013 to April 30, 2014 a total of 543 children received at least one vaccination from the hospital; an average of 49 children per month. Similarly, from September 10, 2011 to June 23, 2014 a total of 1,717 pregnant women received at least one Tetanus Toxoid (TT) vaccination; an average of 41 pregnant women per month.

Malaria Diagnosis and Treatment: The collaboration on malaria was initiated in August 2013 and currently an average of 10 to 15 malaria patients are getting diagnosis and treatment services from the hospital every month.

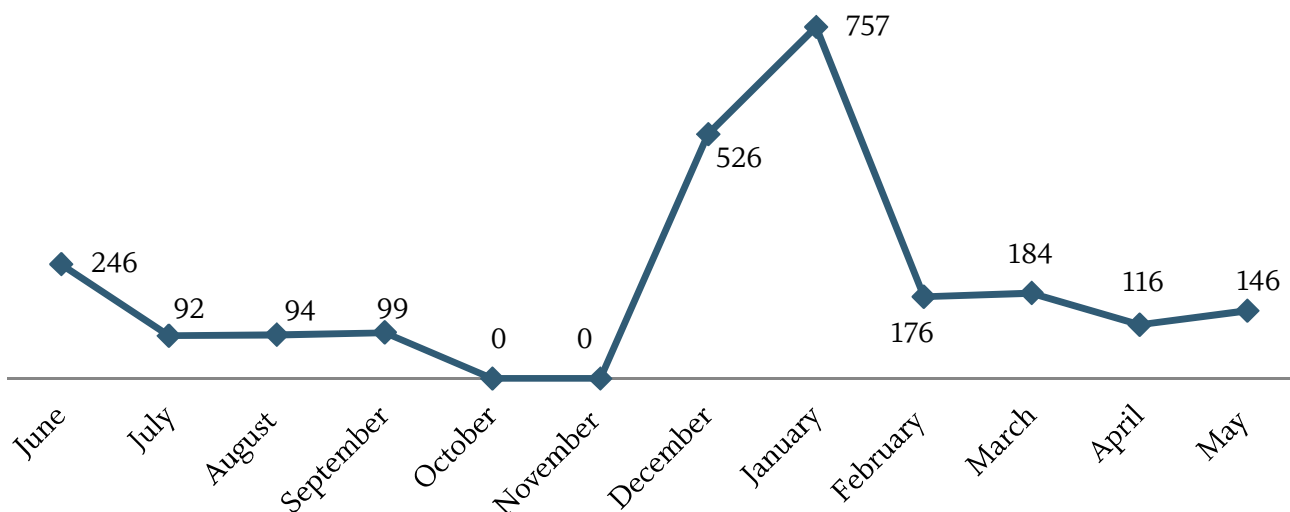
Family Planning: From June 14, 2012 to June 20, 2014 a total of 159 new contraceptive acceptors utilized the family planning service. With regard to the method mix, 93 (58%) used injectable, 63(40%) used implant, and 3(2%) used Oral Contraceptive Pills. On average, seven new clients are receiving contraceptives from the hospitals every month.

The head nurse of the hospital expresses utilization of family planning services:

“We (Bilal Hospital) started providing family planning service last year, it needs time and as most of our clients are Somali they don’t want to use it. It needs negotiation to convince them to use it. Use of PMTCT service is also growing, last year 44% of [HIV positive] ANC clients used PMTCT, this year 100% of [HIV positive] ANC clients are using PMTCT” Head nurse of Bilal Hospital.

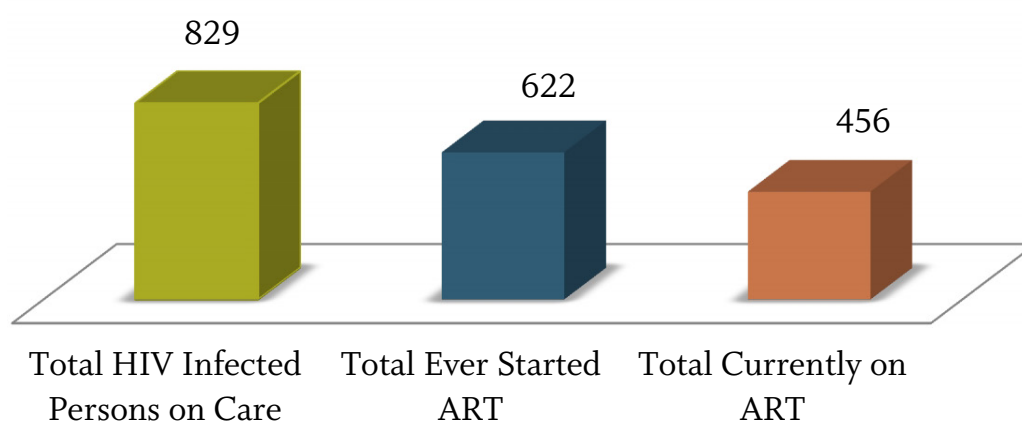
Provider Initiated Counseling and Testing (PICT) for HIV: As presented in Figure 11, from June 2013 to May 2014 a total of 2,436 patents received PICT for HIV with an average of 203 tests being carried out every month. The service was interrupted for the months of October and November, 2013 due to stock out of test kits.

Figure 11: Number of Provider Intiated Couselling and Testing (PICT) for HIV, Bilal Primary Hospital, Dire Dawa, June 2013 to May 2014



Antiretroviral Therapy: Between the years 2005 and 2014, a total of 829 HIV infected persons were recruited for HIV follow-up and care and 622 (75%) of these persons started ART. Of those that started ART, 456 (73%) are still currently on treatment while 168 (27%) have either died, defaulted from treatment, or transferred-out to other health facilities (Figure 12).

Figure 12: Total Number of HIV Infected Persons who are on Care and Support, Ever Started ART and Currently on ART, Bilal Primary Hospital, August 2005 to May 2014, Dire Dawa



Tuberculosis: From August 2010 to June 2014 a total of 209 TB patients received DOTS, averaging 6 new DOTS patient recruits per month. Of those receiving treatment, 10 (5%) died. There were no reports of defaulters or treatment failure.

Affordability of services and cost implications

As a private-for-profit health facility, the hospital charges patients for medical examinations and diagnostic services, but treatment, vaccination, or contraceptives are provided free of charge. The regular fee for a medical examination is 40 Birr with a special rate reduction to only 5 Birr on Fridays. To benefit from these discounted services, patients needing ART and DOTS treatment are intentionally scheduled for Friday appointments.

“These [ART, TB, FP, PMTCT, Vaccination and Malaria treatment services] services are provided at affordable price, the only payment requested is medical examination fee unless they need other diagnostic services. The medical examination fee is 40 Birr per patient per visit on Monday to Thursday but to help those who don’t afford to pay the fee is reduced to only 5 Birr on Fridays. This is affordable to the poor, average and rich patients. The profit to the hospital out of these services is very minimal, almost non-existent compared to the human resource and service delivery room the hospital is contributing” Head nurse of Bilal Hospital.

Main reasons for success

The consistent and reliable support provided by Dire Dawa Regional Health Bureau and partners working with them, as well as the commitment of the hospital including the staff and management have enabled the successful partnership to last over 10 years.

“We [the hospital] get regular support from the RHB; they review our performance, check the quality of our work and mentor us as needed. They check how we are using the supplies and overall quality of our work. I take this positively” Head nurse of Bilal Hospital.

Gaps and challenges encountered and ways to address them

The main challenge the hospital is facing currently is an unreliable supply of TB drugs, which has become more common recently. Previously the hospital collected drugs from the Regional Health Bureau and never had serious problems, but the

hospital has recently been required to collect drugs from the nearby health center. This shift in distribution responsibility from the regional to woreda level has made it very difficult for the hospital to obtain drugs, and has been attributed to the inefficiency of the health center:

“Our greatest challenge right now is inconsistent supply of TB drug. Previously we use to collect our share from the region and we didn’t have serious problem but recently we were told to collect our share from the catchment health center. Since that we have been seriously suffering. I don’t know the reason behind; I guess it might be because of the inefficiency of the health center we are not treated properly. The other problem is shortage of HIV test kit ” Head nurse of Bilal Hospital.

General feedback and recommendations

The experience of Bilal Hospital demonstrates the potential of partnering with private primary hospitals as a means of expanding access to primary health care services with significant public health importance. With minimum support provided from government, significant number of patients who prefer to go to private providers are benefitting from the service.

Yet, these types of partnerships need strong monitoring and follow-up to ensure:

- i. The quality of service is not compromised
- ii. Supplies and drugs are not misused
- iii. Patients are not paying unnecessary and inflated fees
- iv. Supplies are being delivered to the private facility timely and without difficulties
- v. Proper and regular mentoring and technical support is provided to service providers
- vi. Providers are being appreciated, encouraged, and properly compensated in order to maintain their motivation and commitment.

The head nurse of the hospital emphasized this as follows:

“Government need to utilize the private sector very well, lots of work is being done through this sector. It needs attention like the public sector, we are providing quality service better than the public facilities but we are not getting adequate support, for example we are denied of drugs for treating HIV related opportunistic infections, they say this is not for private providers, while we are serving the same community. As professional my general recommendation is if the government’s attitude towards the private sector could improve. We shouldn’t be considered as if we all run for money while we are dedicated for public service. There has to be supportive environment”

Head nurse of Bilal Hospita.

7.1.5. Case of Gizaw Higher Clinic

Partnership agreement description: The partnership agreement is between Oromia RHB (RHB) and Gizaw Higher Clinic to render quality FP, TB, Malaria and PMTCT services to the community at affordable prices.

Background information

Gizaw Higher Clinic was established in 2003 in Shashemene as a private-for-profit higher clinic to provide comprehensive health services, focusing on curative care at the outpatient care level with limited inpatient care for stabilization purpose. Around the clock health services are provided every day. With regard to fulltime staffing there is 1 internist, 1 General Practitioner, 7 Nurses, 2 Laboratory technicians, and 1 X-ray technician. The set-up is well organized with different service delivery units including a delivery room, ultrasound service, an X-ray room, and an isolated room for TB patients. The clinic provides varying services to an average of 30 patients daily.

Description of the partnership

This partnership is between Oromia RHB and Gizaw Higher Clinic to provide quality FP, TB, Malaria and PMTCT services to the community at affordable price.

Responsibility of government: Oromia RHB provides the following support:

- In-service training and on-the-job technical mentoring for service providers on FP, TB, Malaria and PMTCT
- Drugs and supplies needed for the provision of services related to Family Planning, TB, Malaria and PMTCT
- Regular supportive supervision and quality assurance monitoring. Responsibility of Gizaw Higher Clinic: The higher clinic is expected to provide the following support:
- Assigning fulltime health professionals dedicated to providing Family Planning, TB, Malaria and PMTCT services
- Dedicating service delivery rooms for FP, TB and PMTCT services
- Making sure FP, TB, Malaria and PMTCT services are provided according to the guidelines and standards
- Ensuring responsible use of FP, TB, Malaria and PMTCT supplies and drugs provided by the government within the Clinic
- Organizing regular performance reports to share with Oromia RHB as per the agreed timeframe
- Ensuring quality of service including compliance to treatment regimen
- Being responsible and accountable to overall quality of service provision as a service provider.

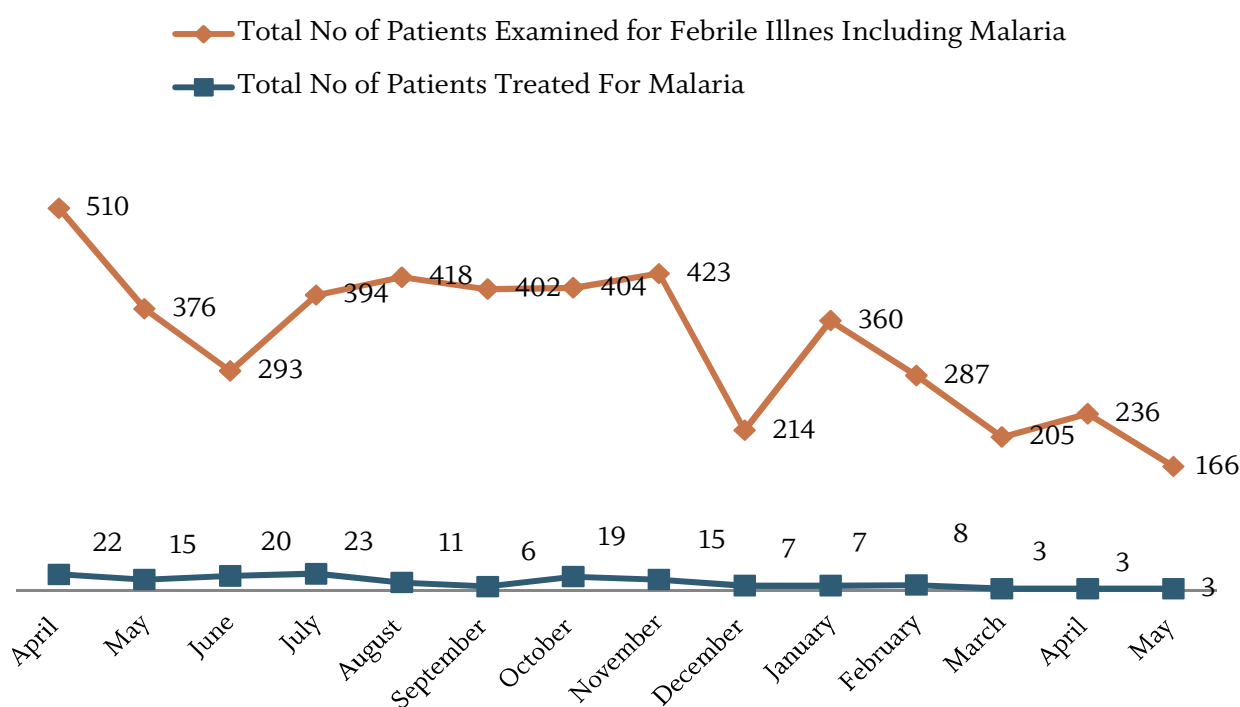
Major achievements

The major achievements of this partnership documented since May 2012 are summarized as follows:

- i. 162 Malaria patients received treatment,
- ii. 128 new contraceptive acceptors received family planning services,
- iii. 84 TB patients received Directly Observed Therapy Short course (DOTS),
- iv. 110 pregnant women received PMTCT services, and
- v. 420 clients received HIV Counseling and Testing Service.

Malaria Diagnosis and Treatment: As presented in **Figure 13**, from April 2013 to May 2014, a total of 4,688 patients were examined at Gizaw Higher Clinic for possible malaria infection, out of which 162 (3.5%) were diagnosed and treated for Malaria. The trend of patients examined for Malaria decreased from 510 per month in April 2013 to as low as 166 per month in May 2014. This could be partly attributed to the seasonality of Malaria, as well as inconsistency in the availability of drugs and supplies, quality of services, or cost of services.

Figure 13: Total Number of Patients Examined for Possible Malaria Infection and Total Number of Patients Treated for Malaria, April 2013 to May 2014, Gizaw Higher Clinic, Shashemene, Oromia Region, Ethiopia

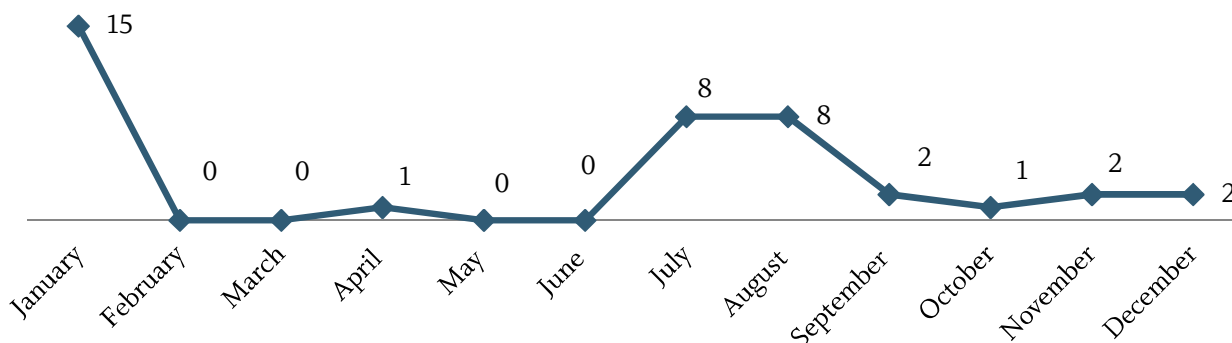


Family Planning: Family Planning (FP) services have been in place at the clinic since May 2012. From May 2012 to April 2014 a total of 128 new clients (average of 6 new contraceptive acceptors per month) received contraceptives, out of which 75 (50%) used Oral Contraceptive Pill (OCP), 35 (27%) used injectable, 13 (10%) used implant, 4 (3%) used emergency contraceptive pills, 1 (< 1%) used condoms.

A full one-year trend of contraceptive use for 2013 is presented in Figure 14. As seen in the figure, the number of new contraceptive acceptors remained low (2 or below) for 9 months, with the number of clients increasing in January (2 injectable, 11 OCP, 1 implant), July (3 OCP, 3 injectable, 1 condom, 1 implant) and August (4 OCP, 2 implant, 2 emergency contraceptive).

Generally, FP services are not well utilized by the community, possibly due to lack of awareness about the availability of the service in the clinic or preference for public and non-for-profit organizations like Family Guidance Association, and Marie Stopes International.

Figure 14: Total Number of New Contraceptive Acceptors by Month From January to December, 2013, Gizaw Higher Clinic, Shashemene, Oromia Region, Ethiopia



Tuberculosis: Over a 33-month period (From July 2012 to March 2014) a total of 84 patients were diagnosed with TB and received treatment from the clinic (average of about 3 new TB patients per month). From July 2013 to March 2014 (21 months period) a total of 873 patients were examined/screened for TB, out of this 47(5%) were found to be eligible for TB treatment. The clinic is doing great job in screening patients for TB, average of 42 patients screened for TB every month.

Prevention of Mother to Child Transmission of HIV and HIV Counseling and Testing:

From August 2012 to June 2014 a total of 110 pregnant mothers received antenatal care. All were tested for HIV with the aim of preventing the transmission of HIV from infected mother to her baby. During the same period, 420 persons received HIV counseling and testing services and 19 (4.5%) were found positive for HIV and linked to facilities providing ART services.

Affordability of services and cost implications

The clinic provides affordable services with the following out-of-pocket fees established: 20 Birr for medical examination of adult patient, 10 Birr for medical examination of child, 5 Birr for injectable contraceptive, 15 Birr for implant insertion, 20 Birr for implant removal, 30 Birr for HIV counseling and testing. Oral contraceptives and condoms are provided for free. The cost for laboratory, radiology and other services was determined considering the income level of the community. The daily dispensary of TB drugs is provided free of charge even during weekends.

The administrator of the clinic explained the costing of services as follows:

“This clinic was established for the memory of late MrGezahegn, mainly to serve the community. Our purpose is not making high profit rather it is providing public service at reasonable cost. As this is not rented building we are providing discounted services. On top of this we have mechanism to provide fee service to extremely poor patients” Administrator of Gizaw Higher Clinic.

Main reasons for success

The clinic’s dedicated staff, availability of service delivery rooms for the various services, and the support of the government in providing in-service training and regular mentoring support serve as key factors for its success.

Gaps and challenges encountered and ways to address them

As described by the service providers, despite key achievements, this partnership is facing many challenges. These are related to the inefficient and weak support provided by Oromia RHB, as well as the zonal and woreda health offices and health centers. Inconsistent supply of drugs and other supplies from the catchment health center seriously affect service provision at the clinic.

Another challenge mentioned is the unfavorable attitude of government officials during monitoring visits, whose faultfinding attitudes discourage the providers. Inconsistent and irregular report requests also interfere with the routine duties of service providers.

Finally, lack of a formal binding contract between the two parties serves as another key challenge, impeding transparency and accountability of stakeholders.

General feedback and recommendations

In summary, this type of partnership could have a tremendous effect in expanding access to key primary care services if managed properly. In order to expand this model to other clinics in the country, the followings are essential:

- i. Existence of close supportive monitoring of service provision,
- ii. Awareness creation for the community to utilize services,
- iii. Consistent supply of drugs and supplies as per the agreement,
- iv. Designing of clear terms of references and binding agreement,
- v. Acknowledgement of the private sector as a key part of the health system; and facilitation of an environment for private health sector to grow and provide high quality service.

7.1.6. Case of Jimma Higher Clinic

Partnership description: The agreement is based on the collaboration and support of FMoH and Abt Associates to render four key public health services: diagnosis and treatment of TB, comprehensive HIV care and prevention/treatment of other STIs, family planning, and diagnosis and treatment of malaria. The purpose of this partnership is to employ private sector in provision of these services free of charge to improve service accessibility for patients, while government maintains responsibility of task coordination, including supplying medication and providing supportive supervision.

Background

Jimma Higher Clinic serves as one of several private higher clinics in Jimma. The clinic traditionally provides outpatient and inpatient services for a variety of program areas, including obstetrics and gynecology, physiotherapy, as well as primary public health services such as TB, ART and STI. Clients visiting this facility for treatment of TB and STI pay user fee.⁵

Description of the partnership

The partnership is in collaboration with the FMoH and supported by Abt Associate. Through the technical assistance of Abt Associates and the Private Health Sector Program (PHSP), Jimma Higher Clinic undertook provision of four key public health services, including:

1. Diagnosis and treatment of tuberculosis (TB)
2. Comprehensive HIV care and prevention/treatment of other STIs
3. Family Planning
4. Diagnosis and treatment of malaria

The purpose of the partnership was to render these key services free of charge in private facilities to ensure availability and accessibility for patients. Partnership works on TB and HIV services have started as part of the pilot program and the clinic has been working in collaboration since then. The partnership does not exist under formal contract, but through a common understanding, with most focus on reporting of services provided free of charge through PHSP/Abt Associate support.

In addition, the facility has regular and direct contact with the city administration health office; the administration provides material supplies required for free services such as TB drugs, reagents, sputum cap and slides. Medical supplies are delivered upon the clinic's request. As long as the requests are based on the logistics request/reporting formats and the supplies are available in the store the health bureau delivers the request accordingly. In exchange, the clinic reports on monthly and quarterly basis to the city health office.

When the pilot program started professionals were trained and the facility was linked to the health bureau. Despite facing challenges in the beginning, this working relationship with the bureau is under good conditions and no service distinction between public and private facilities currently exists, as all services are provided in collaboration with regional health bureau. Referral linkage with other health centers and hospitals is also in good terms. Mainly for ART services, patients with HIV positive diagnosis are referred to public health centers and hospitals.

There are three or four private facilities working on TB/HIV program and there is favorable working relationship with these facilities. There is diagnostic service referral in between these facilities and other public and private facilities. Resource (disposable or permanent) sharing culture via formal procedure is practiced as well.

⁵An assessment of Jimma conducted by the Ethiopian Private Sector Program found that cost of STI treatment at Jimma Higher Clinic and other surrounding private clinics is around 200 birr and generally available to only the more affluent. Although complaints of public service quality exist, treatment is much cheaper at 10-15 birr (Deribew, Amare. February 2009. *Distribution of Most-at-risk Population Groups and Their Perceptions Towards HIV/AIDS: A Baseline Survey in Oromiya Region for the Implementation of Mobile HIV Counseling and Testing*. Bethesda, MD: Private Sector Program-Ethiopia, Abt Associates Inc.)

Major achievements

Several major achievements of this partnership were documented.

Reduced private-public service gap: the partnership work reduced the communication and collaboration gap between public and private facility. There is a productive group effort between the two sector facilities now. It also created an opportunity for professional to build their capacities, share experiences and learn from best practices. If such program were not established the gap would still persist.

Quality of service: the clinic assigned a physician to provide TB-HIV, Malaria, PMTCT, HIV/AIDs services for the clients exclusively. The physician is not expected to undertake other nursing services but give full attention and effort to clients. Thus, the services are rendered promptly with no delays and waiting time.

Service utilization: considering the resources invested over the last 7 years, significant achievements are gained - more than 800 patients received and completed treatment during this period. If the service were not available, the patient would have received the treatment in crowded facilities, which is a potential to increase defaulter rate. Furthermore DOT program is strict and facilities are accessible to the population, which contributed to reduction of defaulter rate.

In addition, cure rate is nearly 93 percent and death rate has significantly decreased. Collaboration work has brought better alternatives for service outlets. In addition, its proximity to the community does help reduce defaulters. The clinic's reputation has improved among the community; services recognition has enhanced, access increased and capacity building support from the city administration health office gained.

Challenges encountered and ways to address them

Despite key achievements attained through this partnership, challenges still remain. These indicated challenges are summarized as follows:

- Communication and interaction with the Regional Health Bureau is very poor.
- Resistance from patients to take prescribed drugs due to their lack of basic nutrition. Such issues create challenges during service delivery and counseling sessions. This is mainly because TB patient are from a cluster of low-income status population.
- There is a very weak supportive supervision from stakeholders.
- Service fee is higher compared to other facilities and there is a longer waiting time as well.
- There are no ART and immunization services in the facility and TB patients with co- morbidity resist referrals to other facilities and which leads to treatment interruption mainly for ART service.
- Staff is pressurized with workload and multiple duties.

Recommendations

In summary, the employment of private sector providers, such as Jimma Higher Clinic, in provision of key public health services is essential in increasing equitable access to quality services for populations in need. Considerations of scaling up to other clinics and sustainability of this model require the following considerations:

- To scale up the service, the partnership should be managed by strong leadership capable enough to deal with challenges beyond the service delivery boundaries and able to bring sustainable solutions.
- TB incidents are frequent in a population cluster of low socio economic status, thus services should be delivered free of charge/subsidized. Considering the TB exposed population group and the long-term treatment period the service would not be affordable if delivered otherwise.
- To promote patient safety and confidentiality, ART service should be built-in to the services. This would contribute

to reduction of defaulter rate in TB programs and others.

- Services such as immunization should be extended to private sector facilities as well and scale up best practices to other public health services.

7.1.7. Case of MizanAman Hospital

Partnership description: This is partnership between three different local cooperatives and MizanAman Hospital. The hospital outsourced three different services to different local cooperatives with the aim of improving service provision and efficiency.

Background

MizanAmanHospital is a public hospital located in Bench Maji zone, SNNP region. The facility serves nearly 2 million people living in Sheka, Kefa, and Benchmaji Zones in SNNP, Gambella region and the MizanTepi University community.

The hospital has a total of 240 staff out of which 145 are health professionals consisting of 10 general physicians (GP), 1 surgeon, 1 gynecologist and 1 emergency surgical officer. Services are provided at outpatient and inpatient units with 103 beds.

Description of the partnership

This partnership is between 2 small-scale cooperatives and MizanAman hospital to outsource cash collection, security, and recording/archive services within the hospital. These services were previously directly handled by the hospital, however, they were inefficient and the community complained about them.

A local cooperative named “Arsema Cooperatives” was contracted to provide the cash collection service at the hospital. There are four daily cash collection sites in the hospital, and the cooperative takes responsibility for managing these sites. They manage recruiting and assigning staff, fulfilling logistics needs, and other management support to run the cash collection system efficiently. The cooperative is responsible for collecting cash daily, depositing it at the National Bank of Ethiopia, and submitting a report to the hospital daily. Another local cooperative, called “DentamoKaytse Cooperatives” was contracted to provide security services for the hospital. The cooperative is responsible to hire, train and assign an adequate number of security officers, and make sure the hospital is safe and well protected. A third cooperative, called “Nushutan Cooperatives”, was contracted to provide the recording/archive service. This cooperative is responsible for managing the electronic patient recording and archive system. For all three cooperatives an agreement was signed between the respective cooperatives and the hospital and is renewable every six months.

Major achievements

Several key achievements of this partnership were documented:

- **Community ownership:** the partnership work resulted in multiple benefits. Primarily, it bridged the relationship between the hospital and the community. Since the youth cooperative members are from the community, community participation and ownership has been ensured.
- **Improvement in client satisfaction:** client's satisfaction and quality of services have improved significantly. Client and staff satisfaction was recorded above 85% consistently since these services were outsourced.
- **Efficiency:** the hospital has benefited from efficiency gains as well. The hospital saved nearly 300,000 Birr as the result of the outsourcing of services from July 2012 to June 2013.

Challenges encountered and ways to address them

The main challenge in the process of outsourcing is the weak technical capacity and organizational structure of the newly formed cooperatives. This is expected to improve as time goes on through capacity building and experience.

7.1.8. Case of DebreBerhan Referral Hospital

Partnership description: DebreBerhan hospital started implementing health care financing scheme in 2010 and now the hospital is working on a partnership agreement with two foreign private sector institutions for clinical services.

Background

DebreBerhan Hospital is a public hospital located 130 km from Addis Ababa in North Shoa administrative zone, Amhara region. The hospital was established in 1937 with 25 beds. Currently it has 130 beds, and the hospital serves a total of 2.4 million population. There are 366 employees: 261 technical and 105 administrative. The hospital provides comprehensive curative and preventive services in inpatient and outpatient departments.

The hospital's sources of income are annual government budget allocated by the Amhara RHB and internal revenue generated from services. For the year 2012/2013 66% of the budget was allocated by government while the remaining 34% was generated from internal revenue.

International Clinical Laboratories (ICL) is a US based company with an outstanding experience providing quality laboratory services including pathology and cytology tests in Ethiopia for nearly a decade. ICL is the only laboratory in the African region to be accredited as diagnostic laboratory by the Joint Commission International USA.

Description of the partnership

An agreement between DebreBerhan Hospital and ICL was signed as part of a strategy to institute a number of policy changes aimed at increasing resources available for the health sector, improving the efficiency of resource use, and promoting quality and sustainability. DebreBerhan Hospital and ICL have agreed to work collaboratively to improve DebreBerhan's laboratory services. The agreement was sought because the hospital's laboratory service was in need of overall capacity building for improvement of services.

The purpose of the agreement is to establish a mutually beneficial public private partnership between the hospital and ICL to provide quality laboratory services and to upgrade the capacity (knowledge and skill) of the hospital staff. The role and responsibilities of the respective organizations are described below:

Responsibility of ICL

The roles and responsibilities of ICL are as follows:

- Provide need-based capacity building training for hospital's laboratory professionals
- Organize necessary logistics and supplies
- Serve as a referral laboratory for DebreBerhan's patients as needed
- Put in place Laboratory Information System (LIS)
- Complete tests within stated Turn Around Time (TAT)
- Provide laboratory services 7 days a week from 8 am to 4pm
- Provide service price attachments for all tests
- Give 30% service discount
- Transport sample once a day
- Perform services with applicable standards recognized by the government

Responsibility of DebreBirhan Hospital

- Provide working space with broadband internet service
- Effect 70% of the payment within 10 days of receipts of invoices
- Maintain accounts and records properly
- Ensure sustainability of support relationship with ICL
- Oversee implementation as per the agreement and provide feedback

Major achievements

The major achievements of this partnership are outlined as follows:

- **Enhanced service quality and client satisfaction:** Service quality improved and clients are satisfied as unnecessary referrals and back and forth communications are avoided. Previously patients were expected to travel to Addis Ababa to get these tests but now as the company opened branch office within the hospital premises they can get the service timely without difficulty
- **Knowledge transfer:** The other achievement is knowledge transfer to the hospital's laboratory professionals. They received training by ICL and their skill has improved significantly, some are taking correspondence training supported by ICL. Overall knowledge and technology transfer is the other achievement through this partnership.

Challenges encountered and ways to address them

Generally there is lack of trust on the work culture and accountability of private sector to carry out ethical services. The public sector does seem to have a positive view on the private sector; the sector is considered as profit seeking. Establishing positive attitude will help to strengthen the partnership

Recommendations

The experience of DebreBirhan Hospital and ICL looks very promising and it will be wise to consider expanding the practice to other public hospitals and other services like Radiology.

7.1.9. Case of MelesZenawi Memorial Dialysis Center

Partnership description: An agreement between Mekelle University Ayder Referral Hospital and Mahal Medical Center Plc was put in place in order to establish a kidney dialysis center (MelesZenawi Memorial Dialysis Center). Ayder Referral Hospital provides the facility and staffing, while Mahal Medical Center Plc provides all the required medical equipment, utilities and supplies for the services.

Background

The Ayder Referral Hospital, located in Mekelle, is the teaching hospital of Mekelle University. It is the second largest hospital in Ethiopia, and the most advanced hospital in the northern part of the country. Established in 2008, Ayder Referral Hospital has 500 inpatient beds, 45 specialists in various areas, and provides services to a catchment area of 8 million people throughout Tigray, Afar, and southeast Amhara Regional States.

Description of the partnership

MelesZenawi Memorial Dialysis Center was established in 2012 based on a 10-year renewable agreement between Ayder Hospital, Mekelle University and Mahal Medical Center Plc to provide renal dialysis service. The dialysis center was established within the premises of Ayder Hospital, Mekelle University and staffed with Ayder Hospital personnel. It serves as the only dialysis center in the region. Services are provided within 8 rooms, with the capacity is able to serve 40 patients per month. All medical equipment and accessories are procured, shipped and fully owned by Mahal, which is a privately owned limited company.

The dialysis center is operating with 9 technical staff (1 Medical Doctor, 1 Biomedical Engineer and 7 nurses) and 2 support staff. Mahal Medical Center Plc has recruited a fulltime manager who oversees the dialysis center. The management team of both the dialysis center and the hospital meet every six months to ensure smooth operation.

Ayder Hospital provides supplies to the center at a wholesale-purchasing price without making a profit. The dialysis center distributes these medical supplies to patients free of charge. Due to this collaborative working agreement, the dialysis service, including the drugs, are delivered at 1350 ETB, which is less than the average cost in other private facilities in the country. In addition to the medical supplies purchased from Ayder Hospital, the center imports 5 types of pharmaceuticals and these are provided free of charge to patients as well.

Mekelle University gave a 500,000 Birr donation to cover the cost of service provided to patients who can't afford to pay. A private donor gave 45,000 Birr for same purpose.

The agreement duration is for 10 years, which is to be automatically renewed unless either of the two parties provide six months advanced notification otherwise. Amendments to the agreement can be made based on need and discussions during the contractual time period. The agreement was entered into in September 2012. Roles and responsibility of the each party are clearly defined and listed below.

Responsibility of Ayder Hospital, Mekelle University:

The roles and responsibilities of Mekele University's Ayder Hospital is

- Provide space within the hospital premises
- Provide electricity, generator, water, cleaning services, civil and electrical maintenance and waste management services
- Provide operating theater room
- Conduct advertising and marketing activities
- Provide at least one ambulance to be used by the center

Responsibility of Mahal Medical Center Plc:

The roles and responsibilities of Mahal Medical Center under the PPP agreement are:

- Provide all dialysis machines and water treatment system
- Accomplish all legalization and government paperwork
- Install facilities and machines
- Provide all medical supplies for the service with stock reserve for 6 months period
- Train nurses, technicians, and biomedical engineers
- Cover the running cost of the center
- Recruit and assign general manger

Major achievements

Several achievements were attained through this partnership:

- The most important achievement is the delivery of quality renal dialysis service in the region at relatively reduced fee. Patient referrals out of Ayder Hospital for dialysis are eliminated, transportation and accommodation costs for seeking care further away are cut and thus Ayder Hospital patients are receiving the service in the comfort of their hometown or nearby. So far services have been extended to 49 people (20 female and 29 male), all from urban areas. Services are running according to plan and agreement between the stakeholders.
- Acute renal failure patients who are unable to afford the service are treated for free or at a reduced price. Out of the total 49 patients, 6 patients received the service free of charge; 5 patients were sponsored by Mekelle University while Mahal sponsored 1 child fully.
- Discussions are held with patients on the services provided at the beginning and during treatment including issues related to treatment options and expenses.

Challenges encountered

- Thus far, the center is not making adequate profit from the service. This is because of reduced price and low level of utilization. Although the center has the capacity to serve 40 patients per month, currently services are provided on average for 13 patients per month.
- While the service fee is too low for the center to make a profit, it is still high for patients to pay, which is believed to be contributing to low service utilization. Due to costs associated with running the center and importing medical supplies it will be hard to reduce the service fee further.

Recommendations

- More promotion work and establishing referral linkages with nearby hospitals and health centers will help to increase utilization further.
- Price reducing schemes like tax exemption and others could help to reduce the fee paid by patients further, while maintaining revenue to the facility.
- Consider scale-up of the initiative to other regions.

7.1.10. Case of Overseas Infrastructure Alliance (OIA) Eye Care Center

Partnership description: This partnership is established based on agreement between Overseas Infrastructure Alliance (OIA) and the Ethiopian government, represented by the FMOH. The purpose of the agreement is to establish a state-of-the-art tertiary eye care center within Zewditu Memorial Hospital (a public hospital) run by local and international eye care professionals, which will eventually be handed over to the government following capacity building of local staff.

Background

Overseas Infrastructure Alliance (OIA) Private Limited company was incorporated in 1989 in New Delhi, India. The company provides project development and management services for energy, agriculture and transportation industries. Currently they are contracted by the Ethiopian Electrical and Power Company to expand the transmission and distribution network within the Hagere Mariam – Mega – Bokuldoma region in Ethiopia, and are also working on expanding 2 sugar projects – the Tenda-ho Sugar Factory, and the Finchaa Sugar Factory.

The partnership was initiated in the year 2008 when the OIA Company sought to pursue business as well as philanthropic interests in Ethiopia. Based on advice from the Indian government, the company decided to invest its philanthropic efforts in work within the health sector, focusing on provision of eye care, as a means of meeting unmet needs in the country.

Description of the partnership

A partnership agreement was signed between OIA and the Ethiopian government, represented by FMOH in 2008. The purpose of the partnership agreement was to establish a tertiary level eye care center with 15 beds, dedicated to becoming a state-of-the-art, ultra-modern ophthalmology facility in Addis Ababa. The ophthalmology center was established within Zewditu Memorial Hospital's premises. Zewditu Memorial Hospital is a public hospital, operated by the FMOH. Technical staff members from "Beyond Eye Care Company" in India oversee management and clinical care. Financial support is provided through an Indian endowment fund, which was founded by OIA and the Indian government.

The FMOH supports the center by providing space, infrastructure, human resources and strategic directions on service delivery. The facility and services are financed by OIA Company in collaboration and with support from the FMOH. Services are offered to give relief to patients suffering from conditions such as cataract, glaucoma, diabetes-related eye problems, as well as to provide services for plastic surgery around the eyes.

Major Achievements

Through this partnership a two-story modern ophthalmology center was built within Zewditu Memorial hospital. Currently the center has a total of 40 staff members: 22 technical staff (6 expatriate and 16 local), 4 administrative staff and 14 support staff. Out of the 16 local technical staff, 12 are nurses are from Zewditu Memorial Hospital.

The ophthalmology center provides a complete range of eye care diagnosis, inpatient and outpatient eye care, and surgery (glaucoma, cataract, eyelid) and runs an optical shop and pharmacy services.

On average, the facility serves 80-100 patients in the outpatient department, and conducts 10 to 15 surgeries daily. The service is open to all patients. The eye examination fee ranges from 40 to 100 Birr, however, patients who can't afford to pay are treated free of charge.

The center provides lectures and training to students in public hospitals. Thus far, two major trainings have been conducted, with formal training and collaboration on research to start soon. Additionally, an in-house training center for surgeons, paramedics and administrative staff has been employed in the facility, which provides medical advisory and consultancy services from OIA.

Key Lessons

The eye care center is a tremendous opportunity for strengthening the capacity of existing specialized eye care practices in the country. This initiative is scalable to other parts of the country and for other specialized care services too.

7.1.11. Case of Vision Maternity Care (VMC)

Partnership description agreement: This partnership is between the government, represented by Bahir Dar Special Zone Health Department, and its Health Center and Vision Maternity Care, a local nongovernmental organization, to provide enhanced quality maternal health care services to the community.

Background

Vision Maternity Care (VMC) is a local Ethiopian charity supported by the Barbara May foundation Ltd, a registered charity based in Australia that seeks to support measures to promote maternal health care in places where there is high maternal mortality and morbidity. VMC was established in 2010, through the initiative of Dr. Andrew Browning (the grandson of Barbara May, and an Australian obstetrician who previously worked in Hamil Fistula Hospital, Bahir Dar branch). Dr. Andrew Browning, in collaboration with the RHB, had previously played an important role in supporting a collaboration to address the high rate of fistula cases in Eastern Gojam by bringing volunteer Australian obstetricians to Eastern Gojam. This initiative served as the stepping stone to the establishment of VMC. Vision Maternity Care plans to construct a hospital in Bahir Dar, and has been provided a health center by the Amhara Regional Health Bureau to convert into the hospital. Currently a 12 bed temporary facility has been constructed, which is part of the health center, and is providing delivery care to approximately 160 women a month. The facility is operating with 21 technical and 13 administrative staff with the aim of serving about 15,000 direct beneficiaries.

A board was established, with members from Regional Bureau of Finance and Economic development, regional parliament, Zonal health department, regional administration, and commercial bank of Ethiopia to manage the Maternity center.

Description of the partnership

Partnership agreement has been signed in the year 2012 between Bahir Dar Special Zonal Health Department and its Health center and Vision Maternity Care to combine efforts and enhance maternal health care services for the community in Bahir Dar city. The Zonal health department identified a government health center in Bahir Dar town to provide service delivery in partnership with VMC and allocated budget and health professionals for the intended service. The health center works closely with VMC to mutually use the available laboratory, pharmacy service, and provided space to deliver enhanced quality maternal health services. VMC facilitates the recruitment of volunteer obstetricians and midwives to provide services in the health center, and provides on-the-job training to professionals working in the health center. VMC also renovated the delivery room and constructed an Operating Theater.

Responsibility of Bahir Dar Special Zone Health Department:

The roles and responsibilities of the Bahir Dar Special Zone Health Department are:

- Recognize Vision Maternity Care as an obstetric care training center
- Select health center and assign the maternity department for VMC to provide health services including caesarian section (CS)
- Collaborate in providing office space within the health center
- Assign two Ethiopian midwives from the collaborating health center to work under the maternity center established by VMC

Responsibility of Bahir Dar Health center:

The roles and responsibilities of Bahir Dar Health center are:

- Provide space to establish the maternity center in the premises of the existing health center
- Share laboratory and pharmacy services with the maternity center
- Support in the procurement of medical supplies
- Provide pharmaceutical supplies to the center

Responsibility of VMC:

The roles and responsibilities of VMC:

- Reimburse the health center for services, supplies and resources utilized by the VMC maternity center
- Assign budget and human resources to cleaning, laundry and kitchen services rendered by the health center
- Recruit volunteers with the support of Barbara May Foundation Australia Ltd.
- Provide orientation to volunteers, assist with transportation and accommodation for volunteers who come to provide services at the maternity center
- Renovate and upgrade the service delivery units and maternity waiting area
- Procure an ambulance to transport laboring mothers from surrounding area to the maternity center
- Provide free maternity care services to women who can't afford to pay
- Share data and periodic reports to the health center and zonal health department

Major achievements

Major achievements of this partnership are summarized as follows:

- Sharp increase in delivery services: before this partnership about 30 women delivered at the health center per month. With the establishment of the VMC maternity center, this number increased to an average of 160 deliveries per month. In the year 2013/2014 alone 1,619 women delivered at the center. On top of this 1,754 mothers received PMTCT services and 1,858 mothers received at least one antenatal care visit. This is considered to be a remarkable achievement.
- Affordability and access: maternity services are rendered at an affordable fee for most clients and are free of charge to those who can't afford to pay.
- Efficiency: services are managed and delivered with a small number of human resources/health professional. Midwives are capacitated to provide multiple and quality services making services more efficient.
- Community participation: stakeholders such as kebele administrators and community representatives monitor the services provided at the facility. A committee with community representation was established to review maternal deaths. There is also a monthly pregnant mothers conference to discuss maternal health and services.

Recommendations

The model can be expanded to other services beyond MCH and this practice could also be scaled-up to other health centers.

Challenges

Sustaining high quality maternity services as the demand grows, and potentially without the support of VMC, will be the biggest challenge.

7.1.12. Case of Gefersa Mental Health and Rehabilitation Center

Partnership description: The agreement is between Federal Ministry of Health (FMOH) and Catholic Bishops Conference and the Congregation of the Brothers of Charity. The purpose of the partnership is to share the general operational responsibilities of the rehabilitation center to promote and improve the care and rehabilitation of mentally challenged people in Ethiopia and to establish a center of excellence.

Background

Geferesa Mental Health Rehabilitation Center (GMHRC) was established in the year 1982 under the Social and Labor Bureau of Oromia regional government. In 2005, the National Initiative for Mental Health in Ethiopia (NIMHE) took over the facility and renovated it to improve its standards and to make it a center of excellence for mental health in Ethiopia. The renovation was made possible by support from Salini Construction, an Italian construction company. After the inauguration of the newly renovated GMHRC in 2010, the facility was handed over to the FMOH. Currently a board that is accountable to the FMOH manages the rehabilitation center. The board is composed of members from partner organizations, FMOH, Brothers of Charity and the Catholic Bishops Conference and NIMHE. The center has 200 beds and 96 staff. Currently a total of 140 patients (36 females and 104 males) are getting rehabilitation services.

For the year 2012/2013 (from July 2012 to June 2013) the FMOH allocated 6,772,840.00 Birr to run the center. The same amount of money was allocated the previous year.

Description of the partnership

The purpose of the partnership agreement among FMOH, Catholic Bishops Conference and the Congregation of the Brothers of Charity is to share the general operational responsibilities of the rehabilitation center to promote and improve the care for and rehabilitation of mentally challenged people in Ethiopia and to establish a center of excellence.

The agreement was entered into in 2011, and the entity responsible for management of the center (The congregation of the Brothers of Charity) has the right to terminate the commitment with a one-year advanced notice to the board. The roles and responsibilities of each partner are presented as follows:

Roles and Responsibilities of FMOH:

- Provide support to the management to smoothly run the center
- Process visa, residence and work permits for the Brothers of Charity permanent employees and volunteers
- Provide legal service to the management as and when requested
- Provide salaries and benefits (housing, transportation, free medical services...) for local and expatriate staff based on government scale
- Allocate budget annually to the center based on request from the management

- Facilitate the procurement of medical supplies
- Pay import taxes and process clearance for donated equipment, consumable materials and medical supplies
- Facilitate regular auditing

Roles and responsibilities of The Congregation of the Brothers of Charity (the management):

- Report regularly to FMOH
- Place an advisory council to support the board of management
- Receive and manage mentally ill patients
- Provide comprehensive physical, psychological, social, spiritual and moral support to patients
- Provide continuous on-job-upgrading and training for staff, families and caregivers with focus on improved service
- Manage the overall human resource and financial matters of the hospital
- Recruit volunteers to come and serve at the center
- Organize income generating and fundraising activities in collaboration with FMOH
- Carryout internal audits

Major achievements

- Mental health services and rehabilitation care is available to anyone in need of mental health care to benefit from the service.
- Awareness creation activities conducted by the center are helping care givers to cope with the stigma related to mental illness. Public awareness creation programs are also broadcasted via different media regarding mental health stigma as well as the services provided at the center.
- Good quality mental health and rehabilitation care is being provided.
- Patients get a balanced diet based on standard menu.
- Patients have appropriate clothing and well kept rooms for accommodation.
- Infrastructure is conducive to staff and patients wellbeing
- Motivational mechanisms are in place for staff.

Challenges encountered and ways to address them

- Human resource and financial administration is not well established. This creates inefficiency in recruiting and retaining staff. Financial flows and management were reported as insufficient.
- The budget allocated by the FMOH is not adequate to run the center. Some activities believed to be important are not in place due to shortage of money.

Recommendations

- The human resource management needs strengthening. It is important to recruit the right staff through the proper system. Incentive mechanisms have to be in place to retain them. The work environment has to be attractive to employees.
- During budget allocation it will be helpful if FMOH could allocate adequate amount of money to run the rehabilitation work well.

Annex II: Data Collection Tools

2.1. Tools I: Discussion guide for exploring public private partnership at health facility level

Federal Ministry of Health Resource Mobilization Directorate, Case Study on Public-Private-Partnership

Discussion guide for exploring public private partnership at health facility level

Full Name of the interviewee: _____

Position: _____

Telephone Number: _____

Email Address: _____

P. O. Box: _____

General Introduction

1. Would you please give us introduction about the health facility including the types of services provided and population covered?
 - Would you please describe the governance structure?
2. Can you describe the type of collaboration and relationships you have with:
 - government sector offices (MOH, RHB, ZHD, WorHo, Hospitals, Health Centre, health posts, and other government offices)?
 - Private sector providers?

Details of the partnership

3. Can you explain the types of support you get from:
 - government / collaborating nongovernmental sector (financial, logistics, supplies, drugs, human resource, technical, and others)?
 - Private sector?
4. Would you please explain if you have an established formal partnership with government health sector / nongovernmental sector?
 - Would you please give us details about this partnership (why and how it was established)?
5. Do you have binding agreement with the collaborating sector office?
 - Would you please describe the process you went through to get the agreement and its content?
 - How long did you have this agreement (from ----- to -----)?

Benefits from the partnership and achievements

6. What did you benefit from the established collaboration / partnership?
7. Would you please explain the key achievements so far?

Monitoring mechanism

8. How do you monitor if the services that are being provided through this partnership are becoming successful?
 - How do you make sure /monitor/ the established partnership is working well?
9. How do you monitor the quality of care provided through the partnership?
 - Is there mechanism of performance review by external auditors or reviewers? If yes, would you please explain the experience?

Accessibility and Equity

10. How do you make sure the services provided through the partnership are accessible to every segment of the population (equity)?

Community Involvement

11. Can you describe about community's involvement in planning and monitoring of services (consumer's informed choice and consumer participation)?
 - Would you please explain how you ensure transparency, accountability, and fairness?

Efficiency

12. How do you explain efficiency of services? Can these services be provided with limited resources?

Scalability

13. How do you describe scalability of best practices and scalability of the initiative (manageability, financial need)?

Challenges

14. What are some of the challenges you have and how do you think this need to be addressed

Conducive environment for PPP

15. I would like to ask you general question about the overall PPP environment
 - Could you please explain about the legal framework on PPP in the country?
 - Has this been challenge for strong PPP? How did you assess the risk? Can you explain if there will risk mitigation plan address these gaps?
 - How do you describe suitability of public policies, enabling environment?
16. Thank you for your time, let me give you chance for you to tell me any relevant information related to PPP.

You need to collect the following documents before you leave the health facility

1. Copy of the bilateral agreement between the private facility and government sector office
2. The recent five years annual report (from 2002, 2003, 2004, 2005, 2006 EFY)
3. Health management information data (from 2002, 2003, 2004, 2005, 2006 EFY)
4. Any evaluation report
5. Any financial data / information / report
6. Any relevant document

2.2. Interview guide for higher-level key informants

Federal Ministry of Health Resource Mobilization Directorate, Case Study on Public-Private-Partnership

Interview guide for higher-level key informants

1. How do you describe public-private-partnership (PPP)?
2. Do you see any potential for PPP in the health sector? How and in which areas? What will be the role of private sector on:
 - Primary health care?
 - Tertiary care?
 - Pharmaceuticals and medical supplies?
 - Diagnostic services?
 - Human resource development?
3. What can the country/community gain by establishing strong PPP?
4. Is there any progress towards establishing PPP in Ethiopia? Why? How?
5. What are the opportunities for PPP in the country?
6. What are the challenges / barriers?
7. What do you think is expected from the government and private sector for better PPP?
8. What are the legal backgrounds for forming / maintaining PPP? How can this be mitigated?
9. What are the key actions that need to be implemented by the different actors to engage the private sector meaningfully for better health services?
10. Do you now any successful model PPP in this country? Can you describe it?
11. Is there any more information that you would like to tell me about PPPs?

Thank you!

2.3. Information Sheet

Background

The potential benefits of the FMOH to utilize the private sector (for-profit and nonprofit institutions) to support government health goals are of interest. Further evidence-based assessments and planning is needed in order to understand the benefits and financial implications to engage with the private sector. This assessment will increase awareness and understanding of the private sector's role in health service provisions and propose new opportunities that could be taken up at scale.

Purpose of this assessment

The objectives of this assessment are; documenting primary care services provided in PPPs, assessing the effect of PPPs on the delivery of efficient, quality and equitable primary care services; and costing indicative services provided through PPPs including the cost of establishing selected PPPs.

Due to the scarcity of national level data on PPPs, findings of this assessment will play a role in filling the knowledge gap and, as appropriate, will be used to plan and execute concrete actions to strengthen PPPs as means to improve access and utilization of primary care.

Voluntary participation /withdrawal

Your decision to participate will have no impact on anything. If you choose to participate in the interview/observations, you may skip any question that you do not feel comfortable answering, and you may stop answering at any point during the interview/observations.

Compensation

You will not receive any money, gifts, or other benefit for participating in this experiment.

Risks

The risks of participation are minimal. We will not be collecting any additional data other than what we ask during the interview/observations, and all information about you and others provided during the interview/observations will be kept strictly confidential.

Questions

If you have any questions about this study, you may contact MrAbdeljelilReshad, Director of Resource Mobilization Directorate, Ministry of Health. Telephone: 251-011-551-7011, Fax: 251-011-5519366 P. O. Box: 1234, Addis Ababa, Ethiopia

Consented to participate: Yes:

☐

Annex III: Additional Literature Review

Table 3.1. Overview of Different Types of PPPs

PPP Type	Asset Ownership	Private Sector Responsibilities	Capital Investment	Commercial Risk	Payment	When to Use
Service Contracting	Public	Service delivery	Public	Public	Service fee to private sector for specified services	When private sector comparative advantage in specific service delivery task
Management Contracting	Public	O&M	Public	Public	Fees paid directly by government for O&M of government services	To utilize technical expertise & managerial efficiency of private sector
Lease	Public	O&M	Public	Private	Private sector pays rent for use of facility; fees charged to user	To improve operating efficiency of public health facility without need for new investment**
Concession	Public	O&M	Private	Private	Concession fee to public sector; fees charged to user	When need private financing for new construction and investment
Divestiture	Private	O&M	Private	Private	Fees charged to user	Need to shift all risk entirely to private entity; need access to private finance
Social Marketing	Private	Service provision	Public	Public	Support provided directly to private providers to increase coverage (e.g. fee paid to private sector for subsidization of commodity/health service)	Useful for commodity or simple health service distribution where favorable distribution channels exist and accessibility in public sector limited; great potential for scale up

PPP Type	Asset Ownership	Private Sector Responsibilities	Capital Investment	Commercial Risk	Payment	When to Use
Franchising	Franchisor	Franchisor: training, protocol establishment; certification; monitoring Franchisees O&M, service provision	Franchisees	Franchisees	Fixed fee or royalty paid to franchisor by franchisees	To rapidly increase coverage of basic health services, capture economies of scale, reduce information asymmetries
Training and Education	---	Knowledge transference through private sector provision of training and education	Public & Private	Private	Fee paid directly by public sector for provision of training and education services	Useful to increase knowledge and awareness particularly among informal sector health professionals (i.e. local pharmacists, shopkeepers); also structure for providing continued education for public sector officials

** stronger incentive to perform in this model compared to management contract, as private sector bears commercial risk

Contracting

Contracting with the private sector serves as a mechanism by which public finances are utilized to procure health care services for public consumers, specified in written and agreed documentation (IHSD, 2004). These contracts also provide a quantified specification of health services outputs and quality standards expected from financial inputs (England, 2000).

Generally, contracts exist in context of delivering specified services (service contracts) or as a means of managing a range of services (management contracts). Under a service contract, the government pays a private entity to perform specific tasks, such as routine laboratory services, or specialized services like radiology, which can be provided within the hospital (contract in) or operate outside public facilities (contract out) (Marek, Yamamoto, Ruster, 2003). Under a management contract, government pays a private entity to manage public facilities, which can include private authority over procurement of labor, supplies, and equipment. The World Bank's Private Participation in Public Services Group distinguishes management contracts where public sector makes human resource employment decisions (contract in model) from those contracts where the private contractor has responsibility of making these employment decisions (contract out model) (Marek, Yamamoto, Ruster, 2003).

Although many of the service contracts entail non-clinical services such as maintenance, catering, security, and laundry services, there is a growing number of utilization of direct contracting with private organizations for the provision of a range of health services to poor and underserved populations. Experiences include contracting with NGOs to provide primary clinical, preventative and reproductive health services (Afghanistan, Cambodia, Colombia, India, Panama); contracting with managed care organizations for provision of comprehensive service plans (Colombia, Estonia, Nicaragua); and contracting with medical cooperatives and other private providers to supply clinical services (Brazil, Costa Rica, Panama) (Mills 1998; Rosen 2000; La Forgia 2005).

Contracting with the private sector may provide several general advantages:

- Consumers are provided improved access to services
- Provision of services by private sector means that the burden on the public sector is reduced
- Improved quality of the services, as private sector is not hampered by the inefficiencies of the public sector
- This mechanism can work to target the poorest populations, who are neglected or not reached under traditional public health system mechanisms (England 2004).

In designing and implementing a contracting PPP model, there are various things that must be taken into account. The design features and context in which contracting intervention is implemented are likely to influence changes of success (Liu et al., 2008). Additionally, contracting out involves complex problems of accountability and governance, that requires a strong and proper regulatory framework established by the public sector.

Reviews on Contracting

1. Mills and Bloomberg (1998) found in their review, that some cases, such as in Zimbabwe and South Africa, contracted providers could provide services of the same or higher quality at lower cost, while in other cases there was no real difference in performance between public providers and the private contracted providers (Ghana and Tanzania). Their findings yielded mixed results, and they concluded that each model in various countries was influenced by the nature of the demand faced, nature and organizational structure of the provider, by the specificities of the contractual arrangements, and finally by the preferences of services provided (Mills and Bloomberg, 1998). The potential for implementation of contracting services to the private sector is highly context dependent. In settings where private sector (both for-profit and not-for-profit) is well developed, or spans across areas or populations that are not reached by public services, utilizing this mechanism may be beneficial (Mills 1997).

2. Another literature review, conducted by England (2004), examined to what extent contracting with the private sector can improve access to health services for the poor. The review concluded that despite the growing popularity of this mechanism of PPP, few experiences of contracting with the private sector were subject to proper evaluation methods, in particular as it relates to program effects on the poor. Rather than concluding on impact of this model, the author highlighted four different approaches of contracting that can target the poor

- Provision of general subsidies for services in areas where public services are not available, assuming the poor will benefit alongside others (e.g. Cambodia, Guatemala and Uganda through contracts with NGO providers).
- Geographic targeting of areas where high concentrations of poor residents reside (e.g. Bangladesh urban slums project)
- Subsidizing of services for those identified as poor, which requires a system of defining eligibility (e.g. Georgia in provision of cardiac surgery, Surinam health cards for the poor)
- Subsidizing specific services related to illnesses that affect the poor (e.g. Nicaragua provided vouchers for sex workers)

3. Loevinsohn & Harding (2005) review 10 developing country cases, where before and after comparisons of health delivery performance indicators associated with management and/or service delivery contracting initiatives were conducted. The findings highlighted that contracting with the private sector for delivery of primary care services are effective, and they concluded that scaling-up is a viable option and should be considered by countries.

4. Liu, Hotchkiss & Boss (2008) conducted a review of 13 country cases, all of which were donor-sponsored initiatives (as many contracting projects tend to be), in which the purchasers were generally the national government and providers usually NGOs. The review found that contracting-out improves access to services, but other dimensions of equity, quality and efficiency often times remain unknown, as mechanisms to measure these factors are not included in monitoring and evaluation schemes.

Table 3.2: Summary of country experiences of contracting

Study	Country	Primary Services Covered	Type of contract	Evaluation Method	Key Findings
Pelletier et al. 2005. OED, 2005. Karim et al. 2003	Bangladesh	community-based nutrition program, providing growth monitoring, supplementary feeding, and nutrition education	service delivery contract with NGOs	Before and after study with control sub-districts based on household survey data	<ul style="list-style-type: none"> • Improved overall knowledge and prenatal care use of mothers on pregnancy and child-care behaviors, including use of services such as vitamin A and iron supplementation and practices around infant feeding • Little evidence of effect on weight gain or birth weight for overall sample, but significant effects on vulnerable sub-groups (OED 2005)
Daniel, La Forgia, 2005. La Forgia et al., 2004. Nieves et al., 2000	Guatemala	basic package of primary health care services, with emphasis on rural and geographically isolated populations, which were underserved by the existing public health network	management contract in select municipalities and service delivery contract	cross-sectional study (three years after contracting) with controls based on household survey data	<ul style="list-style-type: none"> • Immunization utilization rates, prenatal care, and ORS under contracting-out use similar to government model • client satisfaction higher under contracting-out than under traditional public delivery • Difficult to assess program performance specifically, but WB found national child immunisations coverage rates increased five-fold, and prenatal care coverage increased around 5-8 per cent to approximately 30 per cent (Nieves, La Forgia, Ribera 2000)

Study	Country	Primary Services Covered	Type of contract	Evaluation Method	Key Findings
Eichler et al., 2001.	Haiti	primary health care services, including MCH, and FP	service delivery contracts with NGOs where NGOs offered performance bonuses based on agreed targets (for indicators such as % ORS use, % full vaccination of child,)	before and after study based on household survey with no controls	<ul style="list-style-type: none"> •significant improvement in immunisation coverage •improvement in availability of modern contraceptive methods •proportion of mothers using ORT increased •significant increase in quality-related indicators, including % clinics with at least 4 modern methods of family planning, % women using ORT correctly
Chakraborty et al., 1999	India	MCH services	service delivery contract for NGOs working with private providers to improve quality of MCH services	before and after study based on household survey with no controls	<ul style="list-style-type: none"> •reported rapid improvement of skills of private providers (25% to 57% increase from baseline) • significant increases in quality-related indicators, including % treatment ORS for diarrhea cases, % diagnosis touching child as part of exam
Marek et al., 1999	Madagascar	community-based nutrition services, with emphasis on poor populations, which were underserved by the existing public health network	service delivery contracts with NGOs	before and after study with controls based on household survey data	<ul style="list-style-type: none"> •severe and moderate mal-nutrition was found to be reduced by 6% •service coverage increased

Table 3.2: Continued.

Study	Country	Primary Services Covered	Type of contract	Evaluation Method	Key Findings
Lavadenz et al, 2001.	Bolivia	PHC/RH services	management and service delivery contracts with Prosalud NGO, with contracting payment based on achieving process and outcome indicators	before and after study based on routine reporting data with no controls	<ul style="list-style-type: none"> •outpatient consultation increase in contracted network •institutional deliveries increased in contracted network by 41% •increase in delivery at primary care centers
Bhushan, Keller, Schwartz, 2002 Bloom et al. 2006. Loevinsohn, 2001. Schwartz, Bhushan, 2004.	Cambodia	rural primary health care & district hospital services, including immunization, family planning, antenatal care, nutritional services, and simple curative care	service delivery contract and management contract with NGOs, with contract stipulations including penalties for not reaching targets	randomized controlled study with random assignment based on household and provider survey data taken before and after implementation	<ul style="list-style-type: none"> •both service delivery and management contracts outperformed government control districts, in service utilization and health outcomes •significant effects on service utilization rates in contracted districts •access to basic health care increased •lower private spending by the poor
Cercone, Briceño, Gauri, 2005.	Costa Rica	primary health care services	service delivery contract with medical cooperatives and other private firms, where providers are directly managed by government contractors (Costa Rican Social Security Institute or CCSS); contract stipulations including penalties for not reaching targets	retrospective post-intervention time-series evaluation based on routine reporting system data and cross-sectional design; controls included	<ul style="list-style-type: none"> • contracted providers consistently provided better performance than traditional Costa Rican Social Security Institute (CCSS) public clinics. •contracted providers conducted significantly more general practitioner visits per capita and significantly fewer specialist visits per capita than traditional clinics. •use of non-medical emergency per capita not different from CCSS public clinics; mortality also same for both groups •30 percent lower expenditures per capita in contracted providers than in the traditional clinics.

Study	Country	Primary Services Covered	Type of contract	Evaluation Method	Key Findings
Mills A et al. 2004.	South Africa	primary health care services	service delivery contract of individual private GP, with fee for service plus flat fee per prescription as payment scheme stipulated in contract	cross-sectional study with control for comparison based on provider survey data; focus group discussion and record reviews included as supplementation	<ul style="list-style-type: none"> •quality of care qualitatively worse among GP than public clinics •knowledge of providers for services higher among contracted GPs than public clinics •costs per curative health care visit for contracted GPs and public clinics were similar

Infrastructure PPPs

Hospital or infrastructure-based PPPs serve as a broad category in which the private sector's roles range from facility operations to construction and maintenance of facilities as well as provision of services.

Lease Contracts

Lease contract serve as one example of a hospital-based PPP. Under this arrangement, a private contractor pays the government a fee to utilize a public owned facility. The private sector is responsible for operating and maintaining the facility and receives revenues from operation, but ownership still remains in the hands of the government. Under this model, the private sector bears the risk burden of demand, being responsible for losses and unpaid consumers' debt. Optimally, this form of PPP may serve as a viable option for a public facility that needs to improve operating efficiency, but does not require new investment (Marek, Yamamoto, Ruster 2003). Additionally, as the private provider charges an operator fee to consumers in order to receive revenue, this particular PPP mechanism may not be particularly successful in improving equity or increasing services to the very poor.

Concession Agreements

With a *concession* agreement, a private operator is responsible not only for the operation and maintenance of facilities, but also for financing and managing all capital investments. Generally, the operator pays the government a fee, and ownership remains in the hands of government. A Build-Operate-Transfer (BOT) project, a variation of a concession is undertaken to build a facility. Under this arrangement, the private sector is responsible for funding, designing, building and operating the project, transferring ownership to the government at the end of the specified contract term (PPIAF, 2014). (Note: DBO, BDFO variations of concession agreements as well).

The Hospital do Suburbio (HS), the first PPP in health for Brazil, serves as an example of a concession contract. With the technical assistance of the IFC, the Government of Bahia implemented a PPP for the operation and management of the Hospital do Suburbio, for which construction had already began, as a means of ensuring that all of the state's population had access to high quality emergency health services. The transaction structure took the form of a ten-year concession contract, where the hospital's operation and management (including clinical and non-clinical services) were transferred to the private concessionaire (Promedica, a Brazilian regional healthcare company and Dalkia, a French company specializing in facilities management). Promedica and Dalkia is expected to invest \$US 32 million to equip the hospital over the contract time period. The Government of Bahia makes payments to the private sector in accordance to key performance indicators, as a means of incentivizing high performance levels. The hospital provides traditional emergency care, as well as specialized trauma services, orthopedic and cardiac emergencies, and treatment for other complex injuries (IFC, 2013). Indicators from the first and second trimester of hospital operation illustrate that this PPP has been successful in increasing access to healthcare services. Since beginning operations in 2010, the hospital has had 45,000 emergency visits, 90,000 outpatient consultations and has performed more than 1.8 million medical procedures (IFC, 2011). Additionally, the hospital has created 1,200 new positions for doctors, nurses, and other health personnel (IFC, 2013).

Build-operate-transfer (BOT) PPPs, a variation of concession contracts have been utilized in various settings. Like concessions, BOT contracts last longer than most types of arrangements and unlike lease arrangements, they offer a good way to tap the private sector's ability to access private finance and raise funding for new construction and investment (Marek, Yamamoto, Ruster 2003). The Government of the Philippines utilized private sector participation in infrastructure development through the enactment of the Philippine Build-Operate-and Transfer Law, which promoted the expansion of BOT contractual arrangements and infrastructure projects in the social sector. To date, the Government has undertaken multiple healthcare projects, including renovation and upgrading of the country's orthopedic center, and the upgrading and modernization of two-dozen Department of Health hospitals (UNECE, WHO, ADB 2012).

The state of Andhra Pradesh also utilized a BOT model to provide dialysis services to the poor population in the state. In response to the demand of below poverty line patients' need for dialysis services and the public facility limited capacity to perform the services, the Government of Andhra Pradesh contracted B.Braun Medical (India) Pvt. Ltd, a leading healthcare supplier, to build and operate dialysis centers in eleven tertiary care state-run hospitals for a period of seven years. Ownership of these hospitals would be transferred back to the government at the end of the contracted period. This mechanism worked to increase access to dialysis services for those who previously were unable to utilize the services and was found to be an effective system to achieve the objective of service provision for the poor (UNECE, WHO, ADB, 2012).

Integration of all hospital services, including not only the supply of infrastructure (as examples above illustrated), but also provision of clinical services (the integrated hospital PPP model) in a PPP contract has been undertaken in various OECD countries. The first model to use this was the La Ribera hospital in Alzira, Spain, where a private company, RSUTE was contracted to construct a hospital and manage both the clinical and non-clinical facilities. This project impacted access, particularly to services that were not provided previously, as new hemodialysis unit, radiology unit and new health center were built, in addition to investment in diagnostic tools for primary care (Acerete, Stafford, Stapleton, 2011). A similar attempt in Victoria, Australia resulted in a failure, due largely to private operator's limited experience in public service delivery and underestimation of costs (IPA 2013). This failure illustrated the need for transparent pre-bid processes to carefully determine value for money and risk transfer (IPA 2013). Lesotho adopted this integrated hospital PPP model, serving as the first in Africa. Through the contracting of private healthcare provider, Tsepong, this PPP structure resulted in the construction of the Queen Mamohato Memorial Hospital (QMMH), renovation of primary health care clinics. The private contractor is responsible for both management of facilities and equipment and the delivery of all clinical care services (Faustino Coelho, O'Farrell, 2011). Results of this PPP show that access and efficiency have been achieved. Services have widened to populations who previously were not able to access high quality care, and reports show that the project is affordable to the government as PPP cost is not much more than the operation of the old national hospital, with vastly improved facilities and patient care available (UNECE, WHO, ADB 2012).

Divestitures

Divestitures encompass the selling of publicly owned health care facilities to private entities, with indefinite transfer of ownership to the private sector. The Build-Own-Operate (BOO) contract serves as a variation of the divestiture, where the private sector additionally takes on the responsibility of building new facilities at its own expense (Marek, Yamamoto, Ruster, 2003).

The International Finance Corporation (IFC), a member of the World Bank Group, encourages private sector investment in developing countries and has invested in the hospital sector. The development agency finances private sector projects, such as hospital PPPs, and provides advice and technical assistance in the establishment of these hospital infrastructure PPPs.

Social Marketing

PPPs through social marketing work to improve the availability of affordable and quality public health goods and/or services through the engagement of the private sector in commercial distribution and other activities (public advocacy, awareness) to strengthen supply side health systems issues (IHSD, 2004).

Social marketing PPP looks to address supply-side constraints of health systems, such as availability of affordable and quality-assured health goods, by recruiting the private sector in commercial distribution and other associated activities (education, awareness). This mechanism can also work to increase educated consumer demand for, and increase utilization of products through branding, awareness and advocacy campaigning, and behavior change communication strategies. In this way, social marketing addresses public and private market failures in not only the supply, but also the demand of health commodities that produce positive public health benefits.

Through a variety of public and private channels, social marketing programs mobilize private financial resources (mainly in the form of out-of-pocket payments), and subsidize prices through use of public sources, to expand supply of products such as condoms and other family planning methods, ORT, malaria, and TB drugs. These programs generally operate through a special marketing organization (SMO) agency, often an NGO. The SMO, which provides the link between product manufacture, distribution and sale, often takes full responsibility of marketing, including price-setting, promotion, training, and modes of distribution (Smith, Bruha, Zwi 2001).

Commercial outlets, such as kiosks, pharmacists, and mobile vendors can be easier to access and more readily available for consumers. Chapman and Asthaty (2003) reviewed 87 research studies of social marketing programs and reviewed the evidence. The evidence base they found is almost exclusively related to HIV/AIDS, maternal and child health, and family planning, reproductive health, and found that this strategy is most suitable for less complex products and services.

Social marketing interventions produced strong evidence of impact on product behaviors, particularly condom, oral contraceptive, and insecticide treated net use. Evaluations of non-product behaviors have found social marketing to be effective in increasing abstinence and fidelity, and several preventive child health behaviors, including hand washing. Social marketing interventions have had substitution effects (where one behavior is exchanged for another) and have produced halo effects

(indirect effect of social marketing projects where non-targeted behaviors improve as a result of intervention), which have resulted in increased efficiency of the overall contraceptive delivery program in a country.

Table 3.3: Social Marketing Country Examples

Country	Type of Service	Rationale for program	Description of program	Key Findings
Nigeria	Improving access to contraceptives for all populations in country	<ul style="list-style-type: none"> • Low contraceptive prevalence & high levels poverty in country • Accessibility to contraceptives in public sector poor 	<ul style="list-style-type: none"> • Donor-funded project subsidizes marketing of condoms & OC • ‘own brand’ model adopted • SMO local NGO which handles imports and sales, and product promotion 	<ul style="list-style-type: none"> • project widened contraceptive choices among urban and rural population • contraceptives distributed through program account 80% all contraceptives in Nigeria • very poorest are not being reached by program
Tanzania	Increasing access and utilization of ITNs for young children and pregnant women	<ul style="list-style-type: none"> • ITN effective, but public sector unable to provide nets on large scale • Tanzania had strong local large-scale net manufacturing market, but prices inflated 	<ul style="list-style-type: none"> • donor-funded partnership with local manufacturers to increase • manufacture model of social marketing adopted • SMO work with three local manufacturers to produce mosquito nets 	<ul style="list-style-type: none"> • ownership of nets increased rapidly • overall prevalence of anemia decreased • additional employment and investment leveraged by manufacturers (USD \$4-5million and 500 jobs generated for bed net manufacture in TZ) • very poorest not being reached, as ownership greatest at highest income quintile • increased commercial sector activity, with market for nets doubling in 3 years

⁶The ‘own brand’ model is the most common amongst social marketing programs. Standard commercial marketing and sales techniques for promotion and distribution through wholesale and retail outlets to the mass market are applied. The SMO generally receives unbranded products from international or national donors (or may directly procure products from manufacturers) and develops its own brand, packages, and distributes it.

Franchising

Franchising is defined as a process whereby a firm or developer of a successfully tested social concept (franchiser) allows other firms or businesses (franchisees) to replicate its model under its brand name (IHSD, 2004; DSW, 2001). This process shifts capital investment and every day managerial responsibilities to independent businesses (franchisees) (Ruster, Yamamoto, Rogo, 2003). Within the health sector, franchising works to leverage the efficiency of the private sector for the distribution of services and products that improve quality, access, awareness of goods and services with public health benefits (IHSD, 2004).⁶ Potential benefits of this model include quality control, bulk supply of goods and services, mass marketing, and incentives for care providers (Ruster, Yamamoto, Rogo 2003).

One study looked at the evidence on impact on the poor in Pakistan, India and Ethiopia. The study found that franchising had a positive association with client volumes (both generally and family planning services specifically) as well as the number of family planning brands available. The study concluded that franchising provided an opportunity to expand access to reproductive health services (Stephenson et al. 2004). A systematic review evaluating the effect of social franchising on health care quality, equity, cost-effectiveness, and health outcomes found varied results across outcomes and programs. Social franchising was found to be positively associated with increased client volume and satisfaction, but findings on health care utilization and health impact were more varied, with some studies reporting franchises as significantly outperforming other models of health care, while others found franchises to be the same or worse than other models. Cost-effectiveness and equity serves as general challenges faced by franchising models relative to other modes of health care delivery (Beyeler et al. 2013). The authors concluded that more systematic documentation and evaluation of the effect of social franchising is imperative, with special attention on equity and cost-effectiveness of these interventions.

Some Best Practice Country Examples

Several examples of health franchising operating models exist across the developing world. Best practice examples exist in Pakistan, Philippines, and Kenya. In Pakistan, an accredited clinical network, 'Green Star,' was established to expand coverage of family planning services for low-income women in urban and peri-urban areas. The franchisee composition consisted of about 12,000 trained private health providers, including both male and female doctors,⁷ chemists and family health visitors. Many providers were from disadvantaged neighborhoods, to target the low-income women. The franchiser offers supplies, including free contraceptives and clinical supplies, technical training and advertisement (radio, television, print media advertising). Franchisees are informally monitored through monthly visits from Greenstar doctors, and 'mystery clients' are utilized to monitor provider quality. Additionally, a qualified doctor conducts a biannual formal evaluation. The program has been awarded donor funding to continue its activities, with plans to expand both in product types offered as well as in geographical scope with provision of services in rural areas (IHSD, 2004).

Established in 1997, the Philippines Well-Family Midwife clinic network franchises clinics owned by registered and practicing midwives to provide family planning and maternal and child health care services in select urban municipalities. The franchisee composition consists of 205 clinics (as of 2002). The franchisor offers a range of services to franchisees, including leasing of clinical equipment and instruments and clinical supplies able to be purchased at bulk rate, technical training, business training, and advertising. Regular monitoring is conducted by the regional franchiser, and franchisees that fail to conform to standards are served with a written reprimand after the first offense a one-month suspension after the second, and are ejected from the network after the third offense (Ruster, Yamamoto, Rogo 2003). Additionally, the franchisee pays about USD \$10 a month as part of a management fee and about US \$4 per delivery and continued training has additional fees.

Both the Kisumu Medical Educational Trust and the Kenya CFW shops network serve as two examples of franchising in Kenya's health sector (Ruster, Yamamoto, Rogo 2003; IHSD, 2004). Established in 1995, the Kisumu Medical Educational Trust network was created to provide family planning, abortion care, and STI treatment for rural populations in the region. Under this franchise scheme, the local NGO, Kisumu Medical Educational Trust, as franchisor, provided free contraceptives and a

⁷ Many early undertakings of social franchising focused on provision of services such as family planning, and thus closely resembled social marketing schemes in many ways. Generally, franchising is distinct from social marketing by the complexity of the product or service provided and because the provider, rather than the product, is accredited (Smith, Brugha, Zwi 2001).

⁸ Early evaluations of the project identified lack of women doctors trained in FP counseling and FP methods (particularly IUD insertion and injectables) as a constraint in the project. In response to this, the project worked to recruit over 2,500 women doctors across the nation into the 'Green Star' clinical network, as a means of addressing the cultural and social barriers to access of family planning for women in the country (Smith, Brugha, Zwi 2001).

start-up kit for manual vacuum aspiration (MVA), as well as technical and business training. The franchisees, composed of nurses, midwives, clinical and medical officers and community-based doctors, pay a token annual membership fee. The NGO visits these providers once a month to conduct informal monitoring (Ruster, Yamamoto, Rogo 2003).

The Kenya CFW shops network, established in 2000 by the HealthStore Foundation (HSF), worked to increase access to essential medicines and preventive health technologies to peri-urban and rural populations in Kenya (IHSD, 2004). Comprised of a network of 83 identical child and family wellness clinics in Kenya, this network functioned under the brand name 'CFWShops.' Local nurses and community health workers own and run these shops with HSF providing business training, preparing physical location, conducting regular inspections to ensure compliance to business plans, and providing assistance in ordering of inventory and running marketing advertisements (Berk, Adhvaryu 2012). Each CFW Shop only sells CFW products and CFW approved services (which include diagnostic services, treatment options and drug dispensing for common illnesses such as malaria, respiratory and bacterial infections, diarrhea, and parasites, as well as rapid HIV testing, vaccination, ANC care, and a range of hygiene products). A study looking at the impact of this new franchise health clinic model on access to vaccination and treatment for acute illness found that CFW-Shop proximity was associated with significant increases in the probabilities of receiving any medical treatment and on receiving treatment for fever. Moreover, the study found that utilization of CFWShop services was not different for lower-income households relative to higher income households. The authors concluded that a franchise health clinic model could serve as a viable scheme to substantially increase access to essential vaccinations and treatments in low-income countries, with benefits experienced by both poor and wealthy households alike (Berk, Adhvaryu, 2012)