Public Private Dialogue: A Necessary Component to Foster Greater Cooperation in the Health Sector

By Barbara O'Hanlon, O'Hanlon Health Consulting
Benjamin Herzberg, The World Bank Institute
April Harding, The World Bank Institute

2014

Public Private Dialogue: A Necessary Component to Foster Greater Cooperation in the Health Sector

Content

Executive Summary

The purpose of this paper is to assist development practitioners and international donors to better understand the conditions under which a multi-sector dialogue can succeed, and what the necessary strategies are to sustain a Health Sector Public Private Dialogue (H/PPD) in developing countries.

The paper is informed by the new global paradigm that views partnerships, collaboration, and knowledge sharing as prerequisites for achieving sustainable development goals. This paradigm has been gaining momentum since the 1990s UN Resolution on Universal Health Services was established, and then given an extra boost in 2010 when the 63rd World Health Assembly of the World Health Organization (WHO) passed a resolution acknowledging that *private providers are a major source of healthcare in most countries and that private provision of health services can lead to innovation as well as better performance of the health system.*

The WHO resolution validates the strategies high-income countries have used to effectively engage and regulate the private sector and recommends that governments in low- and middle-income countries apply these same approaches within their respective private health sectors. Consequently, development practitioners, and members of government, civil society and academia are now taking a closer look at the effectiveness of Public-Private Dialogues (PPDs), and what role they might play in the healthcare industry within developing countries.

This paper examines cases of H/PPDs in four different developing countries (Guatemala, India, Kenya and Tanzania.) By applying the methodology of good practices in PPD, as found in other more mature development sectors, the paper is able to provide insight into how an effective H/PPD process might be implemented in a developing country. The paper attempts to provide answers to the "how-to" and "why" of PPDs, so that developing country counterparts and international donors can determine if the investment of time and money in establishing an H/PPD will be worthwhile.

The emerging developing country examples we analyze show that H/PDDs share many of the same characteristics and good practices as those in other development sectors. Moreover, an H/PPD can produce some "quick wins" in health policy and programs. We believe that with adequate funding and technical assistance during the initial phases, an H/PPD processes is likely sustain itself to become independent and effective. In Guatemala for instance COSSEP (Comisión de Sectores de Salud Público y Privado contra el VIH) has taken on a new life under the Global Fund CCM. And in Kenya, Public Private Partnership PPP-HK is well positioned to assist the new Kenyan Ministry of Health (MOH) and the nascent PPP Unit to identify PPP opportunities.

While the paper has made an effort to explore the conditions prompting H/PPDs to be formed and the factors contributing to their success/failure, more examples of H/PPDs are needed to better understand if the good practices found in PPDs in other development sectors are truly transferable to the health sector in developing countries, or whether a new set of criteria on what works and doesn't work is needed.

Section One – A new development paradigm?

1.1 The need to work together – a global community

In the past two decades, a new development paradigm has emerged (See Text Box 1.1). The development community has coined several names for this emerging model - "tri-sector partnerships" (Tennyson, 2000), "reform coalitions" (Peiffer, 2012), "multi-stakeholder dialogue" (IUCN, 2012) and "public-private dialogue" (Herzberg, 2006). No matter the name, the new paradigm is founded on the view that sustainable development requires all key players to work together for change. Since 1992, the UN Conference on Environment and Development - the Rio Earth Summit - placed governments and civil society partnerships as central to achieving global sustainable development. Successive UN Summits on population, urban development, gender, and social development have reinforced this approach, expanding the partnerships to include the private sector.

Box 1.1 New development paradigm
"Effective peace building demands a broader notion of human security. We cannot be secure amidst starvation. We cannot build peace without alleviating poverty. We cannot build freedom on the foundations of injustice.
"In today's world, the private sector is the dominant engine of growth – the principal creator of value and managerial resources.
If the private sector does not deliver economic growth and economic opportunity – equitably and sustainably – around the world, then peace will remain fragile and social justice a distant dream."
"That is why I call today for a new partnership amongst governments, the private sector and the international community."
Kofi Annan, Secretary-General, United Nations

The new collaboration and partnership paradigm emerged in response to the failed single sector development approaches that focused only on strengthening the state and its technical and administrative capacity. As Tennyson states, "single sector approaches have been tried and proved disappointing. Working separately, different sectors have developed activities in isolation - sometimes competing with each other and/or duplicating efforts and wasting valuable resources. Working separately all too often led to the development of a 'blame culture' in which non-performance or neglect is regarded as someone else's fault" (Tennyson, 2005 : 3).

Globalization too has led to changing roles for government, businesses and civil society, bringing new expectations and new demands of one other. For example, governments are placing greater emphasis on participation and dialogue as a "deliberate turn in governance" and a way to bolster legitimacy, foster transparency and strengthen accountability (Peiffer, 2012: 16-17). Further, Changing expectations about citizen's roles in policymaking has led to more and stronger civil society organizations (CSOs) effectively demanding greater transparency and accountability from governments and businesses (Peiffer, 2012: 7). Additionally, as the gulf between the rich and poor widens, many international businesses previously only focused on maximizing shareholder value, are now rethinking their responsibilities toward the communities in which they operate. (Tennyson, 2000: 7). In fact, value creation for private firms (the balance between earning wealth and doing public good) is increasingly recognized as an efficient and responsible path toward a sustainable future (Porter 2006: 76 – 89; Reich, 2002: 54).

Further, initiatives that bring together government and business actors, who are working for policy and institutional reforms, are frequently cited as being an important component for sustainable development (Peiffer, 2012: 7-9). Collaboration between these two sectors provides a new opportunity for doing development better, by recognizing the qualities and competencies of each sector, and finding new ways of harnessing these for the common good (Tennyson, 2000: 11). In fact,

some hypothesizes that a partnership approach with comprehensive and widespread cross-sector collaboration is *the only way* "development initiatives can be imaginative, coherent and integrated enough to tackle the most intractable development problems" (Tennyson, 2005: 3-6).

1.2 The need to work together – the health sector

The face of the health sector in developing countries is changing. Key actors in the health sector are experiencing changes in their roles and expectations of one other. Governments, international donors, and non-government organizations (NGOs) - once the central actors in health initiatives - are looking more and more to the private health sector for help in filling the services gap. Likewise, private, for-profit health organizations are beginning to realize that public health goals are important for them in order to achieve their immediate and long-term business objectives, thus, they are taking on a broader view of social responsibility as part of their business models. Consequently, engaging private sector groups in the health sector - whether through dialogue, collaboration, or public-private partnerships[1] – has emerged in policy discussions as an important approach for tackling large, complicated and expensive health problems in developing countries (Reich, 2002: 3).

Conversely, the high-income countries have a long tradition of working with the private health sector. There are established, formal mechanisms in place to tackle difficult issues such as physician reimbursement, benefit packages and quality assurance. For example, Canada, France and Germany have standing committees to discuss healthcare costs. Although each country has different procedures, they all have forums in which key stakeholder groups in health - national or provincial level governments, national health insurance funds and medical associations – participate to establish reimbursement fees. In the area of hospital quality assurance, all European health systems have created by law a mechanism and process that involves multiple stakeholders. The composition and inclusiveness of the process to accredit hospitals varies, including clinical professionals, private hospital owners, government regulatory agencies, consumer groups, academic and training institutions and health care insurers. Any disagreements over this process and/or agreements reached in these areas have largely been resolved through consultation among these parties.

Reasons for the rapprochement between the public and private health sectors in developing countries are similar to those in industrialized countries: neither public nor private health organizations are capable of resolving the challenges confronting health systems today, on their own. In developing countries for instance the private health sector is playing an increasingly important role in the delivery of health services and products. In Sub-Saharan Africa, one of the poorest continents in the world, for-profit healthcare providers account for as much as 50 percent of health services and their role is growing (IFC, 2009: vii). However, the private health sector's ability to help address the challenges found in a developing country's health sector is constrained due to fragmentation and being largely unregulated.

In developing countries, the public and private health sectors are being driven toward each other, with some uneasiness, in order to accomplish public health goals (Reich, 2002: 2). There is some, albeit limited, evidence that formal public-private dialogue in health (H/PPD) can improve the use and effectiveness of existing resources in developing country health sectors (Health Partnerships, 2011: xiii). The literature on maternal and child services shows that closer coordination between the public and private sectors in low income settings has improved access to family planning methods, institutional deliveries with a skilled birth attendant,

---

[1] It is important to note the difference between public-private dialogue (PPD) and public-private partnership (PPP). In this paper, the authors define PPP as a mechanism to mobilize private actors to invest capital to deliver a public good and/or service (transactions) while PPD a structured process for public and private actors to dialogue and interact together. However, many in the international health community also include PPD as part of their definition for PPPs in the health sector in developing countries.

and greater coverage of vaccines for children (See Text Box 1.2).

Several studies, however, state that the opportunities for dialogue among developing country health-sector stakeholders have been limited. Considerable mistrust of the private health sector's motives exists, and suspicion of the profit motive, based on deep rooted philosophical beliefs and personal experiences, is cited as one of the greatest barriers to interactions between the stakeholders (Hozumi, 2008: 8-9, Healthy Partnerships 2011: 29). A lack of understanding is perpetuated by nominal and infrequent interactions between the two main players in healthcare provision, often to the disadvantage of the very population groups who need the services provided (Chowdhury, 2004). In many developing countries, interactions between the public and private health sectors are punitive, with low- and middle-income country Ministry of Health (MOH) regulations and guidelines implemented more strictly than in other sectors (Feeley, 2009: 27-31).

To be sure, a growing number of MOHs in developing countries are implementing strategies and policies to engage and partner with the private health sector, but many are still reluctant to commit to a PPD process (Palmer, 2006; Hozumi, 2008). Approximately 85% of Sub-Saharan African countries have official policies to work with the private health sector, yet the majority of these countries do not implement them (Healthy Partnership, 2001: xv). Even with the best intentions, many governments and private sector groups participating in a PPD country lack an

approach, technical skills and resources to sustain the process (IUCN, 2012:1).

Although H/PPDs in developing country health sectors are beginning to show promise, the international health community still does not know enough about H/PPDs as they apply to the health sector. The purpose of this paper is to assist development practitioners and international donors to better understand the conditions under which a multi-sector dialogue can succeed and what the necessary strategies are to sustain an H/PPD in developing countries.

This paper examines four examples of H/PPDs (Guatemala, India, Kenya and Tanzania) by applying the methodology of good practices in PPD, as found in other more mature development sectors. The paper offers insights into how an H/PPD process might be implemented in a developing country, and it attempts to provide answers to the how-to and why of PPDs (see Box 1.3), so that international donors and developing country counterparts can determine if the investment of time and money in a health PPD will be worthwhile.

Box 1.3 Questions regarding H/PPD in developing countries

- What are the characteristics of successful PPD in health?
- In what ways, if at all, do H/PPDs differ from other development sectors?
- Who are the stakeholders critical to an H/PPD's success?
- What is an appropriate role for the state in an H/PPD? Is political support sufficient or a more 'hands on' role needed? What should be the private sector's role?
- What "leadership" model is effective given the H/PPD's focus on cooperation between equal partners?
- What strategies work to foster collaboration and cooperation between stakeholders in the health sector?
- What challenges do H/PPDs confront? What are strategies to overcome them?
- What environmental factors contribute or hinder an H/PPD process?
- What type of impact can a PPD process have in the health sector? What activities will yield the most impact?

Section Two – Introduction to PPDs in the health sector

Achieving universal health coverage[2] - *ensuring that all people obtain the health services they need without suffering financial hardship when paying for them* - will undoubtedly remain a distant dream in developing countries if the different sectors in the health sector fail to work together more effectively. On May, 2010, the 63rd World Health Assembly passed a resolution acknowledging that private providers are a major source of healthcare in most countries and that private provision of health services can lead to innovation as well as better performance of the health system. The resolution - called, _Strengthening the Capacity of Governments to Constructively Engage the Private Sector in Providing Essential healthcare Services[3]_ - validated the strategies high-income countries have used to effectively engage and regulate the private sector, and recommended that governments in low- and middle-income countries apply these same approaches within their respective private health sectors.

2.1   Defining PPD in health sector

Definitions for PPD vary greatly with a wide range of terms. Examples include "platform", "process", "partnerships", "committee", "roundtable" and "deliberations" (IUCN, 2012). Despite the different terminology and forms, several common features bind these different concepts together:
- participation of multiple public and private sector stakeholders
- Interaction via forums or "spaces" where participants can physically meet and communicate

- convening around common issues or problems that bringing he stakeholders together
  - negotiating, collective learning, problem-solving, and decision-making (IUCN, 2012: 3; Tennyson, 2000: 12).

PPD provide the private sector with "a seat at the table" in policy and other decision-making discussions, while at the same time, encourages the public sector to regard the private sector as equal partners (Herzberg, 2006: 11). a "genuine" and "true" public-private dialogue process will contain one or more of these elements (IUCN, 2012: 3). Box 2.1 offers a working definition of public-private dialogue.

Box 2.1   General definition of PPD
"PPDs are structured mechanisms, anchored at the highest practical level, coordinated by a light secretariat, and aimed at facilitating the discovery process by involving a balanced range of public and private sector actors in identifying, filtering, accelerating, implementing, and measuring sector-related actions and policy reforms." (Herzberg, 2011)

PPDs come in many forms. It can be structured or ad hoc, formal and informal, wide-ranging or focused on a specific issue, permanent or time-bound. A PPD can be initiated by forward-thinking governments, frustrated entrepreneurs, or third parties, such as international donor agencies. Sometimes the process involves only a single group in the private sector, or entails the government interacting with a wide range of private sector entities through umbrella groups that represent the full range of private sector actors.

To-date, most examples of an H/PPD in developing countries have primarily been between public and not-for-profit sectors – faith based organizations (FBOs) and non-government organizations (NGOs). Little, until the last five years, has been done to systematically include the for-profit health sector in an H/PPD process (O'Hanlon, forthcoming 2013).

---

[2] On 12 December 2012, the United Nations General Assembly adopted a resolution urging governments to move towards providing all people with access to affordable, quality health-care services. The resolution emphasizes the important role that health plays in achieving international development goals.   See http://www.un.org/ga/search/view_doc.asp?symbol=A/67/L.36&referer=http://www.un.org/en/ga/info/draft/index.shtml&Lang=E   and http://www.un.org/ga/search/view_doc.asp?symbol=A/67/L.36&referer=http://www.un.org/en/ga/info/draft/index.shtml&Lang=E.

[3] See http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_25-en.pdf

2.2   Risks and Benefits of an H/PPD

A PPD builds consensus on policy reforms, system changes, PPP opportunities and the actions needed to execute them. These are the main benefits of PPDs. In the case of H/PPDs, designing and implementing an "intentional" and structured PPD process can precipitate or follow a policy event that might include: (i) proposing new legislation that encourages PPPs in the health sector, (ii) setting aside an ineffective policy or regulation that restricts private provision of healthcare, (iii) standardizing procedures to be implemented across public and private health sectors, or (iv) creating a new institution such as a PPP Unit within the MOH, to facilitate greater interactions between the public and private health sectors. An H/PPD process can also encourage PPP opportunities, such as contracting FBOs to deliver specific services, leasing public facilities and equipment to private providers, etc.

While a formal PPD mechanism can have an immediate effect on increasing and improving interactions between the sectors, the deeper and more long-term impacts include: (i) building an atmosphere of mutual trust, and (ii) facilitating greater understanding between government and top business leaders in the health sector, and promoting good governance by setting an example of accountability between the sectors.   A list of potential H/PPD benefits include:.

- **Promotes better diagnosis and policy design** by including *all* health sector stakeholders' perspectives and constraints, leading to more realistic and workable private sector reforms.
- **Removes implementation bottlenecks and ensures a greater likelihood of implementation** because the private sector participated in designing the policy reform and now has a better understanding of the government's policy intent.
- **Ensures that reforms effectively target private sector challenges** by providing the private sector a key role in the policy planning process, increasing the likelihood of private sector accepting and putting into practice the reforms.

- **Creates a more predictable business environment** when governments establish policies, health planning and regulations related to purchasing so that both private and public sectors can make investments in the health system based on long-term returns and sustainable initiatives rather than stop-gap measures.
- **Mitigates risk when public and private sectors frequently communicate and share information,** enabling the government to manage conflicts and trouble shoot problems as they arise. (Herzberg, 2006; IUCN, 2012; OECD, 2009)

Box 2.2 Examples of an H/PPD's benefits

- In Tanzania, the government has a Health PPP Strategy. After the MOH shared with the private sector its struggles to find partners, the private-health sector quickly moved to organize into umbrella organizations representing different sub-sectors to facilitate dialogue and PPPs.
- In Guatemala, the private sector worked closely with the National AIDS Program to design a "private sector friendly" form to report new cases of HIV/AIDS. Growing numbers of private healthcare providers now use this form.
- In Kenya, the National Health Insurance Fund announced a new out-patient benefit packages to be delivered through the private health sector. The private health sector carefully analyzed the costs and met with NHIF to inform them it was not feasible. NHIF is reexamining the benefit package.
- In Tanzania, the Association of Private Health Facilities in Tanzania has close working relations with the MOH Councils and often intervenes when of a private health facility is closed without just cause.
- MOHs in Ghana, Kenya, Malawi, Mali and Namibia and Tanzania involved the private health groups in their assessments and were able to identify specific policy barriers and reforms needed to harness the private health sector.

As in any political process, there are risks for both the public and private sector stakeholders. If done poorly, a PPD process can not only waste resources but it can actually worsen the problem it is intended to solve. Table 2.1 illustrates some of the common risks found in an H/PPD. Although there are many risk factors that can derail an H/PPD process, awareness of the proper procedures and careful planning can help mitigate the potential pitfalls.
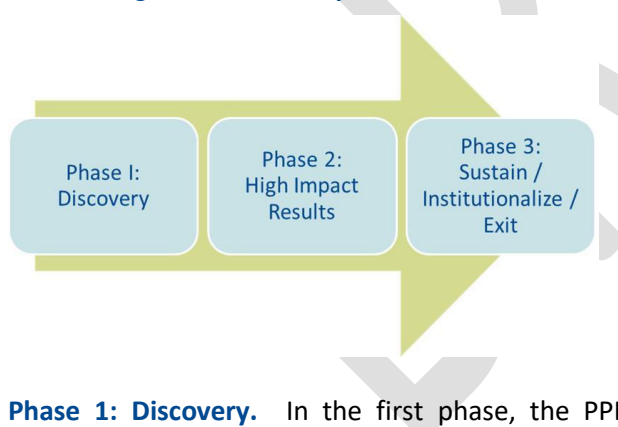
Table 2.1 PPD risks in the health sector

Risk	Description
"Cherry Picking" private sector favorites	MOH officials have long-standing relationships with certain private sector individuals and/or groups in the health sector. An H/PPD can reinforce vested interests and cronyism, give undue influence to certain private sector individuals and/or groups and provide a veneer of legitimacy for bad policies. Similarly the business sector can also abuse this privilege, especially if private sector organizations representing the business community in health are not representative and legitimate.
Over or under representation	The private health sector in most developing countries is not well organized, making it difficult to participate in a H/PPD. Also a H/PPD with underrepresentation reinforces the tendency to only work with same private sector individuals and groups. A MOH can feel threatened if not equally or overly represented in H/PPD.
"Talking shop" syndrome	If poorly planned and unfocused, an H/PPD can devolve into a process that does not achieve results or actions. Participants become disillusioned, disengaged and the process loses credibility. Establishing an H/ PPD therefore demands the existence of certain structural preconditions for both public and private sectors.
One-person show	An H/PPD relies on the energy and commitment of a core group of individuals. However, building the process too closely around an individual creates significant risk, such as becoming a one person show or the process losing steam when the individual become less involved.
"Capture" by powerful interests	An H/PPD risks being monopolized by an extremely small group of powerful lobbies that are often in control of key resources and have crucial influence on the MOH and dialogue process. If not careful, an H/PPD can become a façade and screen for collusion, corruption and government capture of vested interests.
Process is politicized	Private sector leaders may be leading figures in opposition parties making it difficult to keep the PPD process politically neutral. MOH may be tempted to sideline opposition figures or PPD can be perceived as driven by private sector interests, dissuading MOH leaders to support the process.

Based on Herzberg, 2006: 13-14; O'Hanlon, 2013: 3-5, forthcoming; Tennyson, 2003: 5 – 6 and, Pinaud, 2007: 19, 29, 34, 44- 46

2.3   PPD life cycle

A PPD undergoes three separate phases in its life-cycle (Herzberg, 2011:15-18):

Figure 2.1 PPD life cycle

Phase I: Discovery

Phase 2: High Impact Results

Phase 3: Sustain / Institutionalize / Exit

Phase 1: Discovery. In the first phase, the PPD partners' efforts focus on building trust, educating the different sectors about one other, and discovering what works and what does not. This phase yields small results, but quick wins, as the PPD stakeholders begin the process by focusing on less contentious issues and, then later, as the process progresses, on the more difficult ones. PPD participants may use the forum to address some of their long-standing, unresolved issues. However, these more complex and high-visibility issues are high-risk and have potentially negative consequences for the PPD. A PPD process may last from six months to three years.

Phase 2: High Impact Results. Phase 2 is the most productive phase, as the PPD partners are motivated by early results and become more experienced in working together. During this Phase, the PPD partners understand the process and are comfortable with the dialogue mechanism. Many of the partners have gained new skills and capacity during the first phase that they now use in the day-to-day management of the PPD process. The PPD partners begin to realize not only results, but also policy and programmatic successes. As the partners gain confidence, they begin to address more contentious issues that may lead to conflict and possible crises. This phase may last from one to three years, depending on how successful the PPD partners are in resolving conflict, sustaining momentum and achieving results.

Phase 3: Institutionalization/Transfer/Exit. The PPD process now takes on a life of its own. At this juncture it is appropriate for the PPD partners to question its future direction. For example, should the dialogue process be maintained in its current structure? Should it take on new challenges?

Should it be transferred to a more appropriate organization such as a government, institution and/or advocacy group? Or, perhaps, the PPD process has run its course and should be disbanded.

2.4   Winning features of a PPD

There are not enough examples of health PPDs in developing countries to state with confidence that they also undergo the same life-cycle and phases as a PPD in other development sectors. However, the emerging experience reveals that H/PPDs in developing countries share similar characteristics and good practices with those of the other development sectors. Figure 2.2 illustrates the six good practices based on the fields of public participation in governance, public-private dialogue in other development sectors, policy advocacy and strategic communication in health (Herzberg, 2006; Tennyson, 2005; and O'Hanlon, forthcoming 2013).

The good practices include:
- Formalized mandate and public and private institutions aligned with the consensus-driven mandate
- Organizational structure with technical and political capacity
- Balanced representation between the sectors that actively cooperate together
- An honest broker facilitating a process perceived by all PPD partners to be fair, transparent and neutral
- Leadership by a core group of public and private champions who "own" and "drive" the PPD process
- A learning partnership that uses data to make decisions, inform the dialogue process and demonstrate visible results

#1: Formalized mandate and aligned institutions. Poorly planned PPDs run the risk of losing momentum and direction. PPDs must be purposeful and organized around a common vision or goal of a specific set of reform policies (Peiffer, 2012: 20).

Figure 2.2 Good practices in a PPD

Establishing a mandate for the PPD process helps create clarity and direction, establish credibility and increases the likelihood of PPD's success and continuity (Herzberg, 2006: 45). Formal mandates range in ease and complexity from the simplest, that create consensus on a vision / mission statement, to the more complex, that are created by a regulation or a presidential decree, stipulating how PPD fits into the policy process. It is important to note, however, that there is no correlation between mandate and PPD effectiveness (IUCN, 2012: 2). Most practitioners do agree however that formalizing the PPD process is a necessary condition to ensuring a PPD's success and continuity (type of mandate is not as important) (O'Hanlon, forthcoming 2013).

Multi-sectoral partnership processes are extremely complex. They depend on establishing strong working relationship between key individuals from radically different institutions (Tennyson, 2005: 36). At a minimum, actors in a PPD must share a common perception of the problem that needs to be addressed (Peiffer, 2012: 12). Aligning the different sectors and related organizations into a group that will drive a PPD process can be achieved by establishing upfront a common vision, agreement on the "rules of the game" governing how the PPD partners will work with each other,

and consensus around the priority issues to be addressed during the PPD process (O'Hanlon, forthcoming 2013).

Whether a PPD forms along sectoral or cross-sectoral lines is a function of the type of reforms sought, the pre-existing organization of business, and the networks between business and the state. However, coalitions and multi-stakeholder dialogue across sectors face more difficulties in their formation, and may thus be less likely to form (Peiffer, 2012: 23). Aligning multi-stakeholder interests working within a specific sector and/or interest is easier and more likely for "business people to aggregate their interests, than for businesses and government to gain a common understanding of problems, [and] business and government to join forces to bring about change" (Peiffer, 2012: 24).

#2: Organizational structure and political/technical capacity. There is some discussion on whether a PPD needs to be a formal structure. Some argue that an informal structure can serve many different and useful purposes. For example an informal setting can assist negotiations when the two parties hold conflicting visions on private sector collaboration, or can help build trust by allowing both sides to 'test the waters' without committing to one path or another (Peiffer, 2012: 21). Others argue that a new structure/group is needed to create a "level playing field" between the sectors and key organizations participating in a PPD. Moreover, a formal structure sends a positive signal to the private sector that the public sector is committed to working with them (O'Hanlon, forthcoming 2013).

As a result, there is no "one-size-fits-all" structure for a successful PPD process. Institutional design of a PPD process depends on a number of variables, for example how well organized are the non-state actors and their capacity to truly represent their respective sector's interests. Experience shows that a simple, smaller structure that is flexible and reflects the local context can be effective for driving a PPD process. An organizational design operating under the umbrella of a secretariat can effectively integrate a larger number of stakeholders, constructively bring in expertise as needed, and help ensure a coherent approach to PPD (Herzberg, 2006: 53).

Most agree, however, that PPD structures are more likely to succeed when the business community also has a certain degree of *political and technical capacity* that matches or complements the state (Peiffer, 2012: 25). Well-organized business organizations can facilitate interactions between the state and business by representing a wide range of private interests (Pinaud, 2007: 35). In this case, the government is able to work with fewer actors and be certain that the broader business community is supportive of the positions expressed by their leaders. Moreover, a government is more likely to engage a well-organized private sector with political skills to negotiate, deal and lobby the government for their goals (LDP, 2012: 26). Governments are more likely to disregard the business community as a potential partner if the private sector is weak, fragmented, disorganized and lacking in capacity (Pinaud, 2007: 35).

Skills and capacity. Learning new skills and practicing them in a PPD process is one of the incentives to attract and retain busy professionals in a PPD process. Successful leadership requires a range of skills – some that come naturally and others that may need to be acquired. Table 2.2 illustrates the range of skills needed by both public and private sector groups involved in a PPD. Partnerships that fail to internalize learning will fall short of reaching their full potential (Tennyson, 2005: 20-24).

Table 2.2 Good partnering skills

Skills	Overview
Facilitation	Facilitation is a demanding role. Good facilitation is a balance between being tolerant and being tough. A good facilitator can "read" the mood of the group, learning when to give the group space to work through disagreements or when to give them direction.
Communication	Individuals and groups need to become excellent communicators with partners from radically different organizational cultures to enable meaningful interchange.
Quality Conversations	A PPD process is, in essence, a series of conversations. The quality of the conversations between the partners directly influences the effectiveness of the collaboration. Creative conversation is a powerful tool to build transparency and subsequently trust.
Conflict Resolution	Conflict resolution is an essential skill in a PPD process. Through negotiation, the PPD partners can anticipate, contain and resolve disputes so that the partners with shared and opposing interests can reach a mutually acceptable solution.
Action Learning	There are many learning opportunities throughout the PPD process. A good partner never stops listening, observing and reflecting on all aspects of the PPD as it progresses and changes over time. As part of learning on the job, PPD partners need to stop and reflect on experiences, record and analyze them and translate them into useful lessons learned. This regular review helps sustain momentum and energy among PPD partners.

Tennyson, 2003:35–55 and Novak, 2000: Section 4

#3: Balanced representation of all sectors and active cooperation.

The PPD process is based on the basic tenets of partnerships - equity, transparency and shared risks and benefits. Achieving "mutual benefit" is not easy, but it is a necessary condition for a successful PPD initiative. There are proven tactics to help facilitate a "win-win" scenario for all stakeholder groups working together in a PPD process. A consistent feature of a successful PPD is the *seniority of government and private sector* individuals leading a PPD process (Herzberg, 2006: 60). Another key feature is *balanced representation* between the sectors. A productive size is between 15 to 20 member organizations, but the challenge is agreeing on how to achieve the balance. Finally, *active cooperation* between actors from both spheres is a necessary condition for success (Peiffer, 2012: 12). Strategies to fostering active engagement include creating policies and procedures that put into place:

- **Shared leadership:** A genuine PPD process is not directed by one sector and/or organization. Sharing leadership can be achieved by each sector occupying one of the leadership positions (Chair, Vice-Chair and Secretary) and by rotating these positions between sectors.

- **Transparent selection criteria:** Naturally private sector leaders will see opportunities arising from direct access to government and donors in a PPD process. Criteria for participation should be written and publically available, allowing all potential partners to express their interests in participating (Herzberg, 2006: 61).

- **Joint decision-making:** The PPD participants need to define what constitutes consensus; in most cases decisions are negotiated agreements. There are differing opinions on whether the PPD should have decision-making power. For some, a PPD is a forum to inform, seek advice, or recommend while for others decision-making may be one possible purpose, but consultation and social learning are equally important (Peiffer, 2012: 3).

- **Political commitment:** The best way to demonstrate the utility of dialogue and to build trust is to show its effectiveness. Government can send a strong message to the private sector by acknowledging its contribution and making substantive policy decisions that have taken into account suggestions made by the business sector (OECD, 2007: 61). And the private sector can express its support by actively participating when the government convenes a meeting, and by sharing important information when requested.
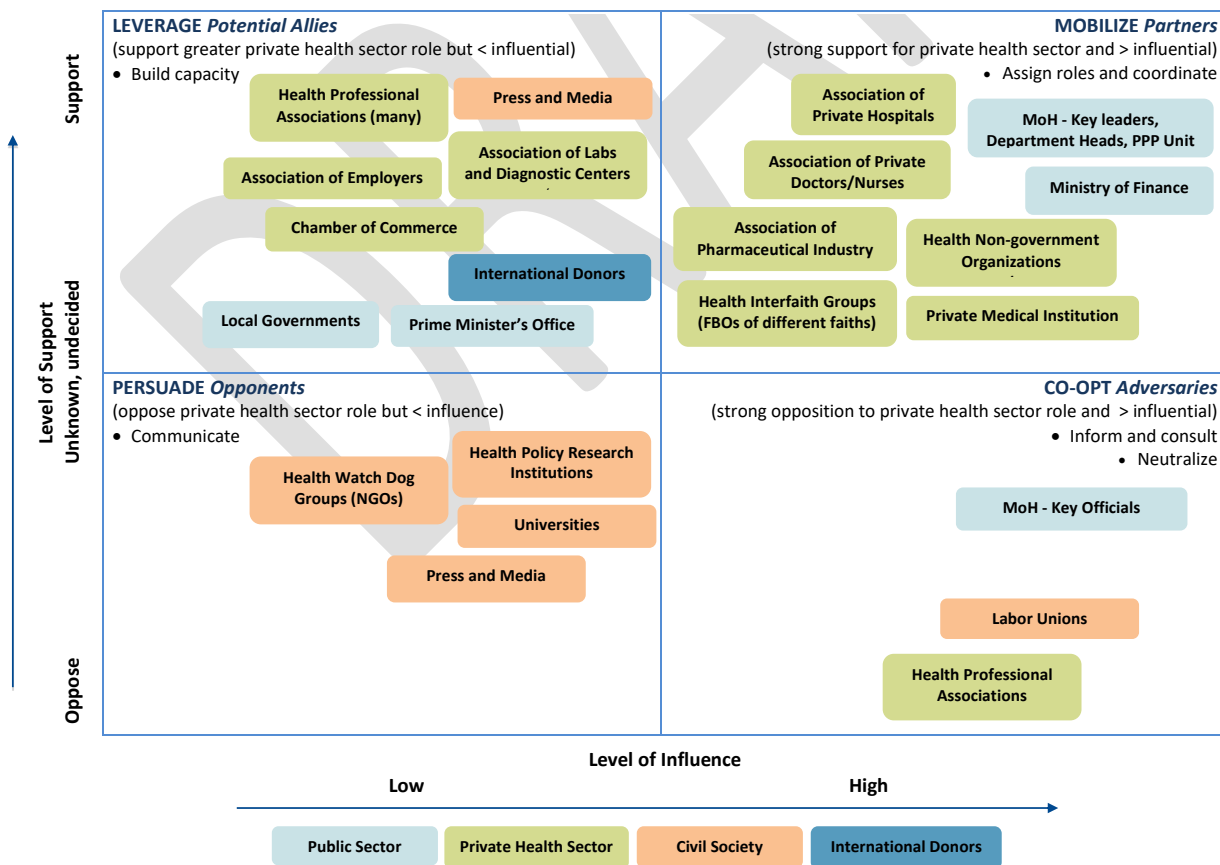
Stakeholder analysis and mapping. Spending the time to analyze a country's interest in cooperating with the private health sector, learning about stakeholder capacity to participate in a PPD process, and identifying stakeholders critical to a PPD's success, can make or break a PPD process. A stakeholder analysis helps to: (i) systematically capture information gained from key informant interviews and other data sources, (ii) refine the list of stakeholders, their interests and potential impact on the PPD process, (iii) identify themes, concerns, and insights shared by stakeholders or differences in opinion, and (iv) assess levels of support and opposition to proposed private sector policy reforms and PPP opportunities.

Figure 2.3 illustrates an analysis of commonly found stakeholders in a developing country health sector. The analysis categorizes each stakeholder into four groups – allies, partners, opponents and adversaries. These categories help identify the

desired behavior and approach to persuade, influence, or empower different stakeholder groups to support an H/PPD.

Influential stakeholders who strongly support greater interactions between the public and private health sectors are critical to an H/PPD's success and need to be mobilized as H/PPD *partners*. In this role they can help kick-start the initial stages of an H/PPD. Potential stakeholders in this category may include: (i) key leaders and institutions within a developing country MOH, such as the Minister and Deputy Minister, Department Heads and the PPP Unit and/or Department of Policy and Planning, depending on where the PPP function resides, (ii) other government agencies like the Ministry of, Finance, and (iii) business leaders and associations representing different sub-groups of the for-profit and not-for-profit health sectors.

Figure 2.3 Stakeholder mapping for the health sector

There are also important groups of **potential allies** who can be tapped to support and possibly join the H/PPD process. Potential allies include: (i) other government agencies such as the Office of the Prime Minister and particularly, the Ministry of Local Governments, who are increasingly becoming implementers of health services at the regional level, (ii) the international donor community funding health services, who can either be strong supporters and/or formidable opponents, (iii) other private sector groups, such as private employers and chambers of commerce who are not in the business of healthcare but are concerned about access to and the cost of health services for their employees, and (iv) the press, who, - depending on how closed or open a government is, can influence public perception on an H/PPD's reforms and PPPs in health. .

There are always reluctant stakeholders who oppose greater collaboration between the public and private sectors in health and any effort to encourage more interaction. In developing country health sectors, there are many civil society groups - health policy and research organizations, universities watchdog groups, and the press - that can be hostile to a greater private sector role in healthcare. In some cases, targeted communication and outreach activities to these **opponents** can persuade and or neutralize their resistance to a greater private sector role in healthcare and an H/PPD.

Ultimately, there will always be key individuals and groups who are fundamentally opposed to a private sector role in health. These **adversaries** are often key MOH officials who can sway other MOH leaders, or groups, such as labor union and/or professional associations, representing public health personnel. In this case, one can only hope to neutralize their opposition by consulting and keeping them informed. Anticipating, addressing and resolving opposition early on can improve overall outcomes of the PPD.

#4: Leadership of core champions. A PPD does not happen unless someone really wants it to. A common hallmark of successful PPDs is that they

have strong and effective **champions** driving the process forward (Pfeiffer, 2012: 18).   The term champion describes "someone from the public and private sectors who uses his or her profile, reputation or influence to promote a cause, project or organization" (Tennyson 2000: 25). An effective champion has a wider view of the sector and places the sector's best interest ahead of his/hers.

At the beginning of a PPD initiative, champions play several important roles as leaders of the PPD process and highly effective spokespeople - giving the PPD invaluable publicity, identifying key player to become involved, encouraging public and private sector stakeholders to get involved. They also play a critical role behind the scenes and maybe most useful as "fixers" who can quietly persuade reluctant players to get around the table and assuage public sector skepticism about the purpose of a dialogue process, so they can support the PPD initiative (Herzberg, 2006: 65-67).

Strategic communication and engagement tactics.
Effective PPD practitioners utilize a variety of strategic communication and engagement tactics to foster participant buy-in and build support for a PPD. These activities require analysis, thoughtful planning, and persistence. A communication strategy is the cornerstone of engagement that will develop a positive image and consistent messaging on why it is important for public and private sectors to engage in dialogue and collaborate with one another. Table 2.4 illustrates the wide range of tactics used to engage the private sector.

Four commonly recognized types of engagement include:

1. **communication**: one-way transfer of information from government, partners to stakeholder audiences;
2. **consultation: two-way process in which participants expect their views to be heard and taken into account;**
3. **participation: two-way engagement in which all parties expect to actively participate as equals and are committed to win-win outcomes, and**
4. **negotiation: two-way process in which both groups expect mutually binding outcomes as outcomes.**

Table 2.4 Activities by level of engagement

Communication	Consultation	Participation	Negotiation
Print Materials: - Fact sheets / Brochures - Newsletters - Issues/Policy Papers - Technical Reports - Posters and Billboards - Press releases, op-ed pieces	Events: - Expert Panels - Briefings - Workshop - Conferences Government Forums: - Town Meetings / Open Houses - Technical Working Groups	Events: - Expert Panels - Briefings - Workshop - Conferences Government Forums: - Town Meetings / Open Houses - Technical Working Groups	Organizing / strengthening public sector capacity to engage and negotiate: - Forming PPP Unit or assigning PPP Adviser - Mentoring government staff to become PPP experts and champions
Media: - Print (news, feature stories, op-ed pieces) - Press releases - News Conferences/ Media briefings - Television programming - Advertising - Radio programming		Interpersonal: - One-on-one meetings - E/Mail and Telephone - Personal networks - Informal gatherings Organizing and strengthening: - Building Professional Associations - Forming networks / coalitions - Mentoring policy champions	Organizing / strengthening non-state representation: - Building Professional Associations - Forming networks and coalitions - Mentoring private sector champions
Website /On-line Forums	On-line Forums	On-line Forums	

Adapted from Herzberg (2008), O'Hanlon (forthcoming, 2013)

PPD champions need to be supported and empowered as change agents while carrying out the necessary communication and engagement activities. Donors can play an instrumental role in supporting these champions and the PPD process. It is very important for them to understand the local context of the issues, however, instead of offering only prescriptive solutions that allow the process to simply run its course (Herzberg, 2006: 69).

#5: Honest broker facilitating a neutral process. Due to the mistrust and suspicion between the public and private sectors, a facilitator can help jump start the PPD process as well as direct and sustain its momentum. In many instances, this task falls to an individual or group of individuals who intuitively and informally "lead" the process. Brokering is a "science" but it is equally an "art". The partnership broker can come from any sector, but it is preferable to have someone with health sector experience, thus allowing them to draw on their experience, as appropriate. Ideally, the partnerships broker is someone who can genuinely claim to have experience in both the public and private health sectors and, of course, has local knowledge. Often the broker is either a local

or an international consultant. An effective partnership broker possesses a combination of concrete technical skills, balanced with special Interpersonal skills (Tennyson, 2005; 35-36).

Key functions of a partnership broker include:
- consulting with stakeholders to determine their interest, willingness and ability to participate in PPD process, and to ensure and sustain the stakeholders' interest and working publicly and behind the scenes to lead the dialogue process– spotting opportunities, negotiating compromises and defusing potentially contentious issues
- liaising with international donors to provide the necessary inputs, such as specialized technical assistance, expert advice,
- providing independent evidence-based research and financial resources; and
- developing a vision and direction strategy while providing focus to the PPD process (O'Hanlon, forthcoming 2013).

Policy and other analyses informing dialogue. In addition to having an impartial broker, another key feature of a successful PPD process is using objective information to inform the dialogue. As there is little to no information collected systematically on the private sector, particularly in the health sector, conducting policy and other forms of research is critical in order to inform the dialogue process with impartial information. Table 2.3 presents the types of analytic activities that can help inform health sector policy and PPP proposals and provide evidence for engagement tactics and strategic communication activities to be carried out in the process. The data collected can be used in

dialogue process, otherwise they may lose interest. Establishing milestones (outputs) guiding the PPD process can help the *champions* measure progress and learn from the process' successes as well as failures. Agreement between the public and private sector PPD members on milestones measuring success is critical for learning. Milestones can focus on structure and process or recommendations. Some structure and process outputs include: (i) a formalized structure for dialogue, (ii) periodic conferences and meetings, and (iii) consensus on key policy reforms. Milestones can also include policy recommendations, legal reforms and/or PPP opportunities (Herzberg, 2006: 77-79).

Table 2.3 Analysis Informing H/PPD

Type of Analysis	Illustrative Examples
Policy environment	• Legal and regulatory analysis to identify barriers to private supply of health care and products • Review of framework to propose how to streamline, harmonize regulations to create "level playing field" across sectors to implement health activities. Survey of other countries health laws, policies and PPP Strategies to recommend approach and language for a H/PPP policy / implementation strategy • Position papers describing how private sector can complement public sector in health priorities
Business climate	• Position papers on investment climate for health with recommendations • Examination of conditions to access to capital for private health businesses • Assessment of barriers to market entry and linkages for private health businesses • Analysis of incentives (purchasing and others) to mobilize private supply of health services and products
PPP opportunities	• Inventory of existing forms of coordination, collaboration and partnerships between the sectors in health • Inventory of existing forms of coordination, collaboration and partnerships between the sectors in health • Case studies of current health PPPs to identify what works, and how to bring to scale • Proposal for Health PPP Strategy outlining when and how government will partner with private health sector • Assessment of feasibility, cost and health impact of proposed PPPs in the health sector

O'Hanlon, forthcoming 2013

three ways: (i) advocacy practices to promote specific policy reforms and health PPPs, (ii) analysis that generates objective information to inform dialogue and policy formulation, and (iii) disclosure of information to ensure accountability and responsiveness. International donors can play an important role in this area by providing resources and technical expertise to the H/PPD partners as they carry out and apply the policy research and analysis.

#6: Evidence-based dialogue and decision-making.
PPD initiatives need "wins" – that is, successes – in order to be sustained over time (Peiffer, 2012: 30). It is important that the PPD participants perceive visible change during the

Monitoring plan to track PPD progress: Both monitoring and evaluation are essential tools for fostering a "learning partnership". There are several research tools available for collecting the necessary data for monitoring a PPD's progress, and evaluating its impact, including rapid appraisals, key informant interviews, questionnaires, focus groups, media scans, tracer studies, and visual observations (Herzberg, 2006:149).

The PPD Evaluation Wheel (see Figure 2.4) is a tool that promotes discussion among PPD participants and in-depth analysis of the PPD process, offering insight on what works and what doesn't. The PPD Wheel is organized by central elements of the process and uses indicators to measure a PPD's

effectiveness. The Wheel can be customized to fit the local context of a PPD process. Each indicator is scored using a scale of 0 (lowest point) to 10 (highest point). Since there are multiple indicators for each element, one takes the average score of the indicators to determine the overall ranking for that particular element on the wheel.

Another key feature of the PPD evaluation wheel is it can be tracked over time and used to compare how different elements of the PPD process evolved.

Timing and sequencing. Although not considered a good practice, *"timing"* and "sequencing" play an important role in the success of a dialogue process. A dialogue process is often initiated at a "critical juncture" in the policy process or when a "trigger" such as a sudden crisis, political threat or even opportunity (Peiffer, 2012: 18). How policies and the political context evolve can also determine the duration of a PPD effort. For instance, if the PPD does not achieve its policy goals or if a reform does not benefit the PPD members as expected, the perceived value of a PPD process may fade. Additionally, a PPD may also have a short life because a policy solution was obtained relatively quickly (Peiffer, 2012: 23).
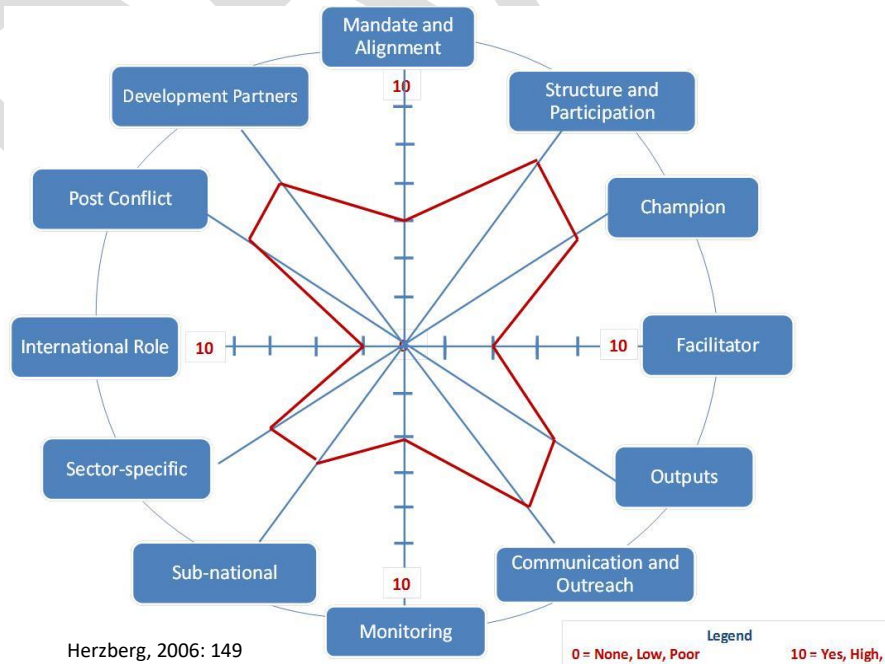
PPD country readiness Diamond: it is important to take the "pulse" of a country to determine if it is ready, and the moment right, for launching a PPD process. Using the PPD Diamond is the first task to gauge stakeholder interest in PPPs and local capacity to implement a dialogue process.

The PPD Diamond is a tool that organizes and displays the data collected through stakeholder interviews. The Diamond analyzes the four necessary factors of a successful PPD: (i) public sector commitment and capacity, (ii) private sector willingness and ability, (iii) critical number of champions in both sectors, and (iv) existing policy forums and mechanisms.

In addition to capturing a country's readiness, the PPD Diamond also quickly points to engagement gaps and opportunities. Figure 2.5 illustrates an H/PPD Diamond analysis for the health sector in Tanzania.

Overall, conditions are opportune to establish an H/PPD forum in Tanzania. The policy framework receives the highest score out of the four conditions (see Box 2.3). The recent Tanzania Private Sector

Figure 2.4 - PPD Evaluation Wheel

Herzberg, 2006: 149

Assessment reveals robust PPP policies, laws, strategies and the MOH is in the process of finalizing operational guidelines for health PPPs.

The Tanzanian private health sector is firmly committed to working with the public health sector and is actively seeking ways to directly engage the government. Moreover, there are large and influential organizations representing private sector constituents, such as the Association of Tanzanian Employers and the Tanzania Private Sector Forum, which have solid PPD experience and have been successful in influencing policy affecting the private sector in Tanzania.

These organizations can assist health sector stakeholders to acquire the advocacy and policy skills needed to be effective. Fragmentation and disorganization of the private health sector is the main reason the private sector does not merit a higher score.
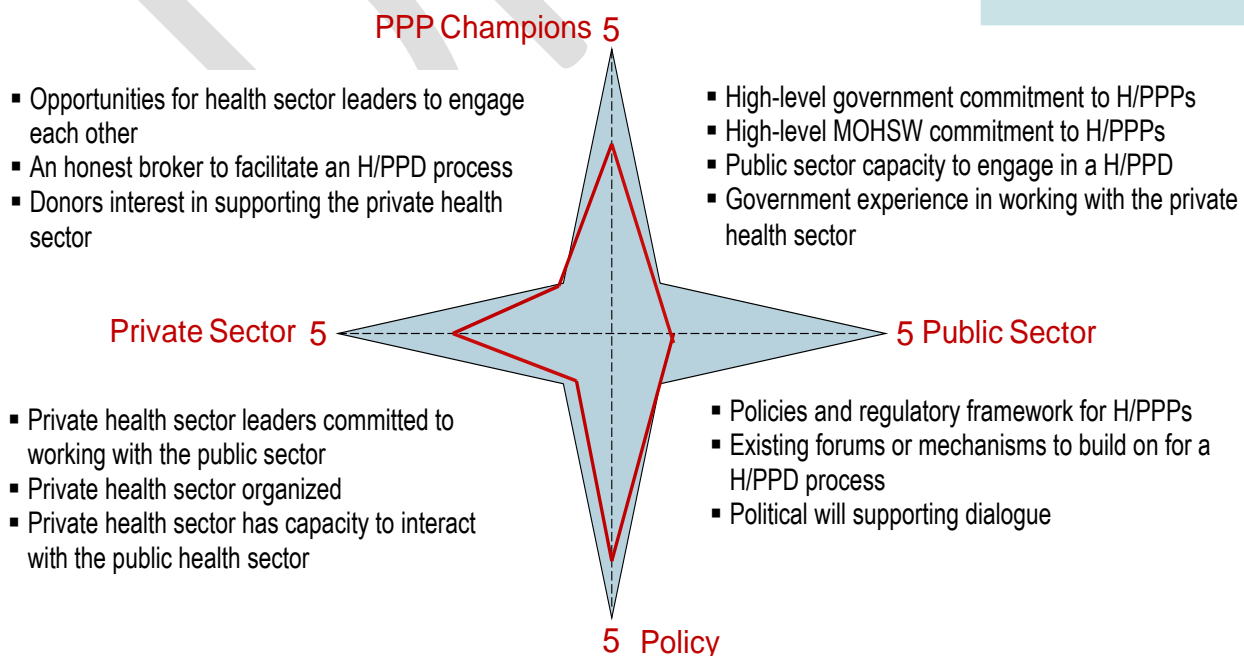
There is currently a small but active group of PPP champions working in the Tanzanian public and private health sectors. Development partners strongly support this burgeoning group of champions and are committed to providing technical support and resources to ensure their success in an H/PPD process.

The only possible constraint to their success is the absence of an honest broker to energize and sustain the momentum once the H/PPD Forum is established.

The public health sector in Tanzania earns a low PPD Diamond score (see box 2.3). Although the government supports the PPP Strategy and Guidelines for health, and has established a Health PPP Unit, MOHSW senior leadership and regional management still lack sufficient understanding of health PPP concepts, and, as such are reluctant to move forward with an implementation plan. The sentiment of the Ministry responsible for the provincial governments is not known.

Box 2.3 Tanzania H/PPD Scores
• Policy Framework: 4.0
• PPP Champions: 3.5
• Private Sector: 3.5
• Public Sector: 3.0

Figure 2.5 H/PPD Diamond for Tanzania

PPP Champions 5

- Opportunities for health sector leaders to engage each other
- An honest broker to facilitate an H/PPD process
- Donors interest in supporting the private health sector

- High-level government commitment to H/PPPs
- High-level MOHSW commitment to H/PPPs
- Public sector capacity to engage in a H/PPD
- Government experience in working with the private health sector

Private Sector 5

5 Public Sector

- Private health sector leaders committed to working with the public sector
- Private health sector organized
- Private health sector has capacity to interact with the public health sector

- Policies and regulatory framework for H/PPPs
- Existing forums or mechanisms to build on for a H/PPD process
- Political will supporting dialogue

5 Policy

Section Three – Four developing county examples of PPDs in the health sector

PPDs in middle- and high-income countries have produced policy reforms and program successes. The challenge now is to determine if a PPD approach can be applied to a health sector in a low-income country. The following section describes examples of nascent H/PPD experience in four developing countries - Guatemala, Kenya, and India. Although organized for different purposes, all four country examples demonstrate that an H/PPD process, based on good practices, can yield some "quick wins" and long-term successes.

3.1   Guatemala: COSSEPP makes a difference in HIV/AIDS

The rationale for an H/PPD

Guatemala has a mixed health system. 5n 2005, approximately 50% of all health care was delivered by the public sector in partnership with several large international and domestic non-government organizations (NGOs), 15% by the social security institution and the remaining 35% by for-profit private healthcare providers.

Private sector providers range from high-end tertiary hospitals, individual practices, pharmacists and traditional providers. According to the Ministry of Statistics, there are approximately 5,200 physicians in private clinics, over 500 private clinical laboratories (Alvaro, 2011) and 292 hospitals. Most private sector hospitals and clinics are concentrated in urban areas while NGOs are in peri-urban and rural areas.

According to the 2003-2007 National Health Accounts, households (69%), government (185), the business sector (11%) and international aid (2%) fund healthcare in Guatemala (Ajay, 2009: 4). Private health care spending as a percent of total health care spending increased from 52% in 1999 to 69% in 2007 and continues to rise. Although the use

of private sector providers involves out-of-pocket payments, many households do so no matter their level of income. The first remedy for most Guatemalans when confronted with illness is to visit a pharmacy or private clinic (Ajay 2009: 3). Out-of-pocket funds are mostly spent on drugs (72.7%), tests, and doctor's visits (Ajay 2009: 5).

In 2000, Guatemala established mandatory norms and regulations regarding the provision of HIV/AIDS testing, care and treatment. The new Law requires *any and all* healthcare providers – including the private health sector – to provide counseling and HIV testing at their facilities. Multiple studies supported by international donors revealed that many HIV/AIDS patients – particularly the most-at-risk population groups - used the private sector (both NGO and private-for-profit) for counseling and testing (CT) services.

A United States Agency for International Development (USAID) funded project conducted a study on the provision of HIV/AIDs CT services in the private norms (Alvaro, 2010). Moreover, very few private providers knew or possessed a copy of the HIV/AIDS norms and guidelines, and most felt that the National HIV/AIDS law did not apply to them. Even though all of the private health providers interviewed received patients requesting HIV/AIDS services, they felt isolated from the government's national HIV/AIDS strategy, had not been included in any policy dialogue on how to address the HIV/AIDS crisis in Guatemala, and were excluded from donor-sponsored training and medical updates on HIV/AIDS (Alvaro, 2010). In short, there was little to no interaction and cooperation between the public and private health providers to implement the national strategy on HIV/AIDS.

The H/PPD approach

With assistance from USAID, several professional associations representing private, public and NGO healthcare professionals came together in July, 2007, to establish a multi-stakeholder dialogue mechanism called COSSEPP-VIH (Comisión de Sectores de Salud Público y Privado contra el VIH). COSSEPP's objective was to recognize and support the private sector's role in the national response to HIV/AIDS.

COSSEP founding members

Early on in the process, the founding members of COSSEPP met to establish the rules of engagement and elected its leadership. At this time, they also decided to formalize its mandate and worked together for a year to register COSSEPP as a not-for-profit entity. The articles of incorporation embodied COSSEPP partners'
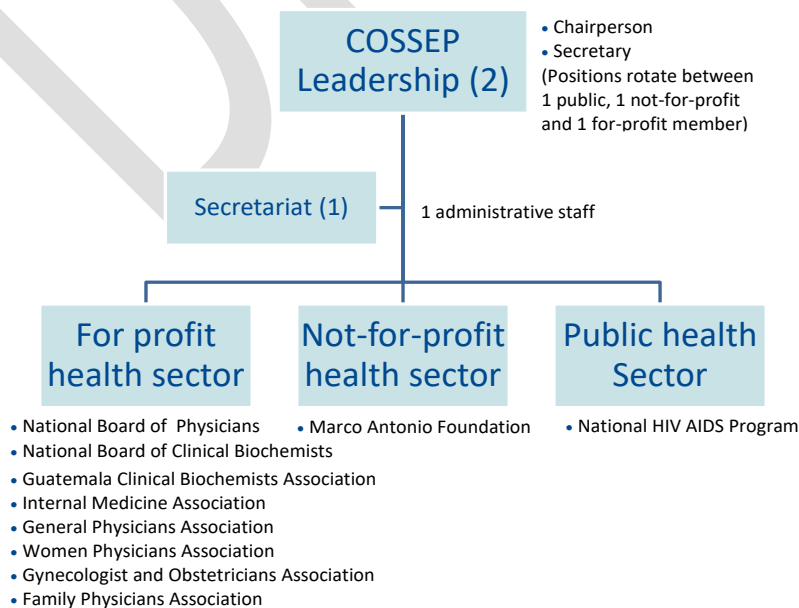
agreement on how the public and private health sectors would work together, including balanced representation, shared leadership and negotiated consensus to make decisions (See Figure 3.3).

As a group, COSSEP identity is closely linked to its HIV/AIDS focus (See Figure 3.4). Together, they defined a work agenda related to HIV/AIDS and agreed to tackle issues such as: (i) participating and shaping policies pertaining to the private health sector's role in HIV/AIDS, (ii) promoting and institutionalizing training of private sector providers to improve quality of CT, (iii) developing a case reporting system for the private sector that meets national norms, and (iv) establishing a reference and counter-reference system between the public and private sectors on HIV/AIDS.

Figure 3.4 COSSEPP'S Logo

Initially, the core group of private partner organizations focused on sensitizing the private sector on the importance of building professional capacity on HIV/AIDS within partner organizations' leadership and members (Alvaro, 2011). The same core group of private sector champions leveraged a Medical Association's 50th Anniversary Conference

COSSEP Leadership (2)
- Chairperson
- Secretary
(Positions rotate between 1 public, 1 not-for-profit and 1 for-profit member)

Secretariat (1) — 1 administrative staff

For profit health sector
- National Board of Physicians
- National Board of Clinical Biochemists
- Guatemala Clinical Biochemists Association
- Internal Medicine Association
- General Physicians Association
- Women Physicians Association
- Gynecologist and Obstetricians Association
- Family Physicians Association

Not-for-profit health sector
- Marco Antonio Foundation

Public health Sector
- National HIV AIDS Program

in 2007 to put HIV/AIDS on the healthcare agenda. At this event, the core group officially launched COSSEP, sponsored a plenary session on international experiences on private sector provision of HIV/AIDS services and conducted training on CT. In the same year, the founding public and private members held a press conference in which COSSEP founding members signed a MOU in public, agreeing to work together on HIV/AIDS.

All COSSEP-VIH members signed a MOU at a press conference

Once established, COSSEP formed strategic alliances with its partner organizations as well as teaching institutions to become a vehicle to reach private providers with HIV information and to carry out trainings. Through the professional associations, one of the first activities was to deliver copies of the National HIV/AIDS Strategy, law, and guidelines to all private providers in Guatemala. With support from USAID, COSSEP members travelled frequently outside of Guatemala City to attend the professional association regional meetings to deliver talks on the status of HIV/AIDS in Guatemala, and how private providers can play an important role. Increasingly, members from the different professional associations requested training. In one year, with USAID support, COSSEP trained and certified over 1,000 private doctors, nurses and bio-chemists in CT and other related HIV/AID services, reaching approximately 18% of private providers.

Over time, the USAID project successfully transferred all the training capacity in HIV/AIDS to key professional associations and teaching institutions. Moreover, COSSEP worked with DRACES, the government body responsible for continuing medical education (CME), and to confer CME hours for the HIV/AIDS training.

COSSEP, with further assistance from USAID, also forged partnerships with pharmaceutical companies as an innovative way of accessing private providers (Alvaro, 2010). Biocross, a local pharmaceutical company, leveraged the company's sales force to access 2,100 private providers with HIV information and to personally contact them regarding HIV training offered by COSSEP. Unitrade, a local biohazard product and handling company, provided private providers with training on biosafety related to HIV. Both companies also shared the cost for training events for private providers

Risks in an H/PPD
Despite the successes achieved by the private members of COSSEP, the public health sector was a reluctant partner. Although COSSEP originally started as a public-private initiative, the public sector stopped participating. The National HIV/AIDS program (CONASIDA) was not interested in working with the private health sector because they were well funded by several international donors and believed they could address the epidemic without the private health sector. The private sector champions in COSSEP, however, never gave up on the public health sector. COSSEP consistently included CONASIDA in all its activities – conferences, workshops, press releases, national and regional meetings, and working meetings to discuss specific issues. Sometimes a CONASIDA representative would attend, most often they did not.

Results from the H/PPD
Over time, CONASIDA turned around and embraced COSSEP's role in the national response to HIV/AIDS. As the private health sector became increasingly better organized, COSSEP had acquired clout with the MOH. Over time, CONASIDA increasingly invited COSSEP to attend meetings and make policy recommendations. CONASIDA asked COSSEP to review revisions to HIV/AIDS legislation, including the draft language regarding the private sector role in HIV/AIDS services. Also, the MOH became motivated to collaborate with COSSEP on areas of

concern to CONASIDA, such as private health sector reporting of new HIV/AIDS cases and referrals. COSSEP worked with CONASIDA to develop a "user-friendly" template for the private health sector report to the MOH and create a directory of the public and private sector to facilitate referrals. Additionally, COSSEP worked with the medical councils to include HIV counseling as a requirement for a laboratory to become licensed.

The main factor, however, contributing to the MOH's change was the Global Fund's invitation to COSSEP to participate as the private health sector representative on the Country Coordinating Mechanism (CCM). As a result, the MOH/CONASIDA acknowledged COSSEP's contribution to the HIV/AIDS epidemic and integrated them into the national response to HIV/AIDS. COSSEP continues its outreach and training of private health providers on HIV/AIDS but the Global Fund CCM has become the vehicle for dialogue and cooperation between the public and private health sector on all issues related to HIV/AIDS.

3.2   Kenya: PPP-Health Kenya as a change agent in policy

The rationale for an H/PPD
During the 2000's, public-private collaboration in Kenya was stymied by mistrust and a lack of understanding of each other. Unclear roles and responsibilities between the public and private sector lead to the duplication of efforts and competition for scarce health resources. These differences culminated in 2004, when the government of Kenya proposed legislation to establish social health insurance. The private sector organized in opposition to this initiative and successfully succeeded in blocking the legislation, creating a great rift between the public and private health sectors.

In 2009, USAID sponsored a health sector project and the International Finance Corporation (IFC) conducted a private health sector assessment (PSA) to determine the current and potential roles of the private health sector, and to provide

recommendations for strengthening and expanding it. The PSA revealed that the private health sector had grown dramatically over the last two decades, owning and managing a majority of the health infrastructure and employing the largest share of healthcare professionals in Kenya (see Box 3.1). In 2009, the total value of the private health care market was estimated to be around 20.7 billion Kenyan Shillings – one of the largest health markets in Sub-Saharan Africa. The rapid growth was due to a variety of factors, including the introduction of user fees and declines in the quality of services provided in public facilities, and relaxed licensing requirements for private providers. The private health sector in Kenya is diverse, ranging from informal, untrained providers to state-of-the-art specialists and hospitals (Barnes et al: 2009, iv).

Box 3.1 Quick facts on the Kenyan private health sector

- The private commercial sector operated 43 percent and the nonprofit sector (NGOs and FBOs) operated 15 percent of hospitals in the country, compared with 41 percent operated by the public sector.

- In 2007, 74 percent of all physicians and 75 percent of nurses were employed by the private health sector.

- In 2005, 39 percent of total health expenditures came from non-public sources, including out-of-pocket payments.

- Of the 20.7 billion Kenyan Shillings spent in the private health sector, 65 percent was spent at hospitals (47 percent at for-profit and 18 percent at nonprofit hospitals); 25 percent was spent at clinics, health centers, and dispensaries; 9 percent was spent at pharmacies; and 2 percent was spent for services provided by community health workers.

The H/PPD approach
In 2008, a team of PPP champions from the two Ministries of Health (MOH) and the private health sector began to raise awareness of the benefits of health PPPs and eventually overcome the MOH's longstanding resistance to working with the private health sector. With assistance from USAID, public and private leaders in the health sector helped form an inter-sectoral working group – the Public-Private Partnership Working Group (PPP Working Group) - to facilitate greater country ownership of the IFC PSA findings. In April 2009, the PPP Working Group organized a workshop in Naivasha to discuss the

PSA's findings and reach consensus on priority recommendations.

This workshop marked the first time both the private and public health sectors came together to discuss sector-wide issues. At this workshop the participants agreed on a common vision for public-private engagement and mandated the PPP Working Group continue leading a consultative process.

Subsequent to the Naivaisha workshop, the PPP Working Group held a series of consultative meetings, laying the foundation for a formal H/PPD process (See Figure 3.1). The first meeting mapped out a reform agenda to foster better public-private coordination and cooperation (See Box 3.2). In the second meeting, the public and private health sector stakeholder groups identified areas of agreement and contention in the priority reform areas listed in Box 3.2, and formed subcommittees to address them.

<div style="background:#cfe7e8;padding:10px;">
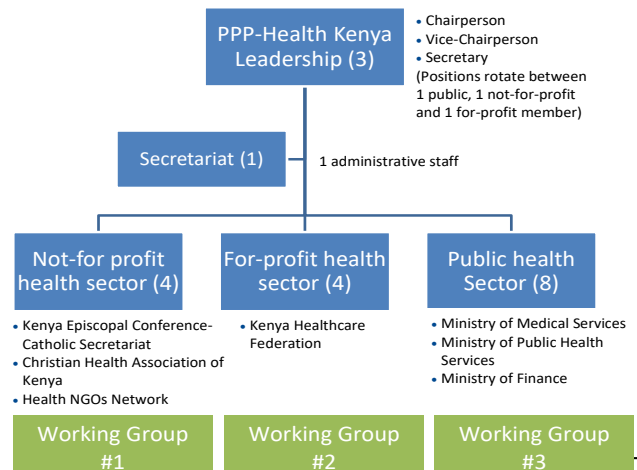
Box 3.2 PPP Reform Agenda

- Institutionalize the PPD forum into a formal entity to participate in all health policy and planning processes.
- Review the Kenya Health Policy Framework to integrate a PPP perspective.
- Update, harmonize and consolidate health acts, reforming health care professionals, facilities, and medical training licensing.
- Integrate private providers into National Hospital Insurance Fund pilot on financing outpatient services.

</div>

In a third meeting, the PPP Working Group formalized the H/PPD mechanism, naming it Public Private Partnership-Health Kenya (PPP-HK). At this meeting, an equal number of public and private sector representatives worked together through a transparent and participatory process to develop the purpose, vision, and mission for the PPD mechanism. The eighteen participants also agreed on its composition (See Figure 3.2), structure, guiding principles for its operation as well as leadership for the first two years. PPP-HK's identity is strongly linked to its mission to promote partnerships in health (See Figure 3.3). Important features of PPP-Health Kenya's design are shared

leadership and balanced representation between the sectors.

Subsequent to its formation, PPD members have worked together to foster a common vision of national health priorities among different stakeholder groups, influence and contribute to policies promoting the private health sector, identify and promote health PPPs, and strengthen communication and coordination among all health stakeholders. Since its creation, PPP-HK has convened the private sector to attend a myriad of MOH-sponsored policy discussions, including regular debriefings with the MOH ministers and the permanent secretary, consultative meetings to provide input on the Kenya Health Policy Framework and the Medical Act, working meetings to discuss the new Constitution's impact on the health sector. The increasing number of public-private meetings has established a new norm for private health sector representation in MOH policy and planning processes. With technical assistance from USAID, PPP-Health Kenya has become more adept at representing public-private health issues. PPP-HK developed a position paper on the new Constitution's impact on the health sector and successfully lobbied to secure a private sector position on the Interagency Coordinating Committee – a key forum coordinating MOH and development partners' activities in the health sector. It also continues to actively participate in the MOH-led health financing review to explore health PPP opportunities.

Figure 3.2 PPP-Health Kenya Organization Chart An

USAID-sponsored project served as an impartial facilitator for the H/PPD process. As one private sector stakeholder observed, the USAID-sponsored project "didn't have a dog in the fight," so the project became a trusted neutral third party (O'Hanlon, 2013: 12). Project staff guided processes, helped create the PPP-HK structure, and provided resources for the PPD engagement and communication activities. The USAID-sponsored project also provided training and helped build H/PPD members and their organizations' capacity in various partnership skill areas. Finally, USAID and the IFC supported key policymakers to participate in international and regional conferences and study tours, so they could gain additional perspectives on health PPPs. Most importantly, however, the project staff listened and provided feedback to the H/PPD members, gathered and analyzed data to inform the dialogue, and provided international experiences or lessons learned.

Figure 3.3 PPP-Health Kenya logo

Risks in an H/PPD

Despite PPP-HK's achievements, the H/PPD process encountered resistance from both public and private health sector leaders. On the government side, a few key senior MOH leaders opposed the idea of greater collaboration with the private health sector. The Minister who led the 2009 Navaisha workshop was relocated to another ministry and his replacement was less open to working with the private health sector. The lack of political support hampered PPP-HK public sector champions' ability to build a broad base of support for health PPPs within both health ministries.

Eventually, the evolving policy environment helped create outside pressure for private health sector engagement. In 2010-11, the Ministry of Finance proposed a PPP Law to Cabinet and it's recently formed PPP Node persuaded the MOH to create its own PPP Node for health in 2011. On the private

health sector side, the division and competition between the private health sector groups persisted for two years during the H/PPD formation phase. Initially, a couple of private health sector associations resisted joining an umbrella association representing all private health sector activities. With skilled facilitation and negotiation between the private health sector groups, the splinter private health sector groups joined the umbrella association to form a united private health sector voice.

3.3 Results from the H/PPD

Today, Kenyan public and private health sector leaders have changed their mindset and developed a completely new way of doing business together. Public-private relations and interactions have improved, opening up new opportunities for collaboration in the health sector that did not exist as recently as four years ago. One private health sector stakeholder characterized the current environment as follows, "Kenyan leaders in both sectors now recognize that health PPPs present a win-win situation because they harness private organizations and their expertise to achieve public good in health" (O'Hanlon, 2013: 18). A public health sector representative stated that "Kenyans have formed a good atmosphere and good working relationships" for advancing health PPPs" (O'Hanlon, 2013: 15).

3.4 India: Mixed policy success of the public-private approach to TB

The rationale for an H/PPD

In the mid-90s, many National Tuberculosis Programs (NTPs) adopted the DOTS (Directly Observed Treatment, Short-course) strategy with great success (WHO, 2000: 17). While case detection has been increasing steadily, DOTS and non-DOTS programs taken together identified only 40% of new TB cases. Anecdotal evidence and the few surveys indicated that a substantial proportion of the cases sought care in the private health sector and that many of the notified cases came to the public sector after seeking care from one or more private providers.

In an effort to better understand the extent and nature of private care in TB, the World Health Organization (WHO) initiated a global situation assessment. Based on the 2000 assessment, WHO issued a ground-breaking study (WHO, 2000) that concluded the private health sector should be viewed as a valuable resource and an opportunity to increase and speed up case findings, improve treatment outcomes, share the service delivery load on frontline health staff and build a degree of long-term sustainability in the TB control efforts. The same report recommended strategies for National TB Programs to engage the private sector. India was one of the first countries to take up WHO's recommendation to work with the private health.

India is one of the world's largest health markets with over 1.2 billion inhabitants. The middle- and upper-classes, which generally live in urban areas, have access to quality medical care. The richest 10 percent of Indians purchase 35 percent of medicines, 42 percent for doctor's/surgeon's fees, and 53 percent of diagnostics and 62 percent hospital/nursing home fees. However, the majority of India lives below the poverty line in rural areas and have extremely limited access to medical care. Most rely on homeopathic or cultural remedies. Yet they still purchase considerable drugs and services in the private sector. The bottom 50 percent of the Indian population account for 21 percent for medicine, 17 percent for doctor's/ surgeon's fees, 11 percent for medical diagnostics and 11 percent for hospital/nursing home fees.

The demand for better quality and more efficient healthcare from India's growing middle class is prompting private hospitals and healthcare providers to invest in healthcare infrastructure and services. In 2010, the private sector spent two-thirds of the

A private provider treating a TB patient

$69 billion expended on healthcare in India. Growth in the private provision of health will continue to be the driver of the Indian health market. Private hospital chains like Max Healthcare

and Apollo Hospitals added the most new beds in the past several years. Healthcare expenditures will double to $129.8 billion by 2015, of which 70 percent will be fueled by private sector expenditures

Seizing the opportunity presented by the WHO's recommendations to work with the private health sector, the government in Delhi launched a public-private TB project. The project's objectives included: (i) involving private providers in TB control and encouraging them to refer TB suspects cases to designated private diagnostic and treatment centers, (ii) training private providers in TB diagnostic and management protocols, (iii) distributing TB drugs to private providers to dispense free of charge, and (iv) improving case detection and treatment outcomes in the private health sector.

The H/PPD approach

A committee of central public and private sector agencies led the public-private TB project in India. The Delhi Medical Association (DMA) acted on behalf of the private sector while the State TB Office (STO), the Delhi Tapedik Unmullan Society (DTUS), and the Institute of Tuberculosis and Allied Diseases (LRS) represented the government of India. Dialogue between the government and the private sector was intense, complex, and lasted for about 18 months before the public-private TB project was launched.   At this time, conflicts between private providers and the public sector were so intense that the project risked failing even before starting. The initial struggles stemmed from distrust between the private and government sector and the mutual lack of experience in inter-sectoral collaboration (Uplekar, 2004: 583). However, the government in Delhi India did not run away from the conflict and invested the time needed to resolve the situation through active dialogue.

In addition to representing the private sector perspective during the design phase of the public-private TB project, the DMA assumed an operational role. The DMA sensitized its members on the importance to TB detection and treatment.

They also recruited, trained and accredited private healthcare providers as well as assured the quality of data collection. DMA also distributed donated drugs to qualified private providers. The DMA worked with government counterparts - STO and the DTUS - to jointly supervise private healthcare providers to ensure compliance with the Revised National Tuberculosis Control Program (RNTCP) guidelines in the project.

The committee structured a partnership model attractive to private providers. Although the government did not pay private providers to participate in the public-private TB project, private healthcare providers received free drugs - contingent on adopting DOTS principles – which helped reduce the cost of services to low-income patients. Some participating private providers reported that the opportunity to provide subsidized services was a business opportunity since it improved their reputation in the community, and thereby increased the volume of potential patients. Private healthcare providers also reported access to diagnostic facilities, educational activities and supervision as important incentives for participation.

A private provider treating a TB patient

Public-private dialogue was advanced by two key factors: (i) a committed government sector, and (ii) a strong professional association (Uplekar, 2004: 584). The Delhi government took the first step and approached the private sector with the project proposal. Throughout the project design, high-level government officials actively participated and met frequently with DMA representatives. In addition, the government committed funding to the project as well as incentives to attract private sector providers. The government was highly motivated

for the collaboration to succeed. They regarded the public-private TB project as an opportunity to manage private providers and align their practices to public health programs. The DMA, on the other hand, was an influential organization representing private allopathic practitioners' interests. The government had to seriously consider their input and suggestions in developing the three TB delivery models.   The fact that the DMA was a strong professional association helped to facilitate the public-private interaction.

A WHO Bulletin in 2004 revealed the Delhi project was successful in contributing to its central objectives of TB control. The Bulletin indicated case detection increased considerably after private providers became actively and formally involved in TB control. Overall treatment outcome was satisfactory. The cure rate for new sputum-positive cases was 74% and treatment success was 81%. And the private sector success rate was comparable to the rate in a government clinic (86%). Almost all patients (92%) expressed a high degree of satisfaction with TB treatment by their private providers.

Based on the successful experience with the private sector in Delhi, RNTCP scaled up the public-private TB project. In 2002-2003, RNTCP rolled out the project in all RNTCP states and intensified it in urban sites.   Global Funds supported further expansion starting in 2005. By 2009, RNTCP supported of over 2,500 NGOs, 25,000 private providers, 260 Medical colleges and 150 corporate health clinics which are providing DOT services (Bhatia, 2010: 11).

Mixed results from the H/PPD approach
Despite the public-private TB project's initial success, the project stalled and public-private relations did not grow. The RNTCP recognized that private providers were losing interest in participating in the TB project. Moreover, the existing guidelines created several barriers to private providers. In January 2008, RNTCP sponsored a national consultation meeting to revise the NGO/Private Provider Guidelines as a focusing event to re-energize public-private collaboration.

The consultation was held with more than 60 participants including government program managers and professional bodies such as DMA, Indian Medical Association and Association of Physicians of India.

A 2010 Global Fund-sponsored report revealed that public-private cooperation on India's TB program has not improved. Although there is wide-spread recognition in the government of India that universal access to TB can only be achieved through large-scale engagement with the private sector, public-private dialogue is not a high priority for the government. Feelings of mistrust and concerns about quality in the private sector linger (Bhatia, 2010: 17). And the private sector felt there was limited engagement in policy and planning and that the government only seeks private sector involvement at the implementation stage. Additionally, the private sector stated there is an unclear vision and lack of information on potential engagement.

Both public and private sector groups are still willing to collaborate but there is inertia in establishing a long term sustainable partnership (Bhatia, 2010: 17). The 2010 report recommended several actions that follow many of the PPD good practices, including: (i) develop a roadmap for private sector participation, (ii) build private sector and government capacity on public-private collaboration, (iii) strengthen communication channels between the sectors; and, (iv) carry out advocacy and outreach activities to engage and mobilize the private health sector (Bhatia, 2010: 18-19).

2008 Consultative Guideline Meeting

Section Four – Lessons learned on PPDs in health

The following section describes three examples of H/PPDs in developing countries. Although a limited number, these cases share many of the characteristics and good practices of PPDs (shown below) in other development sectors. Moreover, the examples show that an H/PPD process can produce results in both policy and programs in the health sector.

4.1 Good practices in H/PPDs

Formal mandate and aligned institutions. All three countries had a formal mandate to come together to address a specific health area – HIV/AIDS or TB – or policy reforms in the health sector. In Kenya and India, both governments fully supported greater public-private collaboration which conveyed legitimacy to the H/PPD process. In the India case, the Delhi government took the initiative to organize the dialogue process. The H/PPD's credibility helped attract both public and private sector individuals and organizations to the process. Although originally designed to be an H/PPD process, the government initially agreed to the H/PPD's mandate, but later lost interest.

A clear mandate and well-defined agenda gave clarity of purpose and direction to the H/PPD. The H/PPD mandate in Kenya promoted PPPs in the health sector while in India it supported improvements in TB detection and treatment in the private sector. In Guatemala, the mandate strengthened counseling and testing in HIV/AIDS. These clear mandates identified the appropriate government and private sector stakeholders to participate in the H/PPD. It also helped focus the communication and engagement activities. Concentrating an H/PPD within one sector (health) and on a specific issue (health PPPs, HIV/AIDS, TB) helped aligned multi-stakeholder interests and fostered a common understanding of the problem. However, once an H/PPD mandate becomes unclear and focus is lost, a PPD process can stall, as did the case in India when the PPD groups no longer identified with the mandate.

Organizational structure and political/ technical capacity. Two out of the three countries - Guatemala and Kenya - established a formal PPD structure. In Guatemala, the private health sector working in HIV/AIDS was already organized into professional associations and NGO umbrella groups, facilitating the creation of COSSEP. However, establishing PPP-HK in Kenya was more challenging. The for-profit health sector was fragmented while the not-for-profit health sector was organized into long-standing and experienced umbrella organizations representing the health FBOs and NGOs. Forming PPP-HK forced private health sector leaders to realize that the for-profit health sector was divided and competitive. As a result, key segments in the commercial sector formed individual professional associations similar to those found in India and Guatemala. In the case of India, the public and private sectors decided to operate informally through a working committee.

Establishing a formal structure provided benefits to the H/PPDs. In Guatemala and Kenya, international donors provided technical assistance to COSSEP and PPP-HK to strengthen their political and technical capacity to implement an H/PPD. With a formal entity, the international donors could also donate financial resources to COSSEP and PPP-HK - both received modest funds to carry out engagement and communication activities. Also, a formal structure harnessed the energy and commitment of its members. Since the public and private stakeholders created COSSEP and PPP-HK, the member organizations in each organization felt ownership of the H/PPD's success. In both cases, COSSEP and PPP-HK members worked together to draft annual work plans, met on a regular basis (every two to three months, sometimes more often) to carry out planned activities, kept formal meeting notes to ensure consistent flow of information and frequently communicated with each other through formal and informal channels. Eventually, both COSSEP and PPP-HK acquired status and recognition in their respective health sectors because of their visible participation in the health policy arena and high-level engagement and communication activities.

Balanced representation and active cooperation. The three aforementioned cases are examples of two different scenarios of representation. The first scenario attempts to have balanced representation between the public and private health sector. In Kenya, the PPP-HK member organizations took painstaking care to ensure there was equal representation between the public and private sectors. In India, initially there was only one organization – the DMA – representing private health sector interest but as the public-private TB project expanded, other professional health associations joined. Although both H/PPDs encouraged balanced representation, the level of energy and active cooperation differed. In Kenya, both public and private sector member organizations remained active, even after four years. The high level of commitment to PPP-HK along with structured and jointly planned activities contributed to Kenya's active cooperation. But private sector interest waned in India despite strong representation from the professional associations. The main constraint was infrequent interactions, probably due to the H/PPD's informal structure and the government's unsure commitment to public-private cooperation.

In the second scenario, the H/PPD in Guatemala started out as a representative process, but soon regressed into a single-sector initiative with a very reluctant government partner. The private sector organizations were undeterred and although they would have preferred to address the gap in private sector quality in partnership with the public sector, they moved ahead without them. COSSEP strategically focused on activities they could control, such as sensitization events at association meetings and conferences, association-sponsored trainings of private providers, to achieve small victories along the way. But COSSEP members realized that in order to achieve sector-wide impact, they would have to work directly with the CONASIDA. They never gave up on including the Guatemala MOH in their activities and ultimately succeeded in gaining CONADSIDA's recognition and cooperation. Although an H/PPD may not start out will all sectors at the table, eventually both public and private sector organizations will have to sit together to achieve lasting results in the health sector.

Leadership of a core group of champions. Progress in the three country examples would not have been made without the persistent efforts of a committed team of champions. All three countries had a small core group of individuals who lead the charge. They represented both sectors (except for Guatemala), held high-level positions, and most importantly, owned and propelled the H/PPD process forward. The champions - particularly in Guatemala and Kenya - were well-positioned within their respective sectors and organizations which allowed them to play key roles in building consensus within their own constituency. The private sector champions in all three countries initially started the H/PPD process sensitizing their respective members on the benefits of partnering with the government and helping them understand their potential contribution to the specific policy / health issue. In Kenya and Guatemala, the private sector representatives held regular debriefings with their respective organizations' leaders and membership to keep them informed as well as to secure their buy-in on the decisions and direction of the H/PPD process.

The like-minded public and private sector leaders dedicated time and resources to make the H/PPD work. In India, the public sector leaders invested the time needed to address private sector concerns and to resolve conflicts as they emerged during the TB design phase. In Kenya, key private sector representatives from PPP-HK met one-on-one with MOH leadership to assuage public sector leader's concern about partnering with the private health sector. And COSSEP leaders' constant efforts to bring the public sector to the table finally produced a positive outcome.

Honest broker facilitating a neutral process. In both Guatemala and Kenya, international donors played an instrumental role by providing technical resources in the form of an honest broker and training in partnership skills. Staff from the two USAID projects played important facilitator roles in Guatemala and Kenya. In both examples, the

honest brokers sensitized public and private sectors on the benefits of an H/PPD, helped organize the formal structure, invested time upfront to clearly outline roles and responsibilities in an H/PPD, listened and provided feedback on the process, modeled good partnering behavior and helped resolve conflict throughout.

The honest brokers also provided technical assistance, teaching H/PPD members in both country examples on how to conduct policy analysis and make persuasive arguments to the government by strengthening their advocacy skills. They also helped COSSEP and PPP-Health Kenya design communication plans and carry out effective engagement activities. As one PPP-HK member stated, "PPP-HK events are always well attended by the private sector because they know the meeting will be well organized, share important information and be sure to integrate the private sector perspective in the meeting report" (O'Hanlon, 2013: 14). The new skills helped "jump start" and sustain the H/PPD process in Kenya and Guatemala.

Evidence-based dialogue and decision-making. Data played a strategic role in the all three H/PPD efforts. Assessment of the private health sector helped define a problem that served as the trigger to form an H/PPD. In the case of Kenya, the private sector assessment was a water shed event. The PSA helped dispel myths on the private health sector by using data. Bringing together the public and private sectors to discuss the data created an objective forum that moved the dialogue away from "finger pointing" to serious debate on the data's implication. In Guatemala, the assessment of private providers' clinical practices confirmed professional associations' suspicion that private providers were not complying with national norms on HIV/AIDS. The study galvanized the associations into action. The WHO study convinced government officials, for the first time, to partner with the private sector in order to address access and quality issues in TB.

Data also helped sustain and provided momentum to H/PPD processes. In Guatemala, COSSEP quickly delivered "wins" which helped attract more private

sector groups/champions to join the H/PPD initiative. COSSEP meticulously documented all its activities and outcomes. With USAID assistance, COSSEP conducted additional research on private providers HIV/AIDS CT services. They used communication tactics effectively to share their results with not only private health providers but the population at large. COSSEP understood how to reach the private health sector and used client-oriented channels, such as annual medical conferences, quarterly professional association meetings in the regions, and detailers to reach individual private providers. They also used the national and local media to share information on their events and accomplishments. These strategies caught the MOH/CONASIDA's attention and eventually convinced the Global Fund to invite COSSEP to represent the private sector.

In Kenya, the USAID-sponsored project shared best practices and other country examples with PPP-Health Kenya to inform their activities. As PPP-HK organized the consultative meetings to reform the Kenya Health Policy Framework, the project shared examples of other country policy frameworks that had strong language defining a private sector role in health. To inform the policy paper on the Constitution's impact on the health sector, the project hired a local lawyer to conduct a legal analysis that was widely shared with both public and private sector groups. USAID and the IFC sponsored PPP-HK members to attend regional conferences and workshops to better understand how other countries created a policy framework supporting the private sector and implemented health PPPs.

4.2 Moving forward on H/PPDs

The emerging examples in developing countries show that H/PDDs share many of the same characteristics and good practices of those in other development sectors. Moreover, an H/PPD can produce "quick wins" in health policy and programs. With adequate funding and technical assistance during the initial phases, an H/PPD processes can sustain themselves to become independent. In Guatemala, COSSEP has taken on a new life under the Global Fund CCM. In Kenya, PPP-HK is well

positioned to assist the new Kenyan MOH and the nascent PPP Unit to identify PPP opportunities.

Although promising, these three examples are insufficient to state conclusively under which conditions a PPD can be implemented in the health sector in a developing country.

Before embarking on an H/PPD, international donors, developing country stakeholders in health and health practitioners will want to understand:

- *If there is a causal link* between an H/PPD process and adopted policy reforms and implementation of health PPPs. The presence of an H/PPD at the time a health policy or health plan is adopted, as is the case of Kenya, is not sufficient evidence that dialogue was responsible for the reforms. More examples are needed to be able to 'trace' where and how an H/PPD is important and causally influential each stage of the health policy process and/or health PPP design.

- *How to implement a PPD in the health sector.* There are a growing number of manuals and toolkits on how to implement different aspects of health PPPs, such as how to create a policy framework, and establish a PPP process and conduct a private sector assessment. There is nothing, however, on how to design and carryout a PPD process adapted to the health sector. Investing in analyzing the details of existing and new H/PPDs to develop tools and methodologies would be an important contribution.

- *Conditions for successful PPDs in health.* While this paper has made an effort to explore the conditions prompting H/PPDs to be formed and the factors contributing to their success/failure, more examples of H/PPDs are needed to better understand if the good practices found in PPDs in other development sectors are transferable to health, or if a new set of criteria on what works and doesn't work is needed.

References

Alvaro, Yma. *Engaging Private Commercial Sector Health Providers to Improve the Quality of their CT Services: A Model from Guatemala*.   Washington, DC: USAID/ Private Sector Partnerships-*One* Project. 2010.

Alvaro, Yma. *Raising the private Sector Voice in Policy Dialogue on HIV/AIDS in Guatemala*. Presentation at Private Sector Partnership-*One* End of Project Conference, Washington D.C., 2011.

Bately, Richard. *Engaged or Divorced? Cross-Service Findings on Government Relations with Non-State Service Providers.* Public Administration and Development: 26, 241 – 251. 2006.

Barnes, Jeff; O'Hanlon, Barbara and Gitonga, Nelson. *Kenya Private Health Sector Assessment*. USAID-SHOPS Project and the World Bank. 2009.

Bhatia, Vineet. *Enhancing Private Sector Contribution to TB care in India.* Samm Health International. Global Funds to Fight AIDS, TB and Malaria. January 2010.

Feeley, Rich; O'Hanlon, Barbara; Stene, Angela; and, Sezgin, Yuksel*. Finding Middle Ground: Making Better Use of the African Private Health Sector Through More Effective Regulations.* PSP-*One*. December 2009.

Herzberg, Benjamin. *Strategic Communications for Business Environment Reforms: A guide to Stakeholder Engagement and Reform Promotion*. The World Bank Group/ International Finance Corporation. October 2007.

Herzberg, Benjamin and Wright, Andrew.   *The Public-Private Dialogue Handbook: A Toolkit for Business Environment Reformers*. The World Bank Group/ Small and Medium Enterprise Department. December 2006.

Hozumi, Dai; Frost, Laura; Suraratdecha, Chutima and Reich, Michael**.** *The Role of the Private Sector in Health: A Landscape Analysis of Global Players' Attitudes toward the Private Sector in Health Systems and Policy Levers That Influence These Attitudes.* Technical Paper No. 2. Rockefeller Foundation. October, 2008.

Involving Private Practitioners in Tuberculosis Control: Issues, Interventions, and Emerging Policy Framework. WHO. TB Strategy and Operations Stop TB Department Communicable Diseases Cluster. 2002

Mahal, Ajay; Bowser, Diana; and, Mitchell, Andrew. *Health Financing in Guatemala: A Situation Analysis and Lessons from Four Developing Countries.* Harvard School of Public Health. June 2009.

O'Hanlon, Barbara, and Joanne Bennett Jeffers. March 2013. *Effective Partnership between the Private and Public Sectors for Health Sector Reform: The Kenyan Policy Success Story*. Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates Inc.

Palmer, Natasha. *An Awkward Threesome – Donors, Governments and Non-State Providers of Health in Low Income Countries.* Public Administration and Development: 26, 231 – 240. 2006.

Peiffer, Caryn. *Policy and Practice for Developmental Leaders, Elites and Coalitions 'Reform' Coalitions Patterns and Hypotheses from a Survey of the Literature*. Developmental Leadership Program. Concept Note #3. May 2012.

Pinaud, Nicolas. *Public-Private Dialogue in Developing Countries: Opportunities and Risks.* Organization for Economic Co-operation and Development (OECD). Development Centre Studies. August 2007.

Porter, M. and Kramer, M. *The Big Idea: Creating Shared Value; How to reinvent capitalism—and unleash a wave of innovation and growth.* Harvard Business Review. 2011

Reich, Michael R. *Public-Private Partnerships for Public Health.* Harvard Series on Population and International Health. April, 2002.

Stott, Leda. *The Partnering with Governments Navigator: Building Effective Collaboration with the Public Sector in Africa.* The Prince of Wales International Business Leaders Forum (IBLF). 2011.

Tennyson, Ross and Wilde, Luke. *The Guiding Hand: Brokering Partnerships for Sustainable Government*. The Prince of Wales International Business Leaders Forum (IBLF) and the United Nations Staff College. 2000.

Tennyson, Ross. *The Brokering Guidebook: Navigating Effective Sustainable Development Partnerships.* The Prince of Wales Business Leaders Forum (IBLF). 2005.

The Business of Health in Africa Partnering with the Private Sector to Improve People's Lives. The World Bank Group. International Finance Corporation. 2009

Uplekar, Mukund. *Public-Private Mix for DOTS Implementation: What Makes it Work?* Bulletin of the World Health Organization. August, 2004, 82 (8).

World Bank Statistics. data.**worldbank**.org/topic/**health**