Private Sector Programme -PSP

Report Jan-April 2005

The Private Sector Programme – PSP - is a collaborative research programme between the Division of International Health (IHCAR) and the International Health Systems Program (IHSP) at the Harvard School of Public Health. The programme also involves eight institutions in China, Vietnam, Laos, India, Uganda and Zambia. The programme has as objective to strengthen health systems' performance and their outcome in terms of improved health. Specifically, the programme seeks ways through which the non-government sector can be involved in providing adequate health care to the population, in particular those in most need. The programme consists of two phases. The first phase seeks to identify and map private health care providers, investigate their operations and practices and study people's health care seeking patterns. In the second phase, interventions for improving the contribution of private care providers to national and international health goals will be evaluated. The programme is currently in its first phase.

The following report provides information on programme developments in the first tertiary (January-April) in 2005. During the period five field visits were paid to collaborating institutions in China, Vietnam, Laos, Ujjain (India) and Uganda by Harvard or Karolinska staff. Progress has been made in all these places A report from each of the missions is found below.

During the period a training course on the role of the private sector in health support and health care delivery was organized in Delhi by the PSP coordinators under an arrangement with the Harvard School of Public Health. The course was attended by staff from five of the eight collaborating institutions. A brief report on the course and a course programme is included below.

During the Delhi course, talks were held between the Zambia study team and the PSP coordinator from IHCAR. Notes from these talks are found below.

During the first tertiary significant efforts were also put into the preparation of an application to Sida/Sarec for research on health systems aspects (public/private) on chronic diseases, especially diabetes type 2, in Uganda.

Overall, the PSP made excellent progress in the first tertiary. Studies are now being implemented in China, Vietnam, Laos, Ujjain (India) and Uganda. In addition, the study in Zambia is likely to start soon. The second tertiary should see further developments and in some instances (China, Uganda) data can be expected to become available from the field work. Also, a session on the role of the private sector will be organized by the PSP team at the World Conference of the International Health Economics Association (iHEA) in Barcelona in July. Thanks to separate funding from Sida all PSP collaborating institutions will be represented at the conference.

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MISSION REPORTS

Report from mission to Center for Health Management and Policy, Shandong University, Jinan, China

By Birger Carl Forsberg, Div of International Health (IHCAR), The Karolinska Institute, Stockholm, Sweden

Dates of visit: January 7-10 2005

The writer visited the Center for Health Management and Policy from January 7-10, 2005. The purpose of the visit was to learn more about the center and to discuss the collaboration between the center and IHCAR, Karolinska Institutet and International Health Systems Program at Harvard School of Public Health on the research program ”The Role of Non-governmental Health Care: A Study of its Scope and Potential with a Focus on Policies to Promote its Contribution to Improved Health.” (PSP).

The center has a faculty of 12 teachers, five of them professors. It is headed by Prof Quingyue Meng. The center runs both a masters- and a PhD-program in health policy and management with about 30 students in each group. Students come from all parts of China as the center has an excellent reputation in the country within its area of work. Admissions are done on the basis of exams and characters. Students usually have a background in medicine, public health, economics or social sciences. The teaching is usually in Chinese but some lectures are given in English. Students are required to study English as part of their master training programme.

Graduates usually get employment with government institutions within public health and administration or with universities. A few graduates also become hospital administrators. (Mostly, hospital administrators in China are doctors with a clinical career behind them.)

There are around 30 research projects at the center, most of them financed by Chinese organisations. Among international funders are WHO and most recently a Japanese foundation that will support the PSP field study.

The writer gave a presentation on the Swedish health care system to an audience of around 30 students. There was a keen interest in the subject and several questions were asked and issues discussed by the students in English during the lecture.

During a separate session with Prof Jiangbin Qu the PSP study was discussed. Also present in the meeting were Qiang Sun, a senior researcher, three masters students: Shuguang Li, Ying Tang and Xifan Zhang, and Xiao Xia Hu, a teacher and researchers who has recently joined the faculty after 13 years abroad in Australia and the USA.

In the session the planned study of the private health sector in Shandong province was reviewed and discussed. The study has received funding from a Japanese foundation. The

estimated cost of the study is USD 30 000. The study will be carried out in rural areas in Shandong province where private health facilities will be assessed. A similar study will be carried out in parallel in urban areas in Guangzhou.

The methodology employed will be:

1. Review of literature
2. Focus group discussions with health administrators at provincial, county and township level.
3. Field survey of clinics
4. interviews with patients
5. Key informant interviews

The field work will be carried out by 20 master students from the Center. They are highly motivated, understand the purpose of the study and the idea of objective study methodology. In some instances they have had previous survey experience.

The sampling is as follows. The 135 counties in Shandong will be divided into high, middle and low income counties. One county will be selected at random from each group. In each of these counties townships will be divided into high, middle and low income. One township will be selected at random from each group. In each township six villages will be selected at random. In each village all private providers will be included in the survey. Villages in which there is no such facility, will be accounted for but a substitute village will be selected until 6 villages that have clinics are included in the sample. The minimum sample size is then 3*3*6=54 clinics. For each clinic the intention is to interview 15 patients who have visited it.

The fact that the sample is small was discussed. It would not be possible, though, to cover a larger sample given the funding. The sample will provide indications of the conditions in the private sector but will not allow for general statements on the conditions of private services in Shandong province. It was suggested by the writer that efforts should be made to at least estimate the size of the private sector and the scope of services offered in the province.

After a discussion on the implications of the selection procedure it was discussed if it would be possible to easily get 15 patients in the clinic. Many of the clinics will not have that many patients in a day. Also, exit interviews were not deemed to be a good investigation method since patients may be reluctant to speak freely in the clinic. Consequently, it was discussed to make a household survey to cover at least 15 persons who had attended the clinic. The methodology to ensure randomization in this case was discussed. Surveyors will select randomly 15 household in the village. Persons will be asked if they have visited the facility within last 3 months. If so they will be interviewed. If there is no one in the household with such a history the surveyor will proceed to next household until 15 patients have been found.

Four forms or questionnaires have been developed for the study. At the moment they are only available in Chinese but they are based on the templates provided by the PSP project.

The first protocol is meant for interviews of facility managers and assessment of the facility. It contains questions on 1. ownership 2. services offered 3. management and training of staff 4. physical assets/equipment 5. income and expenditures of the clinic 6. preventive services offered 7. drugs provided – types, condition and storage 8. disease patterns with listing of 5 most common diseases 9. business operations.

A fairly long discussion took place on the form of ownerships that could be possible to find in the survey. It was agreed that a systematic description of different ownership forms should be done before the survey so that different categories of ownership can be defined. The ones identified in the discussion were: village board owned facility, cooperative where health workers own the facility together, group practice with fees paid directly to each doctor who then shares common costs with his colleagues, group practice with salaried staff that also gets a bonus from the surplus generated, invidually owned solo-practice, and a regular equity-based company where shareholders are the owners. Other forms of ownership may be found in discussion with key informants.

The following specific comments were given by the writer on the protocol.
1. It would be good if some documentation on incomes and expenditures could be presented at the facilities. Estimates of incomes and costs may be more or less precise. If no documentation can be presented (which may be the case) then information on the price of services could be collected and if possible linked to information on the number of patients using these services.Thereby the incomes can be estimated.
2. Some questions on business strengths and constraints could be considered for inclusion. Same goes for questions on attitudes to working with public sector and attitudes to rules and regulations and experience from existing rules, regulations and government supervision. Forsberg promised to provide examples of such questions from surveys carried out in Bangladesh and India.

The second questionnaire is for interviews with health workers/individual providers. Many of the questions in this questionnaire overlap with the manager interview (first questionnaire). It was discussed if it is necessary to pose these questions to every health worker/provider. It was suggested that the questionnaire should be reviewed to avoid that data which will not be used in the analysis are collected. Some questions in the questionnaire that would be interesting to keep are those on health workers' satisfaction with incomes and how they consider their working and employment conditions.

The third questionnaire is meant for private pharmacies. It contains questions on 1. the owner (background, training etc.) 2. operative and administrative mechanisms for running the facility 3. services offered (here is was suggested to classify services into, for instance: western medicine, chinese medicine, over the counter drugs and/or prescription drugs, other commodities such as cosmetics and contraceptives.) 4. drugs most

commonly sold (five best sellers) 5. incomes and expenditures 6. problems/constraints in operations and support needed/desired from the government or other external actors.

The fourth questionnaire addresses patient satisfaction and to some extent outcome of the consultation. The questionnaire consists of the following parts: 1. basic info on patient 2. access to clinic and utilization. Reasons for seeking the particular clinic. 3. Services provided 4. Assessment of services provided 5. Comparison private/public services 6. Problems in health care system, in general and specifically. Opinions on private health care and suggestions for improvement.

Given the comments summarized above the overall design of the study was deemed to be adequate and feasible. It is expected that training, data collection and data analysis will be done this spring. A first draft study report will be ready at the end of June. The final report can be expected at the end of September.

The reception of the writer was exceptional and excellent. The writer would like to thank Prof Meng, Prof Qu and other faculty for all the hospitality and friendship shown during the visit.

Report from mission to Ujjain, India

By Vinod Diwan, Div of International Health (IHCAR), The Karolinska Institute, Stockholm, Sweden

Dates of visit: 26 – 27 February 2005.

Under the PSP project, the R. D. Gardi Medical College has planned and executed the following studies;

- Mapping of the private and public sector provider in Ujjain district and Ujjain city. A scientific report is published in Health Policy (Deshpandey et al).
- Survey of treatment for ARI and diarrhea. The study is completed and data entered in the computer, ready for analysis.

Progress: All studies has now been completed. Data has been entered in computer. Dr Ayesha De Costa will visit Sweden from 21st March for three months to analyse data and write scientific reports for publication.

Report from mission to Hanoi, Vietnam

By Vinod Diwan, Div of International Health (IHCAR), The Karolinska Institute, Stockholm, Sweden

Dates of visit: March 1-5 2005.

Under the PSP project, the following studies are planned;

- Review of current policies and regulations related to non – governmental health providers and analyse the status of private sector providers through review of secondary data.
- Mapping of health care providers in two districts; one rural and the other urban district and describe the facilities with regards to geographic location, space, equipments.
- Describe the case mix of private sector providers and the quality of care for identified tracer conditions (ARI, Diarrhea, high blood pressure).
- Perceptions of private and public providers, local level policy makers and state policy makers with regard to – reasons to enter the market, operational model, price factor, current legislation regarding private sector and needed changes in it, common administrative and managerial problems etc.
- Focused interview with the policy makers at the local i.e. commune, district and province as well as central level regarding future of private health care sector in Vietnam.

The research is funded by Sida- The Swedish International Development Cooperation Agency.

Progress: Under the visit the project objectives and methodology was discussed and finalized. A final protocol will be prepared in coming weeks and the implementation of the study will start in May 2005. Next visit planned for May alternative November 2005.

Report from mission to Vientiane, Laos

By Rolf Wahlström, Div of International Health (IHCAR), The Karolinska Institute, Stockholm, Sweden

Dates of visit: march 28-31 2005

The purpose of the visit was to meet the members of the Lao team in order to update and further develop the project plans for substudies within Phase I B.

Meetings with Professor Sommone Phounsavith (Director, DCM) and the PSP team: Associate Professor Chanphomma Vongsampanh (Deputy Director, DCM, team leader), Dr. Phisith Phoutsavath (DCM), Dr. Bouakhanh Pakhounthong (DCM), Dr. Sivong Sengaloundeth (FDD), Dr. Lamphone Syhakhang, Dr. Kotsaythoune Phimmasone (DBP), Dr. Soulinphone Soudaschanh (HRD), Dr. Chandavone Phoxay (Cabinet), Dr. Hongthong Sivilay (team administrator, DCM).

The work in the team has been seriously hampered by the death of the most active team member, Dr Bouathong Sisounthone, in December 2004. Furthermore, one other team member, Dr. Sifeuang Pasomsouk, died in August 2004. Therefore two new members have joined the team. In particular, Dr Phisith has been appointed as the operational team leader (replacing Dr. Bouathong). There are four women and five men in the team.

The team members come from different departments within Ministry of Health, notably the Department of Curative Medicine (DCM), the Food and Drug Department (FDD), the Department of Budgeting and Planning (DBP), the Human Resource Department (HRD) and the Cabinet.

The project plans for Phase I B were discussed. The background description reviewing policy documents and regulations (Substudy 1) as well as the presentation of characteristics of Non-governmental health services (Substudy 2) are in preparation under the main responsibility of Dr. Kotsaythoune.

Substudy 3 comprises a facility survey of private clinics and was prepared by Dr. Bouathong, but the responsibility is now under Dr. Phisith. The aims of the substudy are to study quality of services and to determine factors influencing performance of private clinics. Structured interviews with health providers, exit interviews with clients and observations of the clinics will be used for the exploration. There are three types of clinics, base on the level of available equipment and staffing: 1) More advanced clinics with modern equipment (X-ray, ultrasound, good laboratory) and often with emergency beds. It is open 24 hours a day and has full-time staff; 2) Clinics with full-time or part-time staff and with a basic laboratory; 3) Part-time personnel with extremely basic equipment (stethoscope, sphygmanometer) and no lab.

Substudy 4 aims at exploring the views and perceptions of health care providers regarding their quality of services and how they can contribute to improvement of health care services and the health of the population. Focus group discussions and some interviews will be conducted. Dr. Lamphone has the main responsibility for this substudy.

There is until now no available funding for substudy 3 and 4. It was suggested that substudy 4 could be merged with substudy 3 in order to become more comprehensive and attractive to potential donors.

A schedule for coming meetings was decided.

Two members (Dr. Kotsaythoune and Dr Hongthong) will participate in the PSP course in Delhi during April 4-9.

Report from mission to Kampala, Uganda

By Dave Washburn, International Health Systems Program, Department of Population and International Health, Harvard School of Public Health, Boston, Massachusetts, USA

Dates of mission: February 20-28, 2005

Project and Team Information

From January 20-28th of 2005, the author of this report visited three sites in Uganda: the capital city, Kampala, and the districts of Mpigi and Iganga. The purpose of the visit was to consult and assist with the initial stages of the PSP survey taking place in the field. The project is a collaborative effort between the Makarere University Institute of Public Health, the Division of International Health at the Karolinska Institutet, International Health Systems Program at the Harvard School of Public Health, supported by the Swedish International Cooperation and Development Agency. The survey is the Phase 1B of the overall project. Initial design of the survey was presented and discussed at the May of 2004 workshop at the Karolinska Institutet entitled: "Working with the private sector to improve health – from theory to evidence and implementation". In June 2004, Professor Yuanli Liu, one of the coordinators of the PSP, Paid a visit to the Uganda PSP Team and helped revise the survey instruments, in part based on the field visit/pilot-testing of the instruments. Before his trip to Uganda, Dave Washburn conducted extensive literature review on the role of private sector in developing countries and shared the results with the Uganda team. He and Dr. Liu also assessed major methodological and practical issues faced by the Uganda team and discussed approaches that Harvard Technical Assistance Team should take to work with the Uganda Team in a more efficient way.

Currently the team in Uganda is implementing a lengthy survey in three non-urban districts in Uganda, including the Mpigi and Iganga districts visited in January. The Kampala team overseeing the process is headed by Professor Joseph Konde-Lule of Makerere University and includes Dr. Virgil Onama and Dr. Sheeba Gitta also from Makarere University, Charles Matsiko from the Ministry of Health and Dr. Sam Okuonzi from the Ministry of Gender. The three district teams are each staffed by four Uganda university graduates with previous experience in survey methods and fluency in appropriate district dialects.

Survey Tools

The several part survey includes a household survey, a health service provider survey, a shopkeeper survey, a policy maker and key informant survey, a GPS mapping tool, and focus group discussions at the village level. With the exception of the policy maker and key informant survey that had not yet been implemented, the author was able to observe examples of each of the other survey instruments in use.

The household survey, designed to be completed in 12 randomly selected houses per village, captures general household information as well as individual information for each household member including age, sex, educational level, marital status and occupation. The tool focuses upon health problems experienced by each household member, health seeking behavior for the various health problems experiences as well as preventative care, why different health providers are chosen, perception of quality of the various providers and payment for services.

The provider survey tool codes facilities by sector, public, private not for profit, private for profit, informal, traditional healer and complementary as well as subcategories of these sectors. Background information for the providers and facilities is captured as well

as the services and referral services provided. For higher level clinics, a series of 4 cases for quality testing in addition to questions about Tuberculosis are presented. An additional health facility survey tool targets shopkeepers who sell drugs and condoms. This tool aims at gauging the quality of prescription services offered at these locations as well as determining what kinds of drugs are available. The GPS mapping tool is then used to geographically locate each of the providers of care.

The open focus groups discussions have been designed to gather in-depth qualitative information from community members on why they choose different health providers for different ailments. These sessions also allow for community members to comment on their most significant health problems and challenges.

The policy and key informant survey tool is tailored to gather information on levels of understanding of and opinions on the government's policies that affect the private sector.

Field Notes

Upon arrival in Uganda, meetings were held with Prof. Joseph Konde Lule and Dr. Virgil Onama and the general structure of the Ugandan health system was discussed. In addition, the most recent survey tools were analyzed, discussed and minor changes were made as appropriate. Sampling methods had already been determined, though some minor changes were made. The first field visit to the Mpigi district showed in-depth examples of traditional healer and NGO providers in rural areas. Extensive interviewing revealed important insights into health seeking behavior in both provider settings as well as apparent barriers to collaboration between different types of health care providers.

The writer then traveled with the project coordinator, Dr. Sheeba Gitta, to the Iganga site where he worked with the survey team for a period of five days. During this time, several communities were visited and each of the relevant survey tools and methods were implemented and observed. The surveyors work from early in the morning until evening and travel as a group, by car, to the various communities. Each surveyor works individually with one team member usually in charge of transporting the others between interviews.

Upon entrance into the communities, the survey team leader first contacts local village leaders who have a significant amount of influence at the village level. A future visit is then planned with these leaders in order to implement the household surveys and gain the assistance of the local authorities in locating households. Also on the first visit, local providers and drug shops are located, visited and interviewed. The households surveys are generally completed the following morning or afternoon, while during the other half of the day another community is approached.

The writer was able to work individually with each of the four surveyors in the Iganga district during different types of interviews over a five-day period. The surveyors were each necessarily fluent in the local dialect and adept at gaining the confidence of interviewees. Upon returning to Kampala, the writer met once again with Prof. Konde Lule, Dr. Sheba Gitta, Charles Matsiko and Dr. Sam Okuonzi for a debriefing session.

The writer noted that the qualitative impressions of the surveyors were very insightful and it was recommended to the lead team in Kampala that following the completion of the field work, a seminar be held at Makerere University where each of the three survey teams could share their impressions from the field. This seminar was planned for a future date.

Initial Observations and Discussion

A very large number of people visit traditional healers, though people do not report that they go as often as they do because of stigma. Many people feel more comfortable visiting traditional healers outside of their own village for the following reasons:

1. Privacy problems when your neighbor (the traditional healer) knows your health issues.
2. It is easier to trust a stranger for some of the issues that people approach traditional healers with.
3. There are financial reasons since traditional healers can and allegedly often do price discriminate. As your neighbor may have a good idea of what resources you have access to, they may have a better sense of the maximum they can get from you. Note that these impressions run imply a somewhat low level of social capital.
4. With their knowledge of the spiritual world and the respect that they command, traditional healers can use fear or intimidation to extort from those that live near them.

Some traditional healers reported as many as 50 patients per day, whereas some local clinics see only 20-30 patients per day. It is important to gain a better sense of the actual volume for both informal and formal providers. Those that visit traditional healers during the day seem to come from further away and may have more money for transportation or even own their own cars. Sometimes, people from neighboring villages will visit traditional healers in the evenings when they are less likely to be seen.

There was some claim that mostly older women visit traditional healers. Though this has not yet been verified, there may be implications for what types of things traditional healers do that could be improved upon. (i.e. issues that face mostly older women who may be less mobile)

Traditional healers are oftentimes the most locally available resource for health. They serve as points of referral and they also provide services. From focus group discussions, villagers claim to know what sort of illnesses require traditional healing versus western medicine. However, some patients visit traditional healers for ailments like malaria that require western medical techniques and curatives. For these cases traditional healers oftentimes refer patients to local clinics where medicines may be available. At the clinics, some personnel believe that traditional healers do not refer quickly enough and patients may suffer as a result. However, traditional healers respond that they also assist patients in reaching local health clinics and will even go with them to the clinic.

Transportation has been an issue for other reasons as well. Ambulances are lacking in the rural communities and many people cannot afford to pay for the expensive gasoline costs they are charged for when the ambulances come. A traditional healer who represented the healers in one sub-county suggested that they could help to serve as an ambulance service if provided with transportation. There was desire expressed to use this transportation for other reasons as well. With increased deforestation, herbalist healers are oftentimes required to go further and further to find the extracts from plants and trees that they require. Storing these extracts can also pose a problem. On side note, some traditional medicines (i.e. from the Moringa tree) are allegedly effective in increasing white blood cell counts.

At present, many traditional healers are loosely organized and required to pay a fee to be associated at the district level of 25,000 Schillings. They are sometimes charged an additional 10,000 Schillings perhaps illegally for trading fees which health providers are not supposed to pay. These fees are collected by local government leaders and do not provide anything to traditional healers in return. Furthermore, these fees prevent other traditional healers from registering, perhaps increasing the number of "quacks" that operate. When local traditional healer organizations try to involve newcomers into their association to evaluate them, they are oftentimes prevented from doing so by local authorities. As such, regulation and organization of the healers is very tenuous. Furthermore, in some districts there is evidence of corruption within the traditional healer associations. Some leaders have allegedly begun to charge other healers per patient they see. In response, healers have become less apt to register or keep records of patients, a practice that was not uncommon beforehand.

Traditional healers themselves do not seem to be overly opposed to working with public or private clinics in the more formal medical sector. One representative expressed interest in official referral slips, help in protecting medicinal trees and a traditional healing center at the main public hospital in Kampala. (Mulago Hospital) Local clinics, on the other hand, have been working very closely with traditional birth attendants, providing training seminars and establishing a high level of standards.

There is great potential for a similar type of arrangement to be set up with traditional healers. The association fees that they already pay could be used to help coordinate this training and standardization of referral processes. Though clinics are supposed to be geographically accessible by all Ugandans, a high number continue to use traditional healers and other providers in the private sector. It is thus practical to involve them in future interventions.

There is evidence that greater regulation and training of local drug sellers may also be necessary. In a few households, it became clear that mothers would purchase drugs or antibiotics directly from drug shops without receiving appropriate information on dosage.

The results of the survey should help to provide valuable information on where people choose to seek care and the reasons that they choose different providers. The first

impression of the writer is that the private sector clinics, NGO clinics and traditional healers are utilized very frequently.

The survey process is expected to be completed in March of 2005. The team from Makerere University is both highly qualified and capable and they have contracted with statisticians to help in the data analysis process.

The reception of the writer was outstanding without exception. The writer would especially like to thank Prof. Konde Lule, Dr. Sheeba Gitta, Dr. Virgil Onama and the Iganga survey team for their hospitality and camaraderie.

Next Steps

Upon his returning back from his Uganda trip, Dave Washburn discussed with Dr. Yuanli Liu about details of the interactions with the Uganda Team and major findings. The major next task is assisting the Uganda team in data analysis, once the data are collected. While waiting for the Uganda team to complete the data collection process, the Harvard TA Team decided to conduct secondary data analysis (the DHS data from Uganda) to understand major factors affecting people's choice of different types of providers. This part of the analysis should be complimentary to the primary data analysis we plan to undertake jointly with the Uganda team later on.

Notes from meeting on PSP in Zambia in Delhi 9 April 2005

Participants: Webby Wake, Pamela Nakamba Kabaso, Birger Forsberg and Jesper Sundewall

Topic: Discussion on how to move the PSP-project in Zambia forward.

Notes

Below is a summary of the main points stemming from the meeting:

It was concluded that:

- We should not deviate too much from the original plan as Birger had suggested in previous communication. All agreed that this was a good idea. The fundament of the first proposal should be kept intact.
- The objectives in the proposal will all be answered. Some through secondary data and some through new data that will be collected.
- The department should examine how the data input and analysis should be conducted. Perhaps it could be a good idea to sub-contract this. In this case, then it should be included in the budget.
- For purposes of data collection and surveys, it is important to recognize the significance of thorough training of the surveyors that will conduct the data collection
- It is important to have support for the study, both from central and local governement representatives.
- We need to move quickly with revising the proposal and secure funding. Funding must be secured before summer if the study is to be conducted as planned.

More specifically:

It was agreed that the study should still comprise two districts – one urban and one rural. The districts will be randomly selected. For the selection, the ranking of districts (according to socio-economic indicators) will be used. The list will be divided into quintiles and one district from the first quintile (urban) and one from the last (rural) will be selected.

For the purpose of the study, CSO has maps with villages and population distribution in general.

For the mapping study, a combination of techniques will be used. First, a mapping will be done based on secondary data (CSO, ZMC, THPAZ etc). Secondly, key informants will be identified (District director, Chiefs, Village headmen). These informants will be able to assist us to identify all providers in the district.

The facility survey, provider interviews and exit interviews will be conducted after the mapping as a separate activity. Providers could technically be surveyed at the same time as they are mapped, but we will instead make a careful selection and then return for the facility survey.

The household survey is of least importance. First and foremost, the mapping and facility survey should be conducted. Provisions for a facility survey should however be made in case it turns out to be desirable. As the situation is right now however, the household survey does not seem to be as important for the research project.

A study trip to Uganda to learn from their experience would be interesting and a line item for this should be included in the budget.

Training of the surveyors is essential to ensure quality of the data obtained. Data collection should be perfect from the start. At least one week of training is required, preferably two weeks. Field supervisors should be identified and trained at an early stage.

Next steps

It was agreed that the Zambia team should undertake the following activities:

1. The proposal needs to be revised. This should be done before, at the latest, on **Friday the 22nd**. The following aspects are of utmost importance:
    a. The budget (must be revised according to thoughts on household survey and statistician recruitment. The budget should therefore be more detailed (per activity)
    b. Proposal should be related to other studies
    c. The time-plan must be revised
2. Templates used by Dirk De Coeyere et al should be obtained. Especially the templates/interview guides for the policy studies
3. It should be reviewed what information the pilot study protocol yielded in the pilot study. This should then be compared to what they perhaps possibly could yield and necessary changes be made.
4. An article manuscript from the pilot study should be drafted. Webby and Jesper and primarily responsible for this activity. A first draft should be presented within the coming months. The first draft could be very rough only comprising background and context information (Jesper) and key pilot study data (Webby). Birger will also examine the possibilities for Webby to visit Sweden, perhaps in July or August, to work on this.

It was agreed that rapid action is necessary to realize the plans of the PSP-study in Zambia. It is evident that if funding is not secured in the next couple of months, then the study will not take place. Therefore, it was concluded that it is of utmost importance to get the study approved by the ministry within the next few weeks. If there is no decision on funding from Sida before the end of the first semester 2005, then the study will not take place.

Pamela will talk to the Director Planning at MoH, Davies Chimfembwe, during the next two weeks. At this occasion, she will lobby for the PSP-project. It was, however, emphasized that we need to move forward quite rapidly in order to realize the PSP-project before the July school break.

Brief Report on the Training Course "Private Health Care: Developing Successful Policies and Programs." Delhi, April 4-9, 2005

From April 4-9 the course on Private Health Care:Developing Successful Policies and Programs in Manesar, Haryana, India. This course was managed by the nternational Health Systems Program, Harvard School of Public Health. The course was directed by Prof Peter Berman and Dr. Birger Carl Forsberg of the Karolinska Institute. The course was sponsored by SIDA and WBI, providing partial funding. World Bank staff Benjamin Loevinsohn and Sundararaman Gopal were also faculty.

Course participants were about 60% from India and 40% from other countries, including Pakistan, Senegal, Zambia, Uganda, Kenya, Mongolia, Vietnam, and Laos. Indian participants included one officer from the national MoHFW, state level officers from Uttaranchal, West Bengal, and Karnataka, academics, technical staff of contractors and NGOs doing PPP work, officers of USAID-India, and one policy analyst from a private pharmaceutical company.

The calendar for the course covered theory and practice in relation to the role of the public and private sector, contracting in and out, social marketing and franchising, PPP in disease control programs, private health sector assessments. A copy of the course calendar is attached. Indian cases were presented on PPM-DOTS, Janani (social franchising), demand side financing (AP) and several other innovative programs in India (some by participants). Six participant groups prepared presentations on innovative proposals for PPP development.

Almost all reading materials and the presentations given during the course were put on a CD which was given to all course participants at the end of the week. The CD has also been sent to PSP institutions that could not attend the course.

A course evaluation was carried out. It will be tabulated and a short report prepared by Harvard School of Public Health.

INTERNATIONAL HEALTH SYSTEMS PROGRAM
HARVARD SCHOOL OF PUBLIC HEALTH
Private Health Care: Developing Successful Policies and Programs
April 4-9, 2005
Delhi, India

Session Times	Monday 4/4	Tuesday 4/5	Wednesday 4/6	Thursday 4/7	Friday 4/8	Saturday 4/9
9:00 – 10:15	Course Introduction Presentation of Participants *Berman/Forsberg*	Govt, NGO, and For Profit Providers: Case on Whom to Choose and Why using PHSA? *Gopalan/Forsberg*	Social Franchising: What and Why? *D Broun*	Contracting: Global Experience, Global Lessons *B Loevinsohn*	Workshop: Using PHSA *Forsberg*	Group Work - Presentations
10:15-10:30	Break	Break	Break	Break	Break	Break
10:30-12:00	What is "the Private Sector": Definition and Measurement *Berman*	Training and Subsidies to Improve Private Provision *Berman*	The Janani Experience *R Priyadarshini*	NGO Contracting in Bangladesh *Sundar Gopalan*	Workshop: Policy Dialogues Between Sectors and Role Play *Forsberg and Berman*	Group Work - Presentations
1:00 – 2:15	Policy Perspectives on the Private Health Sector *Forsberg*	Group work /CS Work	Group work/CS Work	Accreditation, Regulation, Certifcation *Berman*	Optiona;: Group work/CS Work Field trip to PPM-DOTS	12.00-13.00 Plenary Discussion
2:15-2:30	Break	Break	Break	Break	Break	13.00-13.30 Closing ceremony
2:30-4:00	Health System Goals and the Private Market and Overview of Tools Govt Can Use in Policies and Programs *Berman*	PPM-DOTS in India ***PPM Dots rep*** *Dr S. Sehgal*	Finance and Demand Side Strategies: The Andhra Pradesh experience *CBS Venkataramana*	Contracting: Preparing and implementing a contract *Loevinsohn*	Group work/CS Work	Lunch and departures
4:00-5:00	**Introduction to group work/Country Strategy Work**	Brief presentations by participants	Brief presentations by participants	Group work/CS Work (optional)	Group work/CS Work (optional)	