

# Private Sector Participation in Child Health

A Review of World Bank Projects, 1993-2002

Henrik Axelsson, Flavia Bustreo and April Harding

May 2003





# **Private Sector Participation in Child Health**

A Review of World Bank Projects, 1993–2002

**Henrik Axelsson  
Flavia Bustreo  
April Harding**

May 2003



## **Health, Nutrition and Population (HNP) Discussion Paper**

This series is produced by the Health, Nutrition, and Population Family (HNP) of the World Bank's Human Development Network (HNP Discussion Paper). The papers in this series aim to provide a vehicle for publishing preliminary and unpolished results on HNP topics to encourage discussion and debate. The findings, interpretations, and conclusions expressed in this paper are entirely those of the author(s) and should not be attributed in any manner to the World Bank, to its affiliated organizations or to members of its Board of Executive Directors or the countries they represent. Citation and the use of material presented in this series should take into account this provisional character. For free copies of papers in this series please contact the individual authors whose name appears on the paper.

Enquiries about the series and submissions should be made directly to the Editor in Chief. Submissions should have been previously reviewed and cleared by the sponsoring department which will bear the cost of publication. No additional reviews will be undertaken after submission. The sponsoring department and authors bear full responsibility for the quality of the technical contents and presentation of material in the series.

Since the material will be published as presented, authors should submit an electronic copy in a predefined format as well as three camera-ready hard copies (copied front to back exactly as the author would like the final publication to appear). Rough drafts that do not meet minimum presentational standards may be returned to authors for more work before being accepted.

The Editor in Chief of the series is Alexander S. Preker ([apreker@worldbank.org](mailto:apreker@worldbank.org)); For information regarding this and other World Bank publications, please contact the HNP Advisory Services ([healthpop@worldbank.org](mailto:healthpop@worldbank.org)) at: Tel (202) 473-2256; and Fax (202) 522-3234.

ISBN 1-932126-74-0

© 2003 The International Bank for Reconstruction and Development / The World Bank Group  
1818 H Street, NW  
Washington, DC 20433

All rights reserved.

# Health, Nutrition and Population (HNP) Discussion Paper

## Private Sector Participation in Child Health

*A Review of World Bank Projects, 1993–2002*

Henrik Axelsson<sup>a</sup>, Flavia Bustreo<sup>b</sup>, April Harding<sup>c</sup>

a. Consultant, Health, Nutrition, and Population, World Bank, Washington DC, USA

b. Senior Public Health Specialist, Health, Nutrition, and Population, World Bank, Washington DC, USA

c. Senior Economist, Health, Nutrition, and Population, World Bank, Washington DC, USA

**May 2003**

### Abstract:

There is an increasing amount of evidence to support the view that the private sector significantly influences child health and nutrition outcomes through both service provision and supply of health related goods. In this context, this paper analyzes World Bank projects in Health, Nutrition and Population between fiscal years 1993-2002. The paper identifies the range of approaches taken to involve the private sector in improving child health outcomes; the actors involved; the type of activities supported by the projects; and examples of successful private sector participation. The paper's conclusions and recommendations are outlined below.

### Conclusions:

- As measured by the proportion of projects (more than 50%) that involved the private sector in child health, private sector participation was significant.
- As measured by the magnitude of involvement (budget amounts and stated project objectives), the degree of private sector participation was relatively small for most projects.
- Since most projects did not mention a systematic assessment of potential and opportunities to engage the private sector, it was difficult to assess whether or not engagement of the private sector was intentional.
- It was not possible to analyze how and if private sector participation resulted in better health for children, as private sector monitoring indicators measured process and not outcomes.

### Recommendations:

- Encourage engagement of the private sector in World Bank projects addressing child health outcomes.
- Increase support to World Bank staff and its clients, for example through manuals or toolkits and field demonstrations of successful strategies to engage the private sector in child health programs.
- Conduct systematic assessments of the potential of the private sector to contribute to improved child health programs.
- Develop indicators that can measure which approaches lead from private sector engagement to better health for children.
- Incorporate mechanisms, such as health insurance, risk sharing, subsidies and targeted public health expenditures, to protect the poor and ensure that they are not further impoverished due to payments for health care services.

### Key words

Child health services, child health outcomes, developing countries, private sector, non-profit organization, contracting, social marketing, regulation, franchising, information dissemination, training, advocacy, behavior change communication, community financing.

### Disclaimer

The findings, interpretations and conclusions expressed in the paper are entirely those of the authors, and do not represent the views of the World Bank, its Executive Directors, or the countries they represent.

### Correspondence details

April Harding, Health, Nutrition, and Population, World Bank, 1818 H ST., Washington DC, USA; Tel: (202) 458-7371; Fax: (202) 522-3234; Email: [aharding3@worldbank.org](mailto:aharding3@worldbank.org); Web: [www.worldbank.org/hnp](http://www.worldbank.org/hnp)



---

# Contents

---

<b>Acknowledgements</b> .....	vii
<b>Acronyms</b> .....	ix
<b>Foreword</b> .....	xi
<b>1 Background</b> .....	1
<b>2 Purpose and Scope</b> .....	3
<b>3 Methodology</b> .....	5
<b>4 Findings from Review of Project Documents</b> .....	7
4.1 What were the General Findings? .....	7
4.2 Which Private Sector Actors were Involved in the Projects? .....	8
4.3 What Kind of Activities did the Private Sector Implement? .....	9
4.4 Through What Kind of Mechanisms was the Private Sector Engaged? .....	10
4.5 Did the Projects Provide Safeguards to Protect the Poor? .....	16
4.6 How was Private Sector Participation Monitored and Evaluated? .....	16
4.7 Was Engaging the Private Sector Part of the Project Objectives? .....	17
<b>5 Feedback from HNP Task Managers and HNP Anchor</b> .....	19
<b>6 Conclusions and Recommendations</b> .....	21
<b>References</b> .....	23
<b>Annex 1: Reviewed Projects</b> .....	25
<b>Annex 2: Worksheet of Findings—Projects that Involved the Private Sector in Child Health</b> .....	31
<b>Annex 3 : Questionnaire Format</b> .....	37
<b>Figures</b>	
Figure 1: Percentage of Children Treated Outside the Public Sector for Their Most Recent Illness .....	1
Figure 2: Degree of Private Sector Involvement .....	4
Figure 3: Proportion of the Total Number of Projects with Child Health Components that involved the Private Sector, by Year .....	4
Figure 4: Proportion of the Total Number of Projects with Child Health Components that involved the Private Sector, by Region .....	8
Figure 5: Distribution of Private Sector Actors that were involved in Projects .....	8
Figure 6: Distribution of Activities Implemented by the Private Sector .....	11
Figure 7: Distribution of Mechanisms Used In Projects that involved the Private Sector .....	15

**Boxes**

Box 1: Using NGOs to Supplement Government Capacity to Improve Child Health—Peru .....	9
Box 2: Raising Awareness of Child Health Services through IEC Activities—India .....	10
Box 3: Sustainable Food Fortification by Involving the Food Industry—Philippines .....	11
Box 4: Reducing Malnutrition Rates through Community Nutrition—Madagascar .....	12
Box 5: Contracting with NGOs for Immunization and other Basic Health Services—Guatemala .....	13
Box 6: Using Comparative Advantage of NGOs with Social Fund Grants—Guinea-Bissau .....	16

This review builds upon the findings of an earlier review of projects in the Latin America and Caribbean region, which were presented in a joint PAHO and World Bank seminar. Participants in the seminar provided useful feedback for this global review. In addition, the authors would like to thank everyone else who shared their knowledge and expertise and provided valuable comments on this paper, especially Mariam Claeson, Alex Preker, Robert Hecht and Rae Galloway of the World Bank's Health, Nutrition and Population (HNP) anchor, Human Development Network; Ruth Levine, Patricio Marquez, Gerard La Forgia and Daniel Cotlear of the Latin

America and Caribbean Regional Office; Tonia Marek of the African Regional Office; Sarbani Chakraborty and Nedim Jaganjac of the Europe and Central Asia Regional Office; Stephen Commins of the Office of the Vice President, Human Development Network; Chris Drasbek of the Pan American Health Organization (PAHO); and Hugh Waters and Laurel Hatt of the Johns Hopkins School of Public Health. Special thanks are also due to Charito Hain for administrative support throughout the writing of this report, Gisele Biyoo for reviewing the print version, and Kathy Strauss for formatting and graphic design.



ARI	Acute Respiratory Infection	MEMO	Memorandum and Recommendation of the President
CHW	Community Health Worker	MENA	Middle East and North Africa
DALY	Disability Adjusted Life Year	MSPAS	Ministry of Health, Guatemala
DEC	Development Economics and Chief Economist Group	NGO	Non-Governmental Organization
DHS	Demographic and Health Surveys	PAD	Project Appraisal Document
EDU	Education Sector	PAHO	Pan American Health Organization
EAP	East Asia and Pacific	PECSB	Programa de Extension de Cobertura de Servicios Basicos, Guatemala
ECA	Europe and Central Asia	PID	Project Information Document
HNP	Health, Nutrition and Population	PPP	Public-Private Partnership
ICR	Implementation Completion Report	SA	South Asia
IEC	Information Education and Communication	SAF	Social Action Fund
IMCI	Integrated Management of Childhood Illnesses	SAR	Staff Appraisal Document
KAP	Knowledge, Attitude and Practice	SP	Social Protection Sector
LAC	Latin America and Caribbean	SSA	Sub-Saharan Africa
M&E	Monitoring and Evaluation	UNICEF	United Nations Children's Fund
MDG	Millennium Development Goal	WHO	World Health Organization



**T**he role of the private sector has received considerable attention in recent years in discussions on international health policy.

Many governments and local stakeholders, as well as international development institutions, realize that if the global community is to achieve goals such as the Millennium Development Goal of reducing child mortality by two-thirds by 2015, all relevant actors, public and private, must be involved. Although research has been conducted to document evidence on private sector participation in child health, there is a need for more systematic efforts to identify ways of ensuring that increased private sector engagement will translate into improved health outcomes.

This review of World Bank projects in Health, Nutrition and Population between fiscal years 1993–2002 is therefore a timely contribution to the knowledge base on private sector participation in child health programs and projects. Because child health is high on the international health agenda, and as there is increasing evidence that the private sector significantly influences child health and nutrition outcomes through both service provision and supply of health related goods, a review of child health projects is particularly timely.

The review identifies the range of approaches taken to involve the private sector in improving child health outcomes; the actors involved; the type of activities supported by the projects; and examples of successful private sector participation. It finds that although there are examples of private sector involvement in World Bank HNP projects, there is room to do more and to be more effective. The authors argue that there is a need for more systematic country-level assessments of private sector potential to contribute to child health programs. In addition, based on discussions with HNP project managers and policy specialists, the authors recommend the development of manuals and toolkits, and field demonstrations of successful strategies to engage the private sector.

I believe that this review will contribute to the World Bank's larger mission to gather and disseminate knowledge that can improve the design and implementation of successful development programs. It is hoped that it will stimulate further thinking and research to ensure that increased private sector participation in child health programs will translate into better health for the world's children.

Robert Hecht  
*Acting Director and Sector Manager  
Health, Nutrition and Population*

*World Bank  
May 2003*



# 1. Background

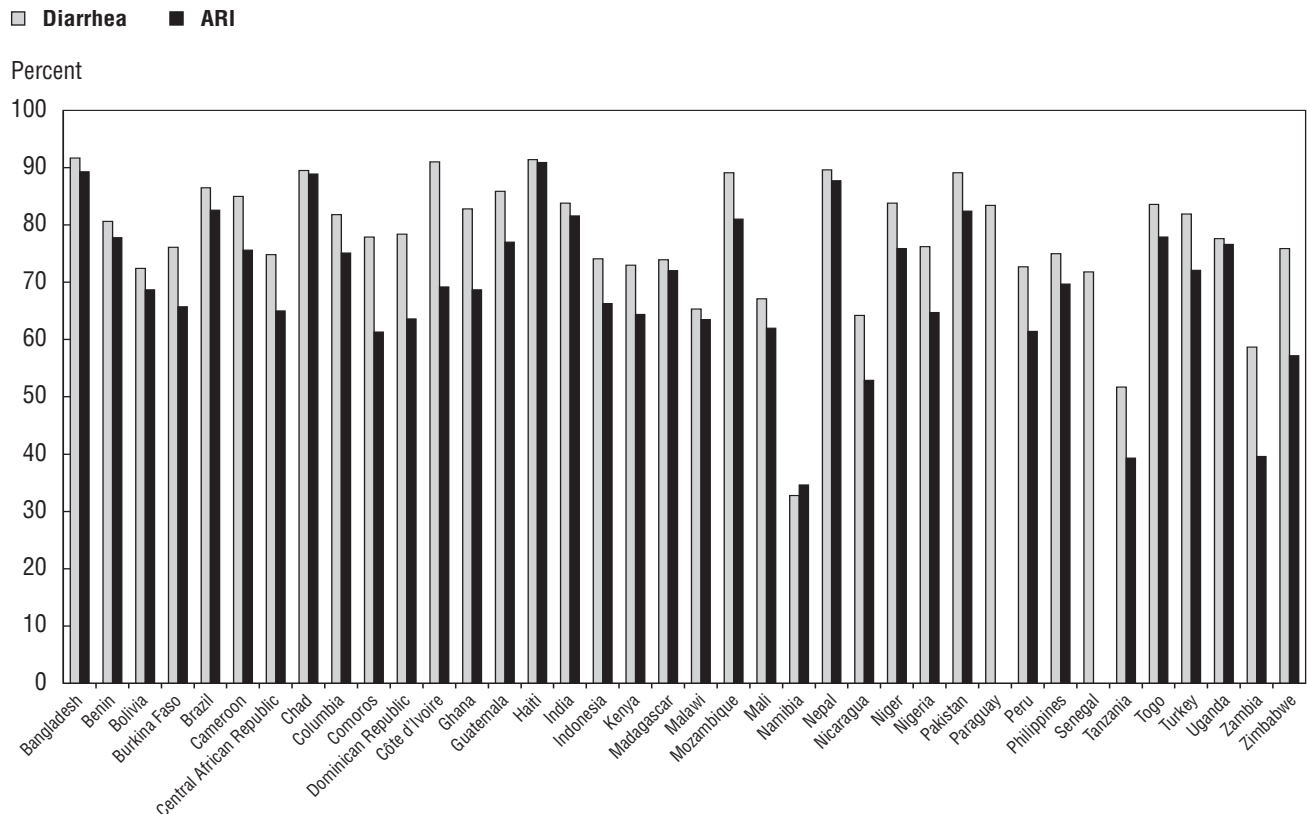
A considerable amount of literature emphasizes that the private sector is playing a substantial role as a provider, supplier, manufacturer, and marketer of health care services (Smith et al, 2001). Following the private sector definition by Hanson and Berman (1998), we include for-profit and non-profit, formal and non-formal entities.

In developing countries, the private sector has a strong presence at the primary care level (Hanson and Berman, 1998). The private sector is a frequent source of diagnosis and treatment of communicable diseases such as acute respiratory infection (ARI), diarrhea, and malaria. Analysis of data from household surveys show that private providers are the

main source of treatment of sick children in many developing countries. As shown in Figure 1, analysis of Demographic and Health Surveys (DHS) from 38 countries revealed that private providers are a significant source of care for childhood diarrhea and ARI for most of the countries (Gwatkin et al, 2000).

However, private provision of health services is only a part of the private sector influence on child health outcomes. Other parts of the private sector that influences child health include manufacturers and marketers, which provide and market goods like pharmaceuticals, bed-nets, soap, and sanitation supplies. In addition to providing health services, non-governmental organizations (NGOs) are often

Figure 1: Percentage of Children Treated Outside the Public Sector for Their Most Recent Illness (Average Socioeconomic Status)



Source: Gwatkin et al, 2000.

engaged in social marketing and the promotion of healthy behaviors. Waters et al (2002) conducted a comprehensive review of the literature on the evidence of the private sector's influence on child health outcomes, and found that the private sector exerts a significant influence on child health; that the quality of private sector services is a cause for concern; but that there is evidence of strategies that can be successfully applied to engage the private sector in appropriate ways (Waters et al, 2002). Bustreo et al (2002) reviewed common modalities used to engage the private sector and called for a more systematic approach to private sector participation.

There is mounting evidence that the private sector is extremely important for reaching poor children as well as those who are better off. For example, DHS data from the Dominican Republic indicate that 66 percent of families in the poorest quintile obtained treatment for acute respiratory infections from private facilities (Waters et al, 2002). This is particularly relevant because, despite progress in reducing childhood mortality in the last decades, more than 10 million children under five years of age die each year. Almost all of these children live in poor households in the developing world (99%) and most of them die from preventable and treatable conditions (Ahmad et al, 2000). Child mortality accounts for more than 50 per cent of the global equity gap in mortality between the world's poorest and richest quintiles (Gwatkin, 2000). In a study from Cebu, The Philippines, it was found that mortality caused by communicable diseases such as measles, diarrhea, and ARI was more concentrated amongst the poor than mortality from all causes (Wagstaff, 2001a). Care for those diseases are often sought from the private sector. In a recent review, the WHO-World Bank Child Health and Poverty Working Group examined the evidence on the direct (proximate) and indirect (underlying) determinants of child health and

found that for almost all determinants, poor children fared worse than their better-off peers (Wagstaff et al, 2003).

Accessing private health goods and services is also costly. The burden of health care costs has been shown to be a determining factor driving families into poverty, and further impoverishes already poor families (Wagstaff, 2001b). Efforts to integrate private providers and suppliers into child health programs will therefore also need to consider when financial support needs to be introduced, via subsidies or other targeted public expenditures.

Child health programs have traditionally been focused on the public sector (Claeson and Waldman, 2000). Though governments are sometimes reluctant to involve the private sector in their initiatives, the significant role the private sector plays in regards to child health, means that programs which focus exclusively on public providers will rarely achieve desired improvements in child health outcomes, such as reducing child mortality by two-thirds by 2015, one of the Millennium Development Goals (MDGs). This recognition has recently prompted many multilateral organizations, bilateral donors, and academic institutions to support efforts to more effectively engage the private sector to improve child health outcomes. For example, the Global Consultation on Child and Adolescent Health and Development, jointly hosted by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) in March 2002, included a session on private sector participation in child health programs. One of the conclusions from the Global Consultation was that partnerships between the public and private sectors are needed to scale up strategies and expand coverage of effective health interventions.

---

## 2. Purpose and Scope

---

If governments are to improve the effectiveness of their child health programs by harnessing the contribution of the private sector, they need to answer several questions. Who are the relevant private sector actors? What determines the behavior of the private sector? What instruments are available to influence private entities? Which instruments work and under which conditions are they effective? A number of World Bank projects, particularly in the Health Nutrition and Population sector, have sought to involve the private sector to achieve improvements in child health outcomes. The purpose of this review of projects is to identify the range of approaches taken to involve the private sector in improving child health outcomes; the actors involved; the type of activities supported by the projects; and examples of successful private sector participation. The review can be used as a starting point to evaluate, and learn from, the Bank's work in this area.

A total of 114 projects were reviewed for this inventory (please see Annex 1 for a listing of these projects.) These had been identified as supporting child health components in previous inventories of World Bank projects (Claeson et al, 2000; Kaur and Tzannatos, 2002). These projects are mainly within the Health, Nutrition and Population (HNP) sector, but also in the Education (EDU) and Social Protection (SP) sectors. Although involvement of private actors in projects in sectors other than HNP clearly influences child health outcomes, this study focuses on HNP projects. In addition, financing mechanisms are crucial elements of policy making and project design. For the purposes of this review, we limited our scope and did not attempt to explore the extent of private sector financing of the projects. However, Annex 1 provides data on private health expenditures as a percentage of total health expenditures for each reviewed country.



---

## 3. Methodology

---

**T**he methodology was adapted from a previous inventory of World Bank projects (Claeson et al, 2000). To obtain data for the inventory, Project Appraisal Documents (PADs), Staff Appraisal Reports (SARs), Project Information Documents (PIDs) and Memorandum and Recommendation of the President (MEMO) were reviewed for fiscal years 1993–2002<sup>1</sup>. To ensure a structured review of the projects’ components and activities, a questionnaire was developed (please see Annex 3). The questionnaire lists key components looked for in

the project documents. For completed projects, Implementation Completion Reports (ICRs) were consulted to compare intended objectives of the projects with the actual accomplishments. Annex 1 identifies the type of document that was consulted for each project. For some projects, task managers were contacted in order to verify the findings and to generate additional information and more detailed illustrations of projects that engaged the private sector in child health activities.

---

1. The Project Appraisal Document, the Staff Appraisal Report, the Project Information Document, and The Memorandum and Recommendation of the President are World Bank documents that describe a loan agreement between a client country and the World Bank.



## 4. Findings from Review of Project Documents

### 4.1. What were the General Findings?

Please refer to Annex 2 for a worksheet of the findings by project in matrix format. The 114 projects that included child health components generally focused on problems or programs such as control of ARI and diarrhea, and nutrition, immunization and other preventive activities. 32 of the projects did so through efforts to expand the application of the Integrated Management of Childhood Illness strategy (IMCI).

Of the 114 projects reviewed, 61 were identified as projects involving the private sector (54%). There appeared to be no clear association between private sector participation in country projects and those countries' level of private health expenditure as a percentage of total health expenditure (provided in Annex 1).

In order to gauge the degree of participation of the private sector in the project activities to improve child health outcomes, involvement was rated to be "Minor", "Moderate", or "Major." This admittedly rather subjective rating was based on two measures: a) available budget information and narrative description in the project documents; and b) the degree of stated intentions to encourage private sector participation.

Private sector participation was rated as "Major" if project documents showed that substantial funding

Figure 2: Degree of Private Sector Involvement

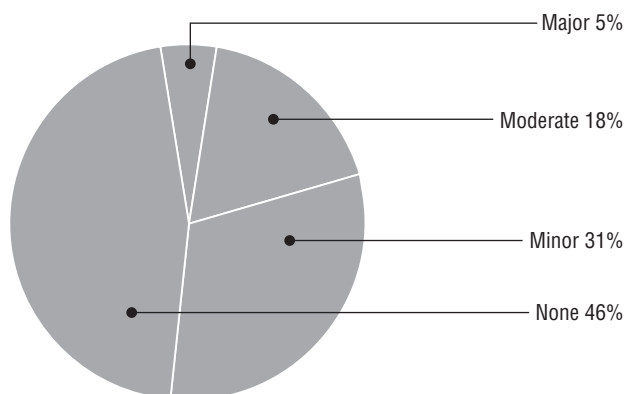
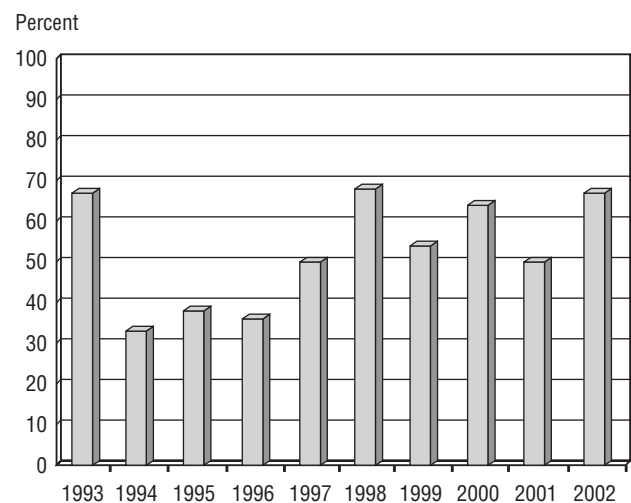


Figure 3: Proportion of the Total Number of Projects with Child Health Components that involved the Private Sector, by Year

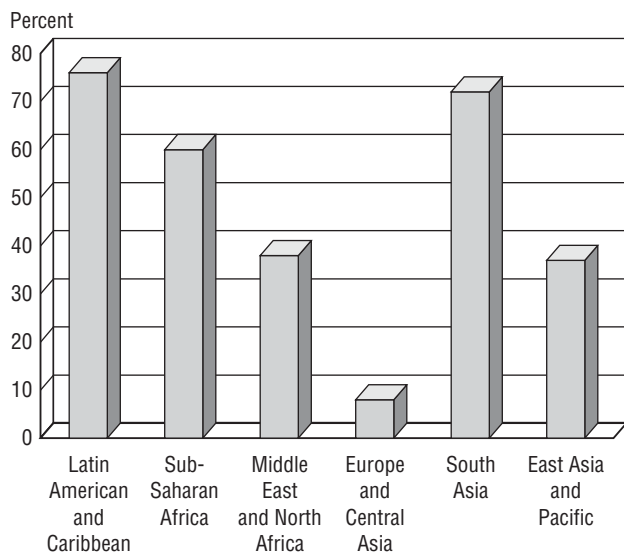


were allocated to child health components that would be implemented by the private sector and/or if the projects documents clearly stated a strong intention to involve the private sector. Private sector participation was rated as "Minor" if there was no evidence of either substantial fund allocation or stated intentions. The remaining projects were rated as "Moderate." As can be seen in Figure 2, although a significant number of projects did involve the private sector in some way, a majority of those projects did so in ways that appeared to be of limited degree.

We also explored if private sector participation was a recently emerging phenomenon. As illustrated in Figure 3, which shows the percentages of the total number of projects with child health components that involved the private sector by year, we were not able to identify any clear trends. However, the studied time period may be too short to draw conclusions on any trends of private sector involvement in child health programs.

In order to investigate whether or not there were regional differences in the involvement of the private

**Figure 4: Proportion of the Total Number of Projects with Child Health Components that Involved the Private Sector, by Region**



sector in child health programs, we also looked at the distribution of private sector participation by operational region. The percentages of the total number of projects involving the private sector by region are provided in Figure 4.

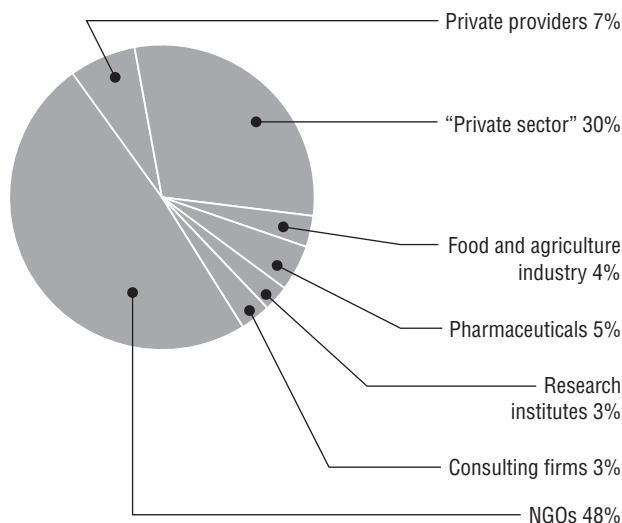
Two comments are warranted here. First, regions that show a high involvement of the private sector in child health programs (e.g. Latin American and the Caribbean and South Asia) are regions that have relatively large private sectors. Second, there is little involvement of the private sector in child health programs in the Europe and Central Asia region (ECA). In ECA, at the beginning of our time period (1993) there was no real private sector in health. This was a legacy of the Soviet-Semashko style system, where the government dominated the health sector by providing all services and producing all inputs. By the late 1990's however, at least half of the Central European countries had converted primary practice to self-employment. The doctors were then contracted by the newly created social insurance fund. It may be expected that there may be increased private sector involvement in ECA in the years to come, as the private sector develops. Of the projects reviewed, the one in the ECA region that involved the private sector in child health was approved in 1999.

Only 17 of the 61 projects (28%) included an assessment of the private sector to ascertain its potential to strengthen child health programs. An assessment of the private sector includes collecting and analyzing the following information: size and geographical distribution; types of actors; training and qualification; role of professional organizations; types and quantity of child health and related services provided; quality of services; constraints faced by the private sector; etc. Some of the projects contained an assessment of private sector during project design, whereas others included an assessment during the implementation of the project.

#### 4.2. Which Private Sector Actors were Involved in the Projects?

Project documents often provided few details regarding the private actors that were involved in the projects. In 35 projects, the general term “private sector” was used. Based on discussions with task managers and staff from the HNP anchor, we believe that this term is used mainly to refer to the for-profit part of the private sector. Please refer to Figure 5 for an illustration of the percentage distribution of the private sector actors involved in child health programs. Please note that some projects involved more than one private sector actor. The total number of private sector actors involved in the projects was used as the denominator for Figure 5. 25 of the projects (41%) con-

**Figure 5: Distribution of Private Sector Actors that were involved in Projects**



tained information on how private sector actors were identified. This information was often not particularly detailed, and it is therefore difficult to analyze whether or not these projects involved an analysis of the comparative advantage of private sector actors.

As evident, NGOs were the dominant source of private sector involvement in child health programs. As defined by Harding (2003), health NGOs are “formal organizations which have clearly defined objectives concerned with health service aims concerning groups outside the organization, which are not-profit-making and which are outside the direct control of government.” For an illustration of how

an NGO might be involved in a child health program, please see Box 1 below.

### 4.3. What Kind of Activities did the Private Sector Implement?

There was no specific description of the activities that the private sector would implement in three of the projects. For the other 58 projects, please refer to Figure 6 for an illustration of the percentage distribution of the activities implemented by the private sector. As with mechanisms and actors, it is important to note that the private sector implemented multiple activities in some projects. The total number of ac-

#### Box 1: Using NGOs to Supplement Government Capacity to Improve Child Health—Peru

In 1994, the time when the project was started, Peru was facing serious health and nutrition problems. The infant mortality rate was 53 per 1000 live births, a rate that was relatively high for the Latin American region. The health status of the population varied between different regions of the country because of gaps in coverage and poor quality of services in rural areas. For example, the risk of infant death was more than three times higher in the southern mountainous region compared to Lima. Levels of child malnutrition had not decreased in a significant way in the last two decades and again varied between regions. For example, more than 50% of rural children were chronically malnourished, compared to 13% for Lima.

The objective of the *Basic Health and Nutrition Project* in Peru was to improve health and nutritional status of poor women and children, particularly in areas with poor health indicators. The project aimed to do so by increasing the use of maternal and child health and nutrition services by extending access and improving the quality of services, and by promoting better health and nutrition practices, with an emphasis on preventive care and education. Previous experiences had shown that private sector actors like NGOs could contribute to community-based activities like growth monitoring and to the delivery of health services where the government did not function fully, or not at all. It was also found that NGOs were more effective in promoting community participation than the Ministry of Health.

In order to take advantage of these comparative advantages, and to complement the government, NGOs were involved in the project through *contracting and cooperative agreements*. Criteria for qualification—such as operational and contracting capacity, experience, and quality of proposal—of NGOs were established. NGOs were engaged to deliver preventive health services in areas where Government coverage is inadequate. They were given access by the project to training, growth monitoring equipment and micronutrient supplements to reach the target population. NGOs also provided technical support and collaborated with government health center staff to provide training to community health workers for community outreach services.

The Implementation Completion Report revealed that the health services provision component of the project was satisfactory. A KAP (Knowledge, Attitude, and Practices) survey showed that there was an increase in coverage of maternal and child health services in the areas of intervention compared to baseline areas. Key variables showing improvement were: early use of prenatal care, professional birth attendance, coverage of integrated well-child services, and feeding children with solid foods first during a meal. At the end of the project the prevalence of diarrhea in children was reduced when compared to control groups. The health promotion component of the project was not deemed as successful, as an effective community health promotion model was not developed by the project, nor was there use of mass media communications component. The contracts with NGOs for training CHWs were focused on increasing demand for health services rather than on changes in health practices. The evaluation report recommended that research for design of Information, Education, and Communication (IEC) messages and production of educational materials should be contracted to skilled third parties such as NGOs, in addition to activities that they already implemented. The report also recommends that mass media should be more exploited in IEC campaigns.

tivities implemented by the private sector in the projects was used as the denominator for Figure 6.

As seen above, activities in which the private sector was most often involved included: health service delivery; training; Information, Education, and Communication (IEC); and supervision and technical assistance. For example, the private sector was involved in the implementation of mother and child health (MCH) components of basic health care packages; training of health staff on different aspects of the IMCI strategy; IEC activities targeted to populations to increase awareness of available health services and to providers to improve their knowledge and practice of appropriate treatments; and supervision and technical assistance to projects and government health facilities. For more detailed illustrations of different kinds of activities that the private sector was involved in, please see Boxes 2, 3 and 4.

#### 4.4. Through What Kind of Mechanisms was the Private Sector Engaged?

Given that the Bank negotiates loans with the borrowing countries, we explored the mechanisms

through which the government used those funds to involve the private sector. A range of mechanisms was used to involve the private sector in child health components of the projects.

Please refer to Figure 7 for an illustration of the percentage distribution of the mechanisms that were used to involve the private sector in the 61 projects. It is important to note that several projects used multiple mechanisms, at the same time, to involve the private sector. For example, a project may have contracted NGOs to provide health services in remote areas and may have also performed a review of the regulatory environment for the private sector in the country. The total number of mechanisms used in the projects was used as the denominator for Figure 7.

As the figure indicates, contracting and grants were the mechanisms most frequently used in the projects to involve the private sector. The mechanisms are briefly defined and their application in the projects is characterized below.

*Contracting* is a mechanism used to acquire a specific service, of a specified quantity and quality, at an agreed price, from a provider. It is a formal rela-

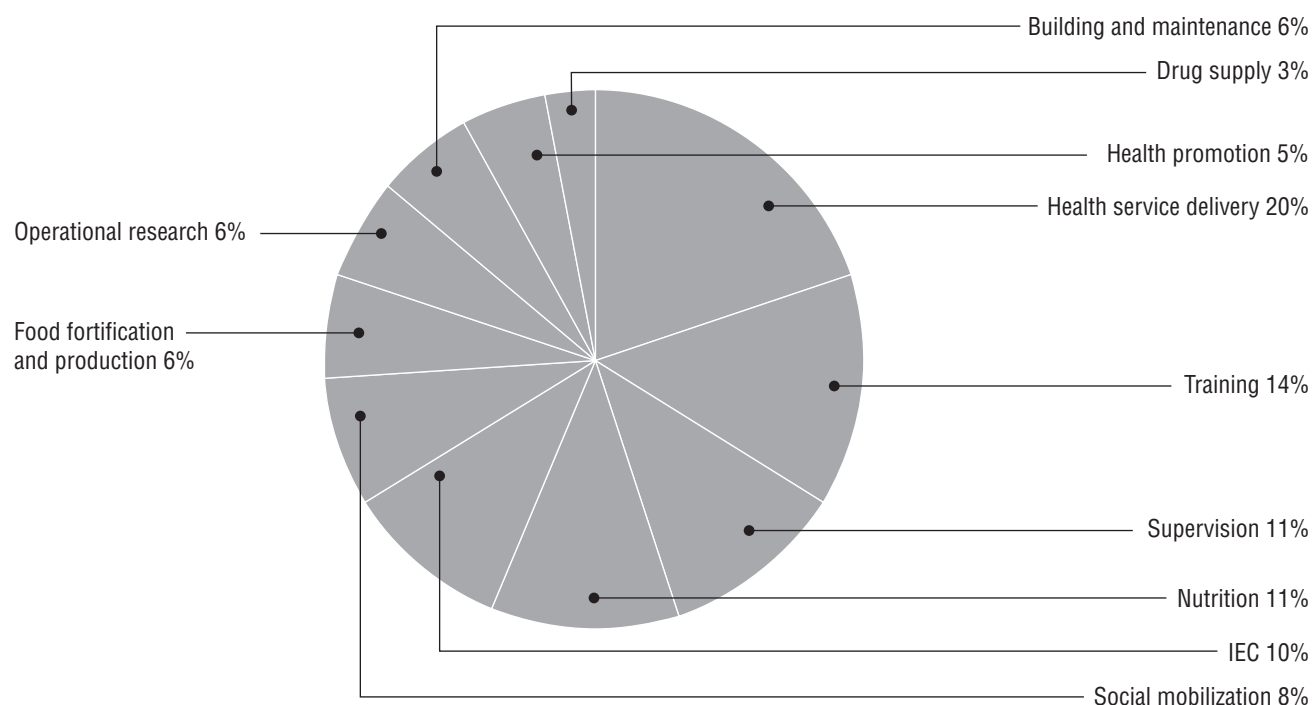
#### Box 2: Raising Awareness of Child Health Services through IEC Activities—India

In 1998, when this project began, about 40% of the population of the Indian state of Orissa was living below the poverty line. A study undertaken during project preparation of the disease burden in Orissa indicated that the burden of communicable disease (62% as measured in terms of Disability Adjusted Life Years; DALYs) was 10% higher than the average for India. Data also indicated that maternal and infant mortality rates were substantially higher than the averages for the whole country. It was suggested that this might have been related to the fact that availability and accessibility of health facilities in Orissa was lower than in other Indian states, and that this has a negative impact on service delivery. This hypothesis was addressed in the project.

The *Orissa Health Systems Development Project in India* aims to improve the performance of the health care system. It also supports efforts to reduce infant and maternal mortality rates. To create community awareness regarding the availability of health services at primary and secondary levels, and to mobilize political support to improve the quality of health care, the project supports the implementation of IEC activities. The target groups for the IEC component are government functionaries at the grassroots level, underserved populations, and health care workers and hospital staff, including private practitioners. Periodic workshops and seminars are conducted to enhance the knowledge, develop the skills and change the attitudes of service providers, service users and the community. NGOs are involved in many of the IEC efforts. For example, NGOs are contracted to conduct health camps in tribal areas.

In addition to raising community awareness of health services, the private sector is also involved in surveillance activities. Through workshops and training programs, the capacity of private medical practitioners and private institutions to report epidemic outbreaks will be strengthened. The project also contains a component for assessing the development of the private sector and a review of whether or not existing regulations concerning the quality of private care are appropriate.

Figure 6: Distribution of Activities Implemented by the Private Sector



### Box 3: Sustainable Food Fortification by Involving the Food Industry—Philippines

In 1998, when this project began, the health status of children in the Philippines had progressed slowly and was worse than it should have been given the level of per capita income. For example, around 30% of children under six were moderately or severely malnourished, a higher proportion than in many poorer countries such as Egypt, Kenya, Tanzania, and Zimbabwe. 50% of Filipino infants and 25% of young children were anemic. The relatively poor progress in child health indicators was attributable largely to economic stagnation and low investment in social welfare programs during the Marcos period, combined with an unchanging and inequitable income distribution.

The Micronutrient Malnutrition Prevention and Control component of the *Early Childhood Development project in Philippines* aims to address the high level of micronutrient deficiencies of children through direct supplementation, improved access to *fortified foods*, and de-worming. The strategy is to eventually phase out direct supplementation, except for special high-risk groups, and correspondingly to promote comprehensive fortification of staple foodstuffs like salt, sugar, flour, rice, and oil. Direct supplementation is to be gradually phased out, with declines planned according to monitoring data on matching expansion in coverage of needs through food fortification. However, to fully address malnutrition in children, it has been recommended that iron drops for children between 6–24 months be provided.

The project works with the private food industry to develop fortification of suitable mass-produced stable foodstuffs. It does so by providing funds to the food industry, on an interim basis, for materials like iodine, vitamin A, and iron for fortification of staple foodstuffs. It also advocates the benefits of food fortification—both as a selling point and as a social contribution—to the food industry. The project also involves social marketing to promote consumer acceptance of, and preference for, fortified foods. It is expected that this initiative would eventually cover much of the Philippine's micronutrient supplement needs, and that it would almost entirely be financed by the food industry, thus supporting sustainability.

#### Box 4: Reducing Malnutrition Rates through Community Nutrition—Madagascar

Madagascar was among the least developed countries in the world when this project began in 1993. Its social conditions were below sub-Saharan African standards. Chronic malnutrition rates were about 40%, and child mortality was about 200 per 1,000 live births. Although food production seemed to exceed estimated needs by 20% or more, almost 40% of the population suffers from food insecurity, because their own production and/or purchasing power are insufficient. Furthermore, markets were inefficient and segmented, which frequently led to significant seasonal malnutrition even in areas producing substantial food surpluses.

To address this situation, the *Food Security and Nutrition project in Madagascar* was launched. Its planning was based on previous pilot projects. It aimed to reduce food insecurity and malnutrition in Madagascar's two most food-insecure provinces (Antananarivo and Toliary) through income generating projects and targeted nutrition programs. The project consisted of three components: income-generating activities through a social fund; nutrition interventions; and institutional strengthening. The nutrition component included a *community nutrition program* that worked through mother groups organized and supported by NGOs and other private organizations. This component of the project provided nutrition education, supplemental feeding, and referred severe cases of malnutrition to nutrition rehabilitation centers. NGOs and other private organizations were selected if they had a proven track record in the field for efficient delivery of programs that reached the most vulnerable groups. The main mechanism to involve the private sector actors consisted of contracting.

The Implementation Completion Report stated that the community nutrition component of the project covered 535 community nutrition centers or sites and provided growth monitoring for almost half a million children in the two provinces that were covered. Project monitoring showed that malnutrition rates in the target community nutrition centers decreased by 58% in Antananarivo and 48% in Toliary between the beginning of the project and March 1998. NGOs have kept most of the 535 nutrition centers active and the community nutrition component of the project has continued to receive support in later projects.

The report also emphasized that the project demonstrated the benefits of working with communities and NGOs with a scope and size that went well beyond previous attempts by pilot type approaches. The report argued that the extensive reliance on NGOs and other decentralized community structures contributed in a significant way to its success. It also added that projects that are managed outside the traditional government structures tend to be more efficient and flexible in getting quick results in the field and in serving the communities.

relationship between, for example, a government and a private provider of health services (Taylor, 2003). The contracting undertaken for these projects consisted of arrangements to acquire specific services, sometimes delivered to specified groups, from private providers. In Senegal and Madagascar, World Bank projects contracted with NGOs to deliver nutrition services such as growth monitoring of children; referral to health services for children and pregnant women; home visits; education sessions to women; and food supplementation to malnourished children (Marek *et al*, 1999). A project in Guatemala contracted with NGOs to deliver a basic health package to rural, indigenous populations. The findings specific to immunization are described in Box 5.

A *grant* is a form of financial support whereby the government allocates funds to private providers that

are delivering activities or products that are important for achieving health objectives (Harding, 2003). The grants used in these projects generally consisted of block funding allocated to NGOs engaged in the delivery of health services, often to target population groups that were easier to reach through NGOs. In Guinea-Bissau, the Social Sector Project provided grants to NGOs and grassroots organization for small-scale, socially oriented projects such as income-generating activities, nutrition programs, maternal and child health, family planning activities, and literacy and skills development (see also Box 6).

*Public-Private Partnership* (PPP) refers to a variety of cooperative arrangements between the government and private sector. The private sector partner may be either a provider or group of providers, or an entity from the commercial produc-

**Box 5: Contracting with NGOs for Immunization and Other Basic Health Services—Guatemala<sup>2</sup>**

In 1995, life expectancy at birth in Guatemala was 65 years, infant mortality was 46 per 1,000 live births, and maternal mortality was between 200 and 460 per 100,000 live births. These health outcomes were worse than in other Latin American countries with a similar level of development. Although the average health outcomes were serious enough, there were significant differences between population groups and regions. Rural populations, especially indigenous groups, had much higher mortality and morbidity rates than urban populations. The causes of morbidity and mortality were primarily infectious diseases, such as ARI, diarrhea, malaria measles, which were exacerbated by poor hygiene and nutrition and an ineffective health system with poor access. The government health system suffered from a lack of trained health personnel, supplies medicines, supplies and vehicles, and there were no alliances with other health service providers and little community involvement. It was estimated that 46% of the population was not covered by the existing health system.

In 1996, a new government took office and in December the Peace Accords were signed, which ended more than 30 years of civil war. The Peace Accords called for the government to increase spending on health, particularly preventive services, to reduce infant and maternal mortality to 50% of the 1996 rate, to maintain the certification of the eradication of polio, and to eradicate measles. Since the public health system was in a poor state and the time period was short, the government realized that it could not achieve these goals through the public sector alone, but needed to involve the private sector as well.

To encourage these efforts, the World Bank supported the government's Program to Extend Coverage of Basic Health Services (PECSB—Programa de Extension de Cobertura de Servicios Basicos). The program was initiated in 1997 and engaged NGOs to improve access to primary health care, including immunization, for poor indigenous populations living in rural areas. The NGOs were engaged through “convenios” or agreements, which acted as a sort of informal contracting mechanism. The *convenios* were used because NGOs had limited capacity to estimate costs or prepare a bidding proposal. Most NGOs would not have worked with the Ministry of Health (MSPAS) if formal contracting was the only mechanism used to engage them. Although critics of the *convenios* argued that they were fragile mechanisms with little legal backing, supporters stated that there was little or no difference between them and formal contracts since the institutional infrastructure required to enforce contracts was weak.

The NGOs were engaged to provide a basic health package, focusing on preventive maternal and child health care and control of infectious diseases such as ARI, diarrhea, and malaria. The different services provided are listed in Table 1. Initially, the NGOs were selected based on experience in health and their level of capacity. It was planned that the selection process would get closer to competitive bidding as the capacity of the NGOs increased. The NGOs were reimbursed by prospective capitated payments in four yearly payments, which varied depending on the size of the covered population and covered program and administrative expenditures. In 1999, the average per capita payment was \$6.25. The total per capita cost was approximately \$8, which included vaccines and essential drugs the MSPAS supplied directly to the NGOs. In February 2000, 3.7 million beneficiaries were covered by the PECSB.

Initially, the *convenios* did not contain measures of output. NGOs were adverse to committing to specific outputs, since they felt that their current capacity did not allow them to agree to deliver concrete outputs such as increasing the immunization rate to 90%. Instead, the NGOs agreed to comply with processes (e.g. frequency of home visits) and schedules (e.g. the order of introduction of the services in the basic health package) and to “deliver agreed health services.” As NGOs were gaining experience and capacity through the delivery of the program, it was planned that performance measures would be included in the *convenios* signed in 2000. A team at the central level of the MSPAS was responsible for monitoring the *convenios*. The project instituted two delivery mechanisms. In the direct model, the NGOs managed and delivered the basic health package on its own. In the mixed model, staff from MSPAS were assigned to each NGO to assist in the implementation of the activities. The direct model tended to predominantly address areas that were further away and more difficult to reach, whereas the mixed model operated closer to towns.

*Continued on next page*

2. This case study is based on an interview with Gerard La Forgia, Senior Health Specialist, Latin American and Caribbean Region, the presentation *Large scale contracting out of basic health services for the poor in Guatemala: results, processes and lessons learned* by La Forgia & Danel (2002), and the paper “Large-scale Government Contracting of NGOs to Extend Basic Health Services to Poor Populations in Guatemala” by Nieves, La Forgia, and Ribera (2000).

**Box 5: Contracting with NGOs for Immunization and Other Basic Health Services—Guatemala (cont'd)**

As mentioned above, as part of the convenios between the MOH and NGOs, the MSPAS would be responsible for supplying vaccines. The immunization services were delivered by a team of one administrator, one medical doctor, one rural health technician, one accountant, one person responsible for entering and consolidating statistics, and volunteer community health workers (CHWs). As opposed to the MSPAS, which mainly delivered immunization services through its fixed health facilities, the NGOs carried out outreach activities. The field workers were trained and supervised by the NGOs, with input from the MSPAS staff in the mixed model.

The results of these two approaches compared to the traditional model with MSPAS managing and providing health services were evaluated by conducting a household survey. The results show that the mixed model provided higher immunization coverage than the traditional model for children under five years of age for BCG, DPT 3, Polio 3, and measles, and that the traditional model outperformed the direct model. Table 2 shows the target immunization rates and the rates achieved by the three delivery models. In contrast to the results on immunization coverage, the direct model outperformed the traditional model on other measures of service delivery (e.g. coverage of prenatal care, growth monitoring, and proportion of children under two years of age with diarrhea who received ORT). In terms of weighted average costs, the direct model (less than \$15 per service) outperformed the traditional model (less than \$20), which in turn outperformed the mixed model (more than \$20). However, for the average number of services delivered by the provider type, the direct model achieved better results (over 1,000 services per month) than the mixed model (over 800) and the traditional model (less than 600).

One possible reason that the traditional model outperformed the direct model in immunization coverage is because it operated with MSPAS staff. Since the MSPAS was responsible for delivering the vaccines, it is likely that the traditional model would have an advantage in terms of access to vaccines. The disadvantage of the direct model not having direct access to MSPAS staff to facilitate vaccine delivery would also be exacerbated by the fact that it mostly operated in harder to reach areas. The mixed model did not have this potential problem, since NGOs operating under the mixed model had immediate access to an assigned MSPAS staff, who could facilitate the logistics of getting the vaccines from MSPAS to the NGOs.

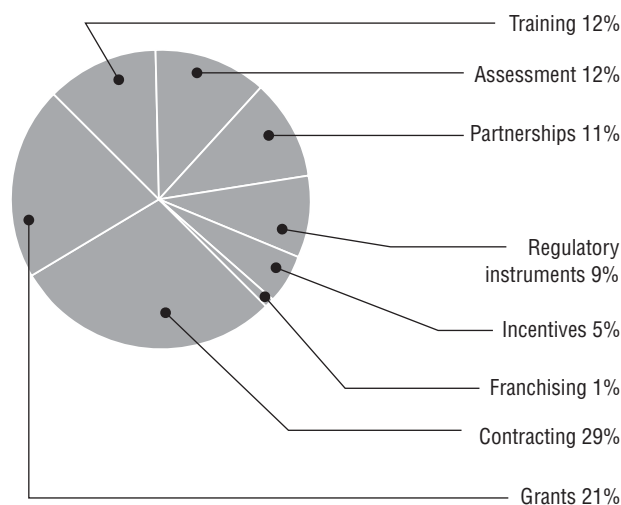
**Table 1. Services Provided in Basic Health Package**

<i>Type of Services</i>	<i>Specific Services</i>
Child Health	<ul style="list-style-type: none"> <li>• Growth monitoring</li> <li>• Immunization</li> <li>• Treatment of ARI</li> <li>• Treatment of diarrhea</li> </ul>
Maternal and Reproductive Health	<ul style="list-style-type: none"> <li>• Antenatal care</li> <li>• Attended delivery</li> <li>• Post-delivery care</li> <li>• Family planning</li> <li>• Supplementation</li> </ul>
Adult Health	<ul style="list-style-type: none"> <li>• Treatment of malaria</li> <li>• Treatment of dengue</li> <li>• Treatment of tuberculosis</li> <li>• Treatment of diarrhea</li> <li>• Emergency care</li> </ul>
Environmental Health	<ul style="list-style-type: none"> <li>• Preventive activities</li> <li>• Education</li> </ul>

**Table 2. Performance—Immunization Indicators**

<i>Percentage of Children &lt; 5 with:</i>	<i>Target</i>	<i>Traditional Model</i>	<i>Mixed Model</i>	<i>Direct Model</i>
BCG	95	83	87	78
DPT 3	95	69	80	63
Polio 3	95	70	82	66
Measles	95	54	61	51

Figure 7: Distribution of Mechanisms Used in Projects that Involved the Private Sector



tion or distribution sectors. Such partnerships provide a method of involving the private sector in delivering public goods or services and/or securing the use of assets necessary to deliver public services. PPPs also provide a vehicle for coordinating with nongovernmental actors to undertake integrated, comprehensive efforts to meet community needs. The structure of the partnership varies, to take advantage of the expertise of each partner, so that resources, risks and rewards can be allocated in a way that best meets clearly defined public needs (New Brunswick government, undated). PPPs are becoming increasingly common in provision of health services.

*Training* consists of education or instruction related to needed knowledge and skills. Training in the projects consisted of educational activities aimed at improving the clinical and managerial skills of the private sector, sometimes through “hands-on” and field-based training. In Peru, the Basic Health and Nutrition project provided training to private sector actors to help them implement project components (see also Box 1).

*Regulatory instruments* consist of assessment and potential revision of the legal framework, or provisions for enforcement aimed at altering the behavior of private actors in order to achieve identified policy objectives. Changes may include passing or amending a law requiring licenses to operate as a health professional, or requiring facilities to have needed equipment in order to operate. This mechanism can also include deregulation efforts that seek to remove excessively cumbersome constraints, for example pertaining to the procedures to establish an NGO. Regulatory instruments in the projects consisted of assessment of, and sometimes change in, the legal framework aimed at improving the quality of care delivered by private practitioners and by easing regulations for private actors to get involved in the health sector. In Uganda, the District Health Services Pilot and Demonstration project encouraged private investment in the health sector by financing a study to review existing regulatory barriers to entry and to establish minimum standards.

Changing *incentives* is another way to alter the behavior of private actors. Incentives can be either positive (“carrot”), in rewarding changed behavior, or they can be negative (“stick”), by punishing those who continue existing undesirable behaviors. Changed incentives can be implemented via use of either financial or non-financial mechanisms. Incentives of private actors under the projects were targeted using both financial benefits (such as tax breaks or credits), or non-financial (such as creation of community goodwill towards private companies).

Under a *franchising* agreement<sup>3</sup> a government agency grants a license to an organization where the latter undertakes certain services, often in a specified geographical region. The franchisee usually recovers its cost through sales of the services (at least to some portion of the users), and benefits from the association with the government or program in terms of expanded demand for its services. In Bangladesh, the Health and Population project is exploring the provision of

3. This definition refers to franchising done under the auspices of the public sector. For a more general definition please see: <http://franchising.cibercafe.pt/english/info.html>.

health services through franchising with selected and specially trained private providers, who would commit to agreed quality of care standards and to fee schedules affordable to low-income groups.

#### 4.5. Did the Projects Provide Safeguards to Protect the Poor?

In 26 projects (43%), engagement of the private sector was part of efforts to reform the delivery of health services. It is important to address equity issues when working through the private sector to improve child health outcomes, to diminish the costs paid by households when they buy private goods or services. Several projects contained measures to protect the poor, for example through health insurance,

risk sharing, subsidies for the poor, and targeted public expenditures. It was not possible to ascertain from the project documents if this was specifically related to increased participation of the private sector, or if it was part of the overall project design, regardless of whether services were delivered by the public or private sector.

#### 4.6. How was Private Sector Participation Monitored and Evaluated?

27 of the projects (44%) included process measures to gauge the involvement of the private sector. They measured, for example, the number of revised regulations and licensing procedures, the number of contracts with the private sector, the number of licensed

#### Box 6: Using Comparative Advantage of NGOs with Social Fund Grants—Guinea-Bissau

In 1993, Guinea-Bissau was facing severe health problems with high mortality and morbidity rates. The infant mortality rate was officially 140 per 1000 live births, but may have been closer to 180 per 1000. A majority of births took place in the home without the assistance of any health workers. There was a lack of water and sanitation and personal hygiene is poor. The health system was negatively affected by a lack of adequately trained health personnel. Health facilities were poorly maintained and lacked the most basic supplies.

The main objective of the *Social Sector Project in Guinea-Bissau* was to improve the delivery capacity and quality of primary health care, especially for vulnerable groups like women and children in rural areas. It used the proven effectiveness and strengths of NGOs and grassroots organizations for implementation of project components. These local organizations had the ability, and a proven track record, to manage projects in the country's diverse cultural patterns and language complexities.

The mechanism for involving NGOs was the establishment of a Social Action Fund (SAF)<sup>4</sup>, situated within an existing umbrella institution that coordinates activities of NGOs. The fund provided *grants*, training and support to NGOs that submitted qualified proposals for small-scale, socially oriented projects such as income-generating activities, nutrition programs, maternal and child health, family planning activities, and literacy and skills development. The main target groups were women and children. The goal was that these interventions would improve health and social indicators.

The project also encouraged collaboration between local and international NGOs. Such arrangements allow the local NGOs to benefit from the experience of the international NGOs, and to develop organizational, managerial and administrative skills for project development and implementation.

The Implementation Completion Report (ICR) stated that the impact of the SAF component in terms of health indicators was modest because only 59 micro-projects were financed, and only a third of those funded health projects. However, the report also argued that the project had demonstrated appropriate approaches and mechanisms to reach the poor. Furthermore, it was recommended in the “Lessons Learned” section that NGOs can and should play an important role in expanding primary health care and prevention. The report also suggested that public/private partnerships and the contracting out of services might be a prerequisite for expansion of health care services, especially in contexts where institutional capacity of the public sector is limited.

4. For more information on how Social Funds can be used in development projects, see [www.worldbank.org](http://www.worldbank.org) (Click on Development Topics > Social Protection and Labor > Social Funds).

private providers, the number of new legal frameworks in place for pharmaceutical firms, the percentage of districts with NGO-provided health services, and the number of new delivery mechanisms tested.

It is notable that the indicators only measured the level of involvement of the private sector, and not how this involvement may have influenced child health outcomes. An example of an indicator that could measure the influence on child health would be a measure of available stocks of essential drugs in private pharmacies.

#### **4.7. Was Engaging the Private Sector Part of the Project Objectives?**

In general, the impression was that the most projects did not explicitly explore the full private sector potential to improve child health outcomes in the country. 14 of the projects (23%) stated objectives to utilize the resources of the private sector.



---

## 5. Feedback from HNP Task Managers and HNP Anchor

---

In addition to providing feedback on findings specific to their projects, task managers also offered general comments based on their experience and expertise in Bank operations. One of their main observations and one that is shared by task managers is that there is a need to increase the engagement of the private sector in child health programs. For example, in the LAC region, multiple actors operate in the health sector, which leads to inefficiencies, duplication and misallocation of scarce resources such as infrastructure, technology, and human resources. By harnessing the private sector and by focusing its involvement in areas where it has a comparative advantage, projects in client countries can help governments free scarce resources for its most important function—stewardship of the overall health sector.

Task managers also expressed frustration with the lack of concrete tools for developing strategies to involve the private sector to improve child health outcomes. One task manager had identified the need to engage the private sector and had identified contracting and regulatory instruments as possible avenues to

work with the private sector, but lacked the tools to do it in the most effective and efficient way. He suggested that the development of evidence-based concrete tools would benefit operational staff in efforts to engage the private sector. Another task manager proposed that—in addition to the development of toolkits and guidelines—regional seminars would be a useful way of sharing examples of successful strategies for engaging the private sector within the Bank.

Task managers and HNP anchor staff also stressed the importance of demonstrating successful examples of engaging the private sector in child health components of Bank projects. These comments emphasize the dual challenge of identifying effective mechanisms to engage private actors in child health programs *and* structuring a Bank project to implement or support engagement with private actors. Regional seminars could be one way of sharing knowledge, but even more powerful would be learning programs and demonstrations in the field of how to effectively engage the private sector to improve child health outcomes.



---

## 6. Conclusions and Recommendations

---

**A**s measured by the proportion of projects engaging the private sector in child health components, private sector participation was significant. More than half of the reviewed projects engaged the private sector in project components to improve child health outcomes. Many different private sector actors implemented a range of activities and were engaged through various mechanisms.

However, as measured by the magnitude of involvement, private sector participation was mostly of a relatively small degree. Activities implemented by the private sector were often not part of core project components, as measured by funding allocations and the stated intentions of the project documents. Overall, it appears that private sector activities were minor components of public sector dominated projects.

The need for a more systematic approach to private sector participation emerged from the review. Since many project documents did not mention any systematic assessment of the private sector, it is a bit difficult to know whether private sector participation was intentional or a result of seizing opportunities at the time of project design. However, based on the lack of stated objectives to involve the private sector, it appears that private sector engagement was often not deliberate. It is difficult to analyze how the involvement of the private sector influenced child health outcomes, as project indicators related to the private sector measured process and not outcomes.

Given the role of the private sector in delivering child health services and its influence on child health outcomes, it is clearly necessary that we improve its engagement in Bank projects. To ensure effective engagement, it is critical to figure out which approaches lead from private sector engagement to better health for children.

Bank staff and its clients working in this area should have increased support to deal with policy

and project related issues on child health and the private sector. Support could be provided in the form of training and “how-to” materials such as manuals or toolkits, and through field demonstrations of successful strategies to engage the private sector.

To provide relevant information for decision-making, it is crucial to conduct systematic assessment of the potential of the private sector. To this end, it would be useful to develop basic guidelines for assessing the role of the existing private sector in influencing child health outcomes. Once opportunities have been identified, guidelines for designing projects with effective mechanisms to engage the private sector can serve as a useful tool for policy-makers and project managers.

Since engaging the private sector is relatively new within the context of Bank projects, it is critical to gain a better understanding of the connection between private sector activities and child health. More importantly, we must find out how the project components affected the private actors and through them, child health outcomes. Therefore, indicators both for process and outcomes need to be developed and included in project design and implementation.

To address the financial burden for the poor of paying for private goods and services, projects should incorporate provisions for health insurance, risk sharing, subsidies for the poor, and targeted public expenditures, as deemed appropriate for the specific country context.

Expanded efforts to identify appropriate ways of engaging the private sector to strengthen child health programs should be undertaken in continued collaboration with the Bank's development partners such as Ministries of Health, WHO, PAHO, UNICEF, USAID, bilateral donors, and NGOs. Finally, dialogue and collaboration with the private sector should naturally be encouraged.



---

## References

---

- Ahmad, O., Lopez, A.D. and M. Inoue. (2000) "The Decline in Child Mortality: A Reappraisal." *WHO Bulletin*, 78(10): 1175-1191.
- Bustreo, F., Harding, A. and H. Axelsson. (2002) *Can Developing Countries Achieve Adequate Improvements in Child Health Outcomes Without Engaging the Private Sector?* WHO Bulletin, forthcoming.
- Claeson, M. and R.J. Waldman. (2000) "The Evolution of Child Health Programmes in Developing Countries: From Targeting Diseases to Targeting People." *WHO Bulletin*, 78(10): 1234-1245.
- Claeson, M., Mawji, T. and C. Walker. (2000) *Investing in the Best Buys: A Review of the Health, Nutrition, and Population Portfolio, FY 1993–1999*. Washington, DC: World Bank.
- Gwatkin D.R. (2000) "Health Inequalities and the Health of the Poor: What Do We Know? What Can We Do?" *WHO Bulletin*, 78(1): 3-18.
- Gwatkin D.R., Rutstein S., Johnson K, Pande R.P., Wagstaff, A. (2000) *Socio-economic Differences in Health, Nutrition, and Population*. Washington, DC: World Bank.
- Hanson, K. and P. Berman. (1998) "Private Health Care Provision in Developing Countries: A Preliminary Analysis of Levels and Composition." *Health Policy and Planning*, 13(3): 195-211.
- Harding, A. (2003) "Introduction to Private Participation in Health Services", in Harding, A. and A.S. Preker (eds.), *Private Participation in Health Services*. Washington, DC: World Bank.
- Harding, A. and A.S. Preker (eds.) (2003) *Private Participation in Health Services*. Washington, DC: World Bank.
- Kaur, I. and Z. Tzannatos. (2002) *The World Bank and Children: A Review of Activities*. Washington, DC: World Bank.
- La Forgia, G. and I. Danel (2002) *Large Scale Contracting Out of Basic Health Services for the Poor in Guatemala: Results, Processes and Lessons Learned*. Washington, DC: World Bank.
- Marek, T. *et al.* (1999) "Successful Contracting of Prevention Services: Fighting Malnutrition in Senegal and Madagascar." *Health Policy and Planning*, 14(4): 382-389.
- New Brunswick Government (undated). *Public Private Partnerships*. Department of Finance, undated. The document is available on the Web at [www.gov.nb.ca/0158/reports/protocol/protocol.htm](http://www.gov.nb.ca/0158/reports/protocol/protocol.htm).
- Nieves, I., G. La Forgia, and J. Ribera (2000). "Large-scale Government Contracting of NGOs to Extend Basic Health Services to Poor Populations in Guatemala, in Rosenmoller, M. (ed.), *Challenges of Health Reform*. Washington, DC: World Bank, Inter-American Development Bank, Caja Costarricense de Seguro Social, University of Navarra.
- Smith E. *et al.* (2001) *Working with Private Sector Providers for Better Health Care—An Introductory Guide*. London: London School of Hygiene and Tropical Medicine and Options Consultancy Services Ltd.
- Taylor, R. (2003) "Contracting for Health Services", in Harding, A. and A.S. Preker (eds.), *Private Participation in Health Services*. Washington, DC: World Bank.
- Wagstaff, A. (2001a) *What Do Poor Children Die From? Some Evidence from Cebu, The Philippines*. Draft. Washington, DC: World Bank.
- Wagstaff, A. (2001b) *Paying for Health Care: Quantifying Fairness, Catastrophe, and Impoverishment, With Applications to Vietnam, 1993–1998*. Washington, DC: World Bank.
- Wagstaff, A., Bryce, J., Bustreo, F., Claeson, M. and H. Axelsson (2003) *Child Health: Reaching the Poor*. Prepared by the WHO-World Bank Child Health and Poverty Working Group.
- Waters, H., Hatt, L. and H. Axelsson (2002) *Working with the Private Sector for Child Health*. Prepared for the SARA Project and the Inter-Agency Working Group on Private Participation and Child Health. Washington, DC: World Bank.



# Annex 1

## Reviewed Projects

Country	Year	Project Name	Sector	Document Reviewed	Private Sector Involvement	Private Health Expenditure (HE) as % of total HE
<b>Latin America and the Caribbean</b>						
Argentina	1994	Maternal and Child Health and Nutrition	HNP	SAR, ICR	NO	71.9
Argentina	1997	2nd Maternal and Child Health and Nutrition	HNP	PAD	NO	71.9
Argentina	2000	Public Health Surveillance and Disease Control	HNP	PAD	YES	71.9
Bolivia	1993	Integrated Child Development	EDU	SAR	YES	36.6
Bolivia	1999	Health Reform (APL)	HNP	PAD	YES	36.6
Bolivia	2001	Health Reform (APL)	HNP	PAD	NO	36.6
Brazil	1999	Disease Surveillance and Control	HNP	PAD	YES	55.9
Colombia	1993	Municipal Health Services	HNP	SAR, ICR	YES	44.8
Dominican Rep.	1998	Provincial Health Services	HNP	PAD	YES	61.3
Ecuador	1993	2nd Social Development Project Health and Nutrition	HNP	SAR, ICR	YES	54.1
Ecuador	1998	Health Services Modernization	HNP	PAD	YES	54.1
Ecuador	2000	2nd Social Development Project Health and Nutrition—Supplement	HNP	MEMO	YES	54.1
Honduras	1993	Nutrition and Health	HNP	SAR, ICR	YES	54.4
Mexico	1996	2nd Basic Health Care	HNP	SAR	NO	52.0
Nicaragua	1994	Health Sector Reform	HNP	SAR, ICR	YES	32.1
Nicaragua	1998	Health Sector Modernization	HNP	PAD	YES	32.1
Panama	1995	Rural Health	HNP	SAR	YES	32.3
Paraguay	1997	Maternal Health Child Health and Development	HNP	SAR	NO	68.0
Peru	1994	Basic Health and Nutrition	HNP	SAR, ICR	YES	61.0
Peru	2000	Health Reform Program—Phase I	HNP	PAD	YES	61.0
Venezuela	2001	Caracas Metropolitan Health	HNP	PAD	YES	38.1
<b>Sub-Saharan Africa</b>						
Benin	1995	Health and Population	HNP	SAR	NO	50.6
Burkina Faso	1994	Health and Nutrition (PDSN)	HNP	SAR, ICR	NO	68.8
Burundi	1995	2nd Health and Population	HNP	SAR	NO	83.0

Reviewed Projects (*cont'd*)

Country	Year	Project Name	Sector	Document Reviewed	Private Sector Involvement	Private Health Expenditure (HE) as % of total HE
Cameroon	1995	Health, Fertility and Nutrition	HNP	SAR, ICR	NO	79.9
Chad	1994	Health and Safe Motherhood	HNP	SAR	NO	21.4
Chad	2000	Health Sector Support	HNP	PAD	NO	21.4
Comoros	1994	Population and Human Resources	HNP	SAR, ICR	NO	31.4
Comoros	1998	Health Project	HNP	PAD	NO	31.4
Cote d'Ivoire	1996	Integrated Health Services Development	HNP	SAR	NO	67.6
Eritrea	1998	National Health Development	HNP	PAD	NO	N/A
Eritrea	2001	Integrated Early Childhood Development	EDU	PAD	YES	N/A
Ethiopia	1999	Health Sector Development	HNP	PAD	YES	58.4
Gambia	1998	Participatory Health, Population and Nutrition	HNP	PAD	YES	50.1
Ghana	1998	Health Sector Support	HNP	SAR	NO	61.4
Guinea	1994	Health and Nutrition Sector	HNP	SAR	NO	39.6
Guinea	1999	Population and Reproductive Health	HNP	PAD	YES	39.6
Guinea-Bissau	1993	Social Sector	HNP	SAR, ICR	YES	N/A
Guinea-Bissau	1998	National Health Development	HNP	PAD	YES	N/A
Kenya	1997	Early Childhood Development	EDU	SAR	YES	69.8
Lesotho	2000	Health Sector Reform	HNP	PAD	NO	N/A
Madagascar	1993	Food Security and Nutrition	HNP	SAR, ICR	YES	46.7
Madagascar	1998	Community Nutrition II	HNP	PAD	YES	46.7
Madagascar	2000	2nd Health Sector Support	HNP	PAD	YES	46.7
Mali	1999	Health Sector Development	HNP	PAD	YES	51.4
Mauritania	1998	Health Sector Investment	HNP	PAD	YES	71.1
Mauritania	1999	Nutrition, Food Security and Social Mobilization	HNP	PAD	YES	71.1
Mozambique	1996	Health Sector Recovery	HNP	SAR	YES	19.0
Niger	1997	Health Sector Development	HNP	SAR	YES	53.1
Senegal	1995	Community Nutrition	HNP	SAR, ICR	YES	41.6
Senegal	1998	Integrated Health Sector Development	HNP	SAR	YES	41.6
Senegal	2002	Nutrition Enhancement	HNP	PAD	YES	41.6
Sierra Leone	1996	Integrated Health Sector Investment	HNP	SAR	NO	83.4
Tanzania	2000	Health Sector Development	HNP	PAD	YES	58.0

Reviewed Projects (*cont'd*)

Country	Year	Project Name	Sector	Document Reviewed	Private Sector Involvement	Private Health Expenditure (HE) as % of total HE
Uganda	1995	District Health Services Pilot and Demonstration	HNP	SAR	YES	68.6
Uganda	1998	Nutrition and Early Childhood Development	HNP	PAD	YES	68.6
<b>Middle East and North Africa</b>						
Egypt	1998	Health Sector Reform	HNP	PAD	YES	52.6
Iran	2000	2nd Primary Health Care and Nutrition	HNP	PAD	NO	59.3
Jordan	1993	Health Management	HNP	SAR	NO	47.0
Lebanon	1995	Health Sector Rehabilitation	HNP	SAR	YES	80.1
Morocco	1996	Social Priorities Program Basic Health	HNP	SAR	NO	72.7
Yemen	1993	Family Health	HNP	SAR	NO	57.1
Yemen	2000	Child Development	EDU	PAD	YES	57.1
Yemen	2002	Health Reform Support	HNP	PID	NO	57.1
<b>Europe and Central Asia</b>						
Armenia	1998	Health Financing and Primary Health Care	HNP	SAR	NO	60.3
Bosnia-Herzegovina	1999	Basic Health	HNP	PAD	NO	N/A
Georgia	1996	Health	HNP	SAR, SUPPL.	NO	73.0
Kazakhstan	1999	Health Reform	HNP	PAD	NO	51.9
Kyrgyz Republic	1996	Health Sector Reform	HNP	SAR	NO	50.0
Latvia	1999	Health Reform	HNP	PAD	NO	38.3
Moldova	2001	Health Investment Fund	HNP	PAD	NO	32.7
Romania	1998	Child Welfare Reform	SP	PAD	YES	32.6
Russian Federation	1997	Health Reform Pilot	HNP	SAR	NO	27.8
Tajikistan	2000	Primary Health Care	HNP	PAD	NO	14.5
Turkey	1995	Second Health Project: Essential Health Services	HNP	SAR	NO	28.1
Turkey	1997	Primary Health Care Services	HNP	SAR, ICN	NO	28.1
Uzbekistan	1999	Health I	HNP	PAD	NO	15.6
<b>South Asia</b>						
Bangladesh	1995	Integrated Nutrition	HNP	SAR	YES	52.5
Bangladesh	1998	Health and Population	HNP	PAD	YES	52.5
Bangladesh	2000	National Nutrition	HNP	PAD	YES	52.5

Reviewed Projects (*cont'd*)

Country	Year	Project Name	Sector	Document Reviewed	Private Sector Involvement	Private Health Expenditure (HE) as % of total HE
India	1993	Integrated Child Development Services Project II	HNP	SAR	NO	85.0
India	1994	Family Welfare	HNP	SAR	YES	85.0
India	1997	Reproductive and Child Health Care	HNP	PAD	YES	85.0
India	1998	Woman and Child Development	HNP	PAD	NO	85.0
India	1998	Orissa Health Systems Development	HNP	PAD	YES	85.0
India	1998	Andhra Pradesh Economic Restructuring	Multi-sector	PAD	NO	85.0
India	1999	Maharashtra Health Systems Development	HNP	PAD	YES	85.0
India	2000	Immunization Strengthening	HNP	PAD	YES	85.0
India	2000	Uttar Pradesh Health Systems Development	HNP	PAD	YES	85.0
Nepal	1994	Population and Family Health	HNP	SAR, ICR	NO	76.5
Pakistan	1993	2nd Family Health	HNP	SAR, ICR	NO	76.4
Pakistan	1994	Social Action	EDU	SAR, ICR	YES	76.4
Pakistan	1996	Northern Health	HNP	SAR, ICR	YES	76.4
Pakistan	1998	2nd Social Action	EDU	PAD	YES	76.4
Sri Lanka	1997	Health Services	HNP	SAR	YES	51.0
<b>East Asia and Pacific</b>						
China	1994	Rural Health Workers Development	HNP	SAR, ICR	NO	59.2
China	1995	Comprehensive Maternal and Child Health	HNP	SAR	NO	59.2
China	1996	Disease Prevention	HNP	SAR	NO	59.2
China	1998	Basic Health Services	HNP	PAD	NO	59.2
China	1999	9th Health Project	HNP	PAD	NO	59.2
East Timor	2002	2nd Health Sector Rehabilitation and Development	HNP	PAD	YES	N/A
Indonesia	1993	3rd Community Health and Nutrition	HNP	SAR, ICR	YES	53.7
Indonesia	1995	4th Health Project	HNP	SAR	NO	53.7
Indonesia	1997	Intensified Iodine Deficiency Control	HNP	SAR	YES	53.7
Indonesia	1997	Safe Motherhood: a Partnership and Family Approach	HNP	PAD	NO	53.7
Indonesia	2000	2nd Water Supply and Sanitation for Low Income Communities	HNP	PAD	NO	53.7
Laos	1995	Health Systems Reform and Malaria	HNP	SAR	NO	51.6

Reviewed Projects (*cont'd*)

<b>Country</b>	<b>Year</b>	<b>Project Name</b>	<b>Sector</b>	<b>Document Reviewed</b>	<b>Private Sector Involvement</b>	<b>Private Health Expenditure (HE) as % of total HE</b>
Malaysia	1994	Health Development	HNP	SAR, ICR	NO	42.3
Malaysia	1999	Social Sector Support	SP	PAD	NO	42.3
Philippines	1993	Urban Health and Nutrition	HNP	SAR, ICR	YES	57.1
Philippines	1995	Women's Health and Safe Motherhood	HNP	SAR	NO	57.1
Philippines	1998	Early Childhood Development	HNP	SAR	YES	57.1
Vietnam	1996	National Health Support	HNP	SAR	YES	83.5
Vietnam	1996	Population and Family Health	HNP	SAR	YES	83.5



## Annex 2

### Worksheet of Findings—Projects that Involved the Private Sector in Child Health

*This worksheet summarizes the findings of the review and was used for calculations of data and for the figures. For an explanation of column headings, please refer to end of worksheet.*

Country	Year	Project Name	Degree of Private Sector Involvement	Mechanisms	Actors	Activities	Identification	Indicators	Focus on poor	Part of reform	Project Objectives
<b>Latin America and the Caribbean</b>											
Argentina	2000	Public Health Surv. & Disease Control	Minor	C, T	NGO	HP, OR	+	-	+	-	-
Bolivia	1993	Integrated Child Development	Moderate	C, G	NGO, PS	HS, T	-	+	+	-	+
Bolivia	1999	Health Sector Reform	Minor	C, T	NGO	Not specified	-	-	-	+	-
Brazil	1999	Disease Surveillance and Control	Minor	G, T	NGO	HS	-	+	+	-	-
Colombia	1993	Municipal Health Services	Minor	C	NGO, PS	BM, ST, T	-	-	+	+	-
Dominican Republic	1998	Provincial Health Services	Moderate	C	NGO, PP, PS	HS	-	+	+	+	-
Ecuador	1993	2nd Social Dev. Health Nutrition	Minor	P	FA, NGO	F, IEC	-	-	+	-	-
Ecuador	1998	Health Services Modernization	Moderate	C, F	NGO, PP	HS	-	+	+	+	-
Ecuador	2000	2nd Social Dev. Health Nutrition—Suppl.	Minor	P	FA, NGO	F, IEC	-	-	+	+	-
Honduras	1993	Nutrition and Health	Minor	Not specified	FA	N	-	-	+	-	-
Nicaragua	1994	Health Sector Reform	Minor	C, R	PF	DS	-	-	+	+	-
Nicaragua	1998	Health Sector Modernization	Minor	A, C, G, R	NGO, PF	DS, ST, T	-	+	+	+	-
Panama	1995	Rural Health	Minor	C	NGO,	N, T	-	-	+	-	-

Worksheet of Findings—Projects that Involved  
the Private Sector in Child Health (*cont'd*)

Country	Year	Project Name	Degree of Private Sector Involvement	Mechanisms	Actors	Activities	Identification	Indicators	Focus on poor	Part of reform	Project Objectives
Peru	1994	Basic Health and Nutrition	Moderate	C, I, P, T	NGO, PS	HS, N, OR, SM, ST, T	–	+	+	–	–
Peru	2000	Health Reform—Phase I	Moderate	A, C	NGO, PS	HS, IEC, ST	–	–	+	+	–
Venezuela	2001	Caracas Metropolitan Health	Minor	A	PS	Not specified	–	+	+	+	–
<b>Sub-Saharan Africa</b>											
Eritrea	2001	Integrated Early Childhood Dev.	Minor	Not Specified	NGO, PS	IEC	–	–	+	–	–
Ethiopia	1999	Health Sector Development	Moderate	A, C, R	NGO, PS	BM, HS	–	+	+	+	–
Gambia	1998	Participatory Health, Pop. Nutr.	Minor	A, C, T	NGO, PP, PS, RI	BM, F, OR, SM	–	–	+	+	–
Guinea	1999	Population and Reproductive Health	Minor	G, I	NGO	IEC, T	+	–	–	–	–
Guinea-Bissau	1993	Social Sector	Moderate	G, T	NGO	HS, N	+	+	+	+	+
Guinea-Bissau	1998	National Health Development	Minor	G, R	NGO, PS	BM, HP, SM	+	–	+	–	–
Kenya	1997	Early Childhood Development	Minor	C	NGO	N, T	+	–	+	–	–
Madagascar	1993	Food Security and Nutrition	Major	C, G	NGO, PS	BM, N	+	+	+	–	+
Madagascar	1998	Community Nutrition II	Minor	C, T	NGO, FA	F, N, SM	–	–	–	–	–
Madagascar	2000	2nd Health Sector Support	Minor	C, P	NGO, PS	HS, ST	+	+	+	+	–
Mali	1999	Health Sector Development	Minor	C, G, R	NGO, PF, PP	F, IEC, SM, T	+	+	+	+	–
Mauritania	1998	Health Sector Investment	Minor	I	NGO, PS	BM, OR	–	–	+	–	–

**Worksheet of Findings—Projects that Involved  
the Private Sector in Child Health (cont'd)**

Country	Year	Project Name	Degree of Private Sector Involvement	Mechanisms	Actors	Activities	Identification	Indicators	Focus on poor	Part of reform	Project Objectives
Mauritania	1999	Nutrition, Food Sec. & Social Mobilization	Moderate	C, G, I, T	NGO	HP, IEC, N, ST, T	+	+	+	-	+
Mozambique	1996	Health Sector Recovery	Minor	C, P	NGO	BM, T	-	-	-	-	-
Niger	1997	Health Sector Development	Minor	A, C, P, R	CF, NGO, PF, PS, RI	BM, DS, HP, HS, OR, ST, T	+	-	-	-	+
Senegal	1995	Community Nutrition	Major	A, C, G, P, T	CF, NGO, PS	F, HS, IEC, N, OR, SM, ST, T	+	-	+	-	+
Senegal	1998	Integrated Health Sector Dev.	Moderate	A, C, G, P	NGO, PF, PS	DS, HS, N, OR, ST, T	-	+	+	+	-
Senegal	2002	Nutrition Enhancement	Moderate	C, T	NGO, PS	HP, IEC, N, SM	+	-	+	-	-
Tanzania	2000	Health Sector Development	Moderate	A, C, G, R	NGO, PS	HS	-	+	+	+	-
Uganda	1995	District Health Services Pilot Demo.	Major	A, C, I, R, T	NGO, PS	HS, ST, T	+	+	-	+	-
Uganda	1998	Nutrition & Early Childhood Dev	Moderate	C, G	CF, NGO	ST	+	+	+	-	+
<b>Middle East and North Africa</b>											
Egypt	1998	Health Sector Reform	Minor	C	CF, NGO, PF, PS	Not Specified	-	-	+	+	-
Lebanon	1995	Health Sector Rehabilitation	Moderate	C, G, T	NGO	HS	+	+	+	+	-
Yemen	2000	Child Development	Moderate	A, C, P	PS, NGO	HS	-	-	-	-	-
<b>Europe and Central Asia</b>											
Romania	1998	Child Welfare	Minor Reform	G	NGO	HS	+	+	+	-	-

Worksheet of Findings—Projects that Involved  
the Private Sector in Child Health (*cont'd*)

Country	Year	Project Name	Degree of Private Sector Involvement	Mechanisms	Actors	Activities	Identification	Indicators	Focus on poor	Part of reform	Project Objectives
<b>South Asia</b>											
Bangladesh	1995	Integrated Nutrition	Major	A, C, G	NGO	N, SM, ST, T	+	-	+	-	-
Bangladesh	1998	Health and Population	Major	C, F, G, I, R	NGO, PP, PS, RI	HS, OR, T	+	+	+	+	+
Bangladesh	2000	National Nutrition	Moderate	C	NGO	HP, N, ST	+	-	+	-	-
India	1994	Family Welfare	Moderate	G	NGO	HS, IEC, SM	+	+	+	-	+
India	1997	Reproductive and Child Health Care	Moderate	C	NGO, PS	HS, IEC, T	-	-	+	+	-
India	1998	Orissa Health Systems Development	Minor	A, C, P, T	NGO, PS	IEC	+	-	+	+	-
India	1999	Maharashtra Health Systems Dev.	Minor	A, C, R, T	NGO, PP, PS	IEC	+	-	+	+	-
India	2000	Immunization Strengthening	Minor	G, P	NGO, PP, PS	HS, SM	-	-	+	-	-
India	2000	Uttar Pradesh Health Systems Development	Moderate	A, C, G, P, R	NGO, PP, PS	HS, T	-	+	+	+	+
Pakistan	1994	Social Action	Minor	G, P	NGO, PS	HS	+	+	+	+	-
Pakistan	1996	Northern Health	Major	G, T	NGO	HS, IEC, SM, ST, T	+	+	+	-	+
Pakistan	1998	2nd Social Action	Moderate	C, G, P	NGO, PS	HS	-	+	+	+	+
Sri Lanka	1997	Health Services	Minor	G, T	NGO, PS	HP, N, ST	-	+	-	-	-
<b>East Asia and Pacific</b>											
East Timor	2002	2nd Health Sector Rehab. and Dev.	Moderate	G	NGO	HS	+	-	+	-	-

**Worksheet of Findings—Projects that Involved  
the Private Sector in Child Health (cont'd)**

Country	Year	Project Name	Degree of Private Sector Involvement	Mechanisms	Actors	Activities	Identification	Indicators	Focus on poor	Part of reform	Project Objectives
Indonesia	1993	3rd Community Health and Nutrition	Minor	A, G	NGO	HS, T	-	-	+	-	-
Indonesia	1997	Intensified Iodine Deficiency Control	Minor	R	PS	F	-	+	-	-	+
Philippines	1993	Urban Health and Nutrition	Minor	C, G, P	NGO, PS	HS, IEC, N, ST, T	-	-	+	-	+
Philippines	1998	Early Childhood Development	Minor	G	FA	F, N	-	-	+	-	-
Vietnam	1996	National Health Support	Minor	A	PS	HS	-	-	+	-	-
Vietnam	1996	Population and Family Health	Minor	G, I, R, T	NGO, PS	HS	-	-	-	-	-

**Explanations of Column Headings:**

**Mechanisms:** A = Assessment of Private Sector, C = Contracting, F = Franchising, G = Grants, I = Incentives, P = Public/Private Partnerships, R = Regulatory Instruments, T = Training

**Actors:** CF = Consulting Firms, FA = Food and Agriculture Industry, NGO = Non-Governmental Organizations, PF = Pharmaceutical Firms or Pharmacies, PP = Private Providers, PS = "Private Sector", RI = Research Institute

**Activities:** BM = Building & Maintenance, DS = Procurement/distribution of Drug Supply, F = Food Fortification/diversification and Production, HP = Health Promotion, HS = Health Services, IEC = Information, Education and Communication, N = Nutrition Services, OR = Operational Research, SM = Social Mobilization and Marketing, ST = Supervision and Technical Assistance, T = Training

**Identification:** Did the project describe how private sector actors were identified? ("+" = YES, "-" = NO)

**Indicators:** Did the project include indicators for measuring the involvement of the private sector? ("+" = YES, "-" = NO)

**Focus on poor:** Did the project include interventions targeted to the poor? ("+" = YES, "-" = NO)

**Part of reform:** Was the project part of a reform of the health sector? ("+" = YES, "-" = NO)

**Project objectives:** Was it mentioned explicitly anywhere in the section on project objectives that the project aimed to involve the private sector? ("+" = YES, "-" = NO)



# Annex 3

## Questionnaire Format

**Country:** \_\_\_\_\_

**Project:** \_\_\_\_\_

**Year:** \_\_\_\_\_

**Document:** \_\_\_\_\_

Question	Yes (check)	No (check)
<i>General</i>		
Does the project include child health components?		
Does the project engage the private sector in child health components?		
<i>Objectives</i>		
Do the objectives explicitly include strategies to involve the private sector?		
Is involving the private sector a substantial component of the objectives?		
<i>Activities</i>		
Does the private sector implement program components?		
What part of the private sector is involved?		
Is it in charge of implementing these components, or are the components assigned to the private sector by the government? (Yes = in charge, No = assigned by government)		
List what kind of activities the private sector is doing (i.e. service provision, drug supply, bed-nets distribution, health promotion etc.).		
Do the activities include using (partnering with) the private sector to change household behavior?		
If yes, how?		
Are any activities specifically focusing on the population in lower quintiles of the income distribution?		
If yes, how?		
<i>Process</i>		
How is the private sector assessed and how are private providers identified?		
What mechanisms are used to involve the private sector (i.e. incentives, regulation reform, contracting etc.)?		
<i>Health Sector Reform</i>		
Are activities involving the private sector part of a health sector reform?		
<i>Monitoring and Evaluation</i>		
Are there indicators to measure the involvement of the private sector?		
If yes, what kind of indicators?		
Is the private sector involved in evaluation of the outcomes of the development objectives?		
<i>Additional information</i>		
List any additional comments		







HEALTH, NUTRITION,  
AND POPULATION



HUMAN DEVELOPMENT NETWORK

THE WORLD BANK

---

**About this series...**

This series is produced by the Health, Nutrition, and Population Family (HNP) of the World Bank's Human Development Network. The papers in this series aim to provide a vehicle for publishing preliminary and unpolished results on HNP topics to encourage discussion and debate. The findings, interpretations, and conclusions expressed in this paper are entirely those of the author(s) and should not be attributed in any manner to the World Bank, to its affiliated organizations or to members of its Board of Executive Directors or the countries they represent. Citation and the use of material presented in this series should take into account this provisional character. For free copies of papers in this series please contact the individual authors whose name appears on the paper.

Enquiries about the series and submissions should be made directly to the Editor in Chief Alexander S. Preker ([apreker@worldbank.org](mailto:apreker@worldbank.org)) or HNP Advisory Service ([healthpop@worldbank.org](mailto:healthpop@worldbank.org), tel 202 473-2256, fax 202 522-3234). For more information, see also [www.worldbank.org/hnppublications](http://www.worldbank.org/hnppublications).



**THE WORLD BANK**

1818 H Street, NW  
Washington, DC USA 20433  
Telephone: 202 477 1234  
Facsimile: 202 477 6391  
Internet: [www.worldbank.org](http://www.worldbank.org)  
E-mail: [feedback@worldbank.org](mailto:feedback@worldbank.org)

ISBN 1-932126-74-0