An organisational typology of public-private engagement for health in Southern Africa: A systematic review

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Preamble
Abstract

In Southern Africa, as elsewhere, public-private engagement (PPE) for the provision and financing of healthcare is considered a pervasive and valuable mechanism for meeting the health needs of the population. A wide range of mechanisms for engagement are available, each with organisational models that make them suited to overcoming particular barriers in particular health system contexts. The extent to which a PPE initiative produces the desired outcome is largely dependent on the organisational structure of the collaboration. This study uses scoping and systematic review methods to develop a typology of PPE models visible in Southern Africa and investigate the organisational variations between them. While a variety of PPE models are utilised in the current Southern African context, donor-dependency remains high and there is room to expand engagement of this sort by adopting more innovative mechanisms for engagement and organisational models. An account of the models of PPE being initiated in the Southern African context constitutes a first step toward an analysis of the effectiveness of various mechanisms, and points the way to areas of possible expansion of efforts to engage with the non-state health sector to more effectively align goals in the interest of public health. To some extent, possible models are determined by country context and state capacity. Nonetheless private resources for health, including capital, human resources and technical capacity of for-profit and not-for-profit non-state health sector organisations, represent a rich source of health systems resources that could be more fully utilised through more innovative PPE initiatives for delivery and financing of health care.
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Lastly, I would like to express thanks to my friends Isabella Kentridge and Ben Stanwix whose support has been priceless.
Preamble

Plagiarism declaration

I, Eleanor Beth Whyle (WHYLEE001), hereby declare that the work on which this dissertation/thesis is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

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University of Cape Town, March 2015
Dissertation Contents

Preamble

Part A: Dissertation Protocol

Part B: Literature Review

Part C: Journal Article Manuscript
Acronyms and Abbreviations

ACHAP  African Comprehensive HIV/AIDS Partnerships
ALAFA  Apparel Lesotho Alliance to Fight AIDS
CHI    community health insurance
CHM    Community Hospital Management
DBFO   design, build, finance and operate
DFID   Department for International Development
DoH    Department of Health
DP     dual practice
EC     emergency contraception
ECP    emergency contraception pill
FBO    faith-based organisation
GAVI   Global Alliance for Vaccines and Immunisation
GEMS   Government Employees Medical Fund
GFATM  Global Fund to Fight Aids, Tuberculosis and Malaria
GHI    global health initiative
GPPP   global public private partnership
HPSR   health policy and systems research
LMIC   low-and-middle income country
MoH    Ministry of Health
MOU    Memorandum of Understanding
NDoH   National Department of Health
NGO    non-governmental organisation
NPO    non-profit organisation
PDS    part-time district surgeon
PEPFAR  The United States President’s Emergency Plan for AIDS Relief
PFI  private finance initiative
PPE  public-private engagement
PPIP  public-private integrated partnership
PPM  public-private mix
PPP  public-private partnership
PSI  Population Services International
RWOPS  remunerated work outside the public sector
SFH  Society for Family Health
SWAp  sector-wide approach
UNICEF  United Nations International Children's Emergency Fund
VCT  voluntary counselling and testing
WHO  World Health Organisation
Part A: Dissertation protocol

A framework of organisational models for engagement between state and non-state providers and financers for health in Southern Africa: A systematic review

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Student Number: WHYELE001

MPH: Health systems
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**Introduction:**

“The private sector must be an integral part of any solution to providing more equitable health care to all people” (IFC 2011; p. xiv)

**The state of health systems in Southern Africa**

Health system functioning in Africa is in urgent need of improvement (IFC 2011). However, the region, particularly more southern countries, is characterised by a scarcity of resources for health (IFC 2008; IFC 2011; Streefland 2005). Most Southern African countries have insufficient public health infrastructure and reliance on external resources for health is increasing in Southern African countries (Foster 2012). A large portion of all health services in the region are provided by private-sector health care workers, and as such, increasing engagement between public and private sectors is key to improving health service delivery in the region (IFC 2008; IFC 2011). Given the realities of health systems in Africa, the public sector alone cannot, and perhaps cannot be expected to, shoulder the burden of directly providing health services (IFC 2011).

**The role of the private sector**

As depicted in Figure 1 below, only three of the countries in Southern Africa devote at least fifteen percent of government expenditure to health\(^1\) (World Health Organization 2014). As a result, the private health sector constitutes a large component of the health sector in sub-Saharan Africa (IFC 2011). For the purposes of this study, the ‘private sector’ is assumed to include to all health providers and financers that are not subject to the direct control of the state (Foster 2012). The health systems of most low-and-middle-income countries (LMICs)

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\(^1\) Zimbabwe is excluded from this chart due to the lack of available data.
constitute mixed systems in which out-of-pocket payments and for-profit service provision exists alongside a public, state-funded health system (Nishtar 2010). In Southern Africa, an average of thirty-seven percent of total health expenditure is private expenditure from households, private insurance schemes, charitable donation and private corporations (The World Bank 2014). Of this, almost forty percent was paid out-of-pocket by households, amounting to thirteen percent of total health expenditure comprising of out-of-pocket payments (The World Bank 2014).

**Figure 1: Government Expenditure on Health in Southern Africa**

![Government expenditure on health as a percentage of general government expenditure](image)

(Source: World Health Organisation 2014)

In Namibia and South Africa, the private health sector caters primarily to the privately insured and private health insurance constitutes a key form of health financing (Foster 2012; IFC 2011). However, in other Southern African countries the private sector constitutes an important source of care for the poor and vulnerable (Lange et al. 2008; Patouillard et al. 2007). It is important to note that while the rich and the poor tend to access different types of private providers – with the poor more likely to utilise informal and lower quality private
services – the private health sector as a whole is as common a source of care among the poorest quintiles in Africa as it is among the rich (Hanson et al. 2008; IFC 2011). Across Africa, the distribution of public and private provision of health care remains almost equally divided across all wealth quintiles (IFC 2011). In sub-Saharan Africa, half of all health care spending, and half of all health services originate in the private sector (IFC 2011).

As such, the private sector presents a significant source of much needed financial capital, intellectual capacity and human resources that can be harnessed for the delivery of public services (IFC 2011; Smith et al. 2008). This constitutes “a tremendous opportunity to leverage the private sector in ways that improve access and increase the financing and quality of health care goods and services throughout Africa” (IFC 2008; p. iii).

Public-private engagement

Up until the 1980s the state was commonly understood to be the rightful primary provider of health services in LMICs (Buso 2004). In the late 1980’s however, recognition of the limited capacity of LMICs to increase public spending on health, led international agencies to propose an alternative health system organisation: a reduction of government spending for health and a greater role for the nongovernment sector (Akin et al. 1987; Buso 2004). Although many of the reforms suggested at this time have since been discredited (McIntyre et al. 2007; Buso 2004), public-private engagement (PPE) for health remains an integral component of many health systems in both developed and low-and-middle income contexts (Buso 2004). PPE can be understood as deliberate engagement or collaboration between the private health sector and the government, that is systematic (goes beyond individual interventions and programmes), and is in accordance with national health priorities (IFC 2011). Governments worldwide are increasingly stressing the importance of private sector
involvement for the development, financing and provision of health system infrastructure and service delivery (Roehrich et al. 2014). In South Africa, for example, the National Health Act aims to “promote a spirit of cooperation and shared responsibility” between the public and private health sectors and permits the public health sector to enter into contracts with private practitioners (Republic of South Africa 2004; p. 4).

**What is public-private engagement?**

Engagement between public and private health sectors can be defined as “the deliberate, systematic collaboration of the government and the private health sector according to national health priorities, beyond individual interventions and programmes” (IFC 2011). In this study, the ‘private sector’ is assumed to refer to all health providers and financers working outside the direct control of the state (Foster 2012). PPE includes for-profit and not-for-profit entities. As such, the definition includes for-profit hospitals, private health insurance, private health providers, private pharmacies, not-for-profit or faith-based organisations (Foster 2012), as well as providers of traditional medicine. Faith-based organisations have long been an integral component of health service provision in many of these Southern African countries (IFC 2011). However, public engagement with self-financing, or for-profit, providers is far less common, despite the fact that these account for the majority of non-state service provision (IFC 2011). This review will include both for- and not-for-profit private entities, although making this distinction is not the focus of this study.

It is also useful to distinguish between private financing components and private provision components (Foster 2012). Public sector provision may be included in this review to the extent that it is privately financed, either on the demand-side (for example through payments made by individuals covered by private health insurance) or on the supply side (through
donor funding). This is because PPE models of this sort constitute an important component of the health system in many countries.

PPE is not synonymous with privatisation. PPE represents a middle-ground on the spectrum between purely public management and full privatisation, the latter involving the irreversible transfer of ownership to the private sector (Cruz and Marques 2013; Rebeiz 2011). PPE arrangements involve a temporary or partial transfer of assets, or a sharing of the responsibility for service provision between the public and the private sector (Cruz & Marques 2011; Cruz and Marques 2013).

‘Public-Private Partnership’ (PPP) is a term used to specify a particular type of public-private engagement (IFC 2011). PPP can be defined as “a long-term contract between a private party and a government entity, for providing a public asset or service, in which the private party bears significant risk and management responsibility, and remuneration is linked to performance” (World Bank Group 2014; p. 14). In all PPPs the private party bears significant risk and a considerable responsibility for management (Widdus 2005). PPPs will be included in this analysis as a particular type of PPE, however, the analysis will not be limited to the strict definition commonly applied to PPPs and will consider engagement between the state and non-state organisations more broadly.

Widdus (2005) draws a distinction between partnerships or collaboration for product development, dealing with the development of drugs and vaccines, and those for improved access. Access-focused partnerships, including PPE for health financing and provision of health services, are the focus of this review. PPE initiatives for product development will not be included in this review for two reasons. Firstly their organisational model often differs
significantly from that of access PPE initiatives and as a result their inclusion would broaden the scope of this research beyond what is feasible. Secondly, PPE initiatives for product development are often large-scale PPPs involving large private entities and high-level government involvement. The focus of this review is therefore predominantly on local-level, small scale PPE initiatives reported in Southern Africa.

In the field of Health Policy and Systems Research (HPSR) – which examines the “organization, financing, and delivery of public health services within communities, and the impact of these services on public health” (Mays et al. 2003; p. 180) – PPE is commonly discussed as a mechanism for knowledge translation. Although the focus of this study is the “organisation, financing and delivery” of health services (see Mays et al. 2003; p. 180), PPEs for knowledge translation will not be discussed. Knowledge translation for public health involves expediting the implementation of research into practice and strengthening health services by bridging the gap between evidence based research and its implementation in health services (Knowledge Translation Unit 2013). As such, knowledge translation collaborations involve engagement between researchers, patients and service providers with the aim of improving the provision of services in accordance with the best available evidence. While PPE initiatives of this sort constitute an important area of collaboration between state and non-state actors, they will not be included in this review because, firstly their organisational structure tends to be very different from those of PPE initiatives with non-state health providers and financers, and secondly, they commonly involve institutions of higher education or national organisations (large organisations with substantial backing and resources), and as such do not constitute the small-scale, local level PPE that are the focus of this review.
The need for research on public-private engagement

In the last ten to fifteen years PPE initiatives have been said to have made a significant impact in the fight against diseases that disproportionately affect the poor (Widdus 2005). Additionally, non-state actors – including for-profit and not-for-profit organisations, as well as individuals – are often the predominant providers of primary health services in the majority of LMIC (Batley and Mcloughlin 2009). In recent years the discussion surrounding the value of public-private engagement for health has shifted from a polarised debate about whether the private sector is an appropriate sphere for the delivery and financing of health care, to a discussion that largely takes private sector involvement in health as a given, and asks how public-private cooperation can enhance the efficacy and efficiency of health systems (Buso 2004). Nonetheless, concerns about the role of the private sector in health are not uncommon. While some are opposed to the involvement of the private sector – particularly the for-profit sector – in health as matter of principle, others object on the basis of legitimate concerns regarding the difficulties of imposing consistent regulation and quality control on a sector as diverse and fragmented as the private health sector (IFC 2008). In sub-Saharan Africa, these difficulties of regulation have been said to lead to inconsistent quality and allow an unscrupulous minority of providers to prevail (IFC 2008).

However, while these concerns are legitimate, it is important to note that PPE, correctly implemented, presents an opportunity to control the actions of the private sector in the best interest of the public. As such, these concerns do not constitute a reason to abandon PPE altogether, but rather point towards the need for an improved understanding of PPEs as mechanisms to ensure that the private health sector acts in accordance with national priorities, and their effective implementation. Nonetheless, Roehrich et al. (2014) have found that despite the rising popularity of PPPs for health, in depth empirical investigations and
conceptualisations remain rare. Furthermore, significant variation exists in the organisational structure of PPE initiatives including motivations, contributions and expected benefits of the relevant partners (Widdus 2005). The volume and quality of information on the topic is insufficient for the development of ‘best practice’ guidelines for PPE (World Bank Institute 2012).

This study seeks to go some way towards a rectification of this lack of information by developing a typology of the organisational models of PPE initiatives for health in Southern Africa through a systematic review of the available literature. The typology, or conceptual framework will be an organisational device comprising of ideal types PPE that aid conceptual understanding but do not necessarily reflect PPE projects in reality. The term ‘typology’ was chosen to be reflective of the aim of this paper to systematically classify PPE initiatives according to organisational structure in order to facilitate comparative research (Wendt et al. 2009) and improve understanding more generally. It is hoped that through the development of a typology of PPE initiatives this research will contribute to increased private-sector involvement in health provision and financing in Southern Africa. Further it is the goal of this study to constitute a first step towards an analysis of the effectiveness of PPE initiatives in Southern Africa in improving health outcomes and access to care. A typology of the organisational models of PPE initiatives must be constructed before it will be possible to assess which PPE organisational model is most effective in various settings.

**Background**

**Research question**

What are the various organisational models for engagement between state and non-state providers and financers for health in Southern Africa?
Objectives of review

The aim of this systematic review is to identify and synthesise existing literature on PPE initiatives in order to develop a typology of organisational models of PPE initiatives, and to apply this typology to the Southern African context to examine the range and quantity of PPE initiatives in Southern Africa. It is hoped that this review will contribute to health system development in Southern Africa by facilitating private-sector involvement in health financing and provision. In addition, this review should constitute a first step towards an analysis of the effectiveness of various PPE organisational models in context.

Justification of review

The evidence base for health systems strengthening is insufficient (Gilson 2012) and many authors have pointed out the particular lack of comprehensive information on PPE initiatives for health (IFC 2011; Kivleniece & Quelin 2012; Roehrich et al. 2014). Relatively little is known about the particularities – including the roles and responsibilities of the various players – that constitute public-private sector engagement (IFC 2011). Roerich et al. (2014) also point out the shortage of studies that provide a holistic view of PPPs in health care delivery – that is, the role of PPE initiatives from a systems perspective. An improved understanding of public-private collaboration in Southern African health systems is necessary (IFC 2011).

This scarcity of comprehensive information on PPE for health is evident in the limited range and quantity of literature available on the topic of PPE for health in Southern Africa. An initial search in Scopus and AfricaWide was conducted to investigate the range and extent of existing evidence. Search terms included ‘public private partnership’ and ‘public private
engagement’ (or variations and abbreviations thereof) and ‘Southern Africa’ and the search was limited to health-related documents published since 2003. The search revealed 85 and 36 documents respectively. However, the majority of documents identified by the search were either focused on a particular disease or programme, involved investigation of a global partnership, utilised a case-study approach for the investigation of one particular PPE, dealt exclusively with collaboration for product development, or did not have a PPE focus at all. The initial search revealed no studies that reviewed or synthesised the existing evidence on PPE for health. One study \textit{Public-Private health sector mix – way forward} (Buso 2004) was found that used a review of the existing literature to conduct an assessment of different PPE models. However, this study was not systematically conducted and did not produce a comprehensive account of PPE models. In addition, this study was conducted in 2004, putting it at the outer edge of the renewed interest in PPE and making its evidence somewhat outdated.

The shortage of comprehensive information available in the published literature, combined with the importance of PPE to the efficient use of available resources and, ultimately, the good functioning of health systems in Southern Africa, indicate the need for studies such as this one. In order to foster improved health outcomes with a mixed public-private model governments should strive to find ways to stimulate the development of a responsible and responsive private sector for health (IFC 2008). Studies that give a comprehensive account of PPE organisation and functioning will go some way towards stimulating this development by educating practitioners, policy-makers and potential project managers of the range of organisational and financial models available to them. In addition, it is hoped that this review will constitute a first step towards developing a robust understanding of how the
organisational models of PPE initiatives contribute towards their sustainability and effectiveness.

Methodology

Approach to the review: Campbell Systematic Review

Literature reviews can be used for a number of purposes, including the identification of central issues within a field of study, critical analysis of existing evidence, and to make connections between related topics (Cooper 2010). Another potential goal of a literature review, and the ultimate aim of this study, is to integrate the work of others into a comprehensive overview (Cooper 2010).

A Campbell systematic review is a “methodologically sound review of the effects of a well-described intervention in a well-described population” (Hannes and Claes 2007; p. 749). Traditionally, systematic reviews are aimed at answering questions about the effectiveness of a particular intervention (Hannes and Claes 2007). For this review, given the limited information available on the organisational models for PPE initiatives and the effectiveness of PPE initiatives, that aim would beyond the scope of what is feasible. However, it is the intention that this review be a useful first step towards establishing how the organisational models of PPE initiatives impact their effectiveness. As such, the Campbell systematic review methodology is apt despite the fact that effectiveness of interventions will not be examined. This is precisely because using this methodology will ensure that the work done for this review is fit to be expanded upon at a later stage to gauge the effectiveness of different PPE organisational models.
A second reason for using the Campbell systematic review methodology is the capacity of this method to facilitate the use of a wide range of sources of evidence. The Campbell Collaboration focuses on the fields of crime and justice, education, and social welfare (The Campbell Collaboration 2009). These areas of investigation are regularly multi-disciplinary, and review methodologies accordingly require the searching of a wide range of databases. “Given the diverse nature of the research questions addressed in the social…sciences, potentially relevant studies are likely to be widely distributed and unreliably categorised” (Hammerstrøm et al. 2010; p. 9). Furthermore, this study is a health policy and systems research (HPSR) study in that the study investigates the financing, organisation and delivery of health services with the ultimate aim of contributing to health systems strengthening (Gilson 2012). By nature, HPSR is multi-disciplinary and incorporates evidence from a wide range of fields (Gilson 2012). In addition, a large percentage of research relevant to reviews in these fields is not regularly published in academic journals and must be located in government reports, dissertations, conference proceedings, and industry reports (Tranfield et al. 2003; Petrosino et al. 2001). “Policy-makers and managers increasingly require access to high-quality evidence synthesis that includes research and non-research evidence” (Mays et al. 2005; p. 18). Given that many PPE initiatives for health are not presented in health-related academic journals, or any academic literature, the Campbell review methodology, which involves searching a wide range of sources, including grey literature, is particularly fitting.

**Literature search strategy**

In conducting a Campbell systematic review, it is vital that multiple databases be included in the search. This is because no individual database hosts the entirety of related articles (Hammerstrøm et al. 2010). In addition, as a result of unstructured abstracts, or errors of categorisation, many relevant documents might not be retrievable within a particular database
This is especially problematic in searchers for non-clinical topics (Hammerstrøm et al. 2010). The use of multiple databases also guards against bias (Hammerstrøm et al. 2010). The need to minimise bias must be balanced against time and budget constraints. Hammerstrøm recommends remaining aware of publication bias and language bias, and striving to minimise their effects (Hammerstrøm et al. 2010).

One of the defining features of a Campbell review is that it includes grey literature (Campbellcollaboration.org 2014). Grey literature consists of literature that is not controlled by commercial publishers including government, academic and industry documents that are not formally published in books or journals (Hammerstrom et al. 2010). The inclusion of grey literature in this study will not only guard against publication bias, but will also ensure that PPE initiatives that do not have an academic component are nonetheless included in the review.

**Phase 1: scoping review**

“A comprehensive, unbiased search is one of the fundamental differences between a traditional narrative review and a systematic review” (Tranfield et al. 2003; p. 215). As such, the first step in conducting a systematic search for literature involves the identification of key words and search terms, which are built from a scoping study and the available literature (Tranfield et al. 2003). In line with this recommendation, and in order to ensure that all the relevant literature is identified in this study, the review methodology for this study will be divided into two phases. The first phase will consist of a scoping study to aid in the development of a more focused search strategy by facilitating the identification of relevant search terms and an appropriate search period (Roehrich et al. 2014).
To commence the scoping review, keyword searches in PubMed, AfricaWide, Scopus and Web of Science will be conducted. Search terms will include ‘public private partnership’, ‘public private engagement’ and ‘health’, as well as relevant variations thereof such as ‘public private sector collaboration’, ‘PPP,’ ‘health financing,’ and ‘health services’. The results of the search will be limited to reviews published in the last 10 years that focus on organisational models. Those that have a disease or programme focus will be excluded because it is unlikely that these reviews will include sufficient information regarding the organisational characteristics of the PPE in question. An iterative search based on the citations included in the selected studies will be carried out. The identified documents will be assessed, in order to determine the themes and codes used to describe and analyse the organisational models of PPE initiatives. This process will result in a set of preliminary codes (Cooper 2010). At this stage in the process, if it is judged necessary to further refine the search strategy, limited interviews would be conducted with knowledgeable colleagues and key stakeholders. Details on interview methods will be discussed below.

**Phase 2: Systematic search for instances of public-private engagement in Southern Africa**

The second phase of this study will consist of a systematic review of PPE for health in Southern Africa. The systematic review must include a “thorough, objective and reproducible search” that includes a range of sources (Lefebvre et al. 2008; p. 97). As such, a range of databases will be searched are PubMed, AfricaWide, Scopus, Web of Science, Business Source Premier, EconLit, Equinet and PAIS International (see Hammerstrøm et al. 2010). Google Scholar and Google will be searched to ensure that a broader range of non-academic literature is captured (see Lefebvre et al. 2008). However, the search function in these databases does not allow for multiple sets of search terms grouped by Boelean operators and
as such precludes a search strategy sufficiently detailed to be useful for the initial systematic search. As such, these databases will be searched at a later stage in the research process, to ensure that all available information on included PPE initiatives is accessed. The choice to include business-related databases as well as medical databases is justified by the need to ensure that the review includes the full range of available evidence. Some PPE initiatives for health are undertaken as business ventures and are not presented in medical journals.

The search strategy for the systematic review is informed by Hammerstrøm et al.’s guidelines on information retrieval for Campbell systematic reviews (2010). The choice of search terms will be based on the purpose of this study and the keywords identified by the initial scoping review. In addition, an iterative process will be used in which search terms will be refined on the basis of what has been retrieved in previous searches (Hammerstrøm et al. 2010; Lefebvre et al. 2008). Variant spellings, synonyms, related terms and truncations will be accounted for (Hammerstrøm et al. 2010; Lefebvre et al. 2008). In addition to natural language terms, standardised subject terms (controlled vocabulary search terms) will be included to ensure that relevant documents employing different terminology for the same concept will be identified (Hammerstrøm et al. 2010; Lefebvre et al. 2008). The thesauri of various databases will be scanned to ensure that the terms used in the search are reflective of alternative terminology and are sufficiently sensitive (Hammerstrøm et al. 2010). A similar search strategy will be conducted in each database, but search terms will be customised to reflect the standardised subject terms used in each database (Hammerstrøm et al. 2010). Lefebvre et al. (2008) recommend that an academic librarian or information specialist should be consulted while refining the search strategy. The input of a health sciences librarian will be sought for assistance in the clarification and finalisation of search terms.
For literature reviews focused on a particular intervention, the use of three sets of search terms is recommended (Hammerstrøm et al. 2010; Lefebvre et al. 2008). Hammerstrøm et al. (2010) recommend the three sets of search terms include: the condition of interest, the intervention of interest and, finally the population of interest. These sets of search terms can be modified for the present purpose. The first set includes the type of intervention; search term will include public-private engagement, public-private collaboration, and public-private partnerships. The second set specifies the intervention area of focus; in this case there are two areas of focus: health care delivery and health care financing. Finally, the third set of search terms will specify the geographic area of focus, in this case Southern Africa. Limiting commands, including the relevant time period and language, are then used to further refine the search. Hammerstrøm et al. (2010) note the use of many limiting commands greatly increases the risk of bias. As such, limitations will include only the language of the identified material and the date of publication.

Lefebvre et al. (2008) recommend including a wide variety of search terms within each set, but limiting the number of sets in the search strategy. The Boolean operator ‘OR’ will be used to join the terms within each set (See Lefebvre et al. 2008). Finally, ‘AND’ will be used to join the three sets. This search strategy may sacrifice a degree of sensitivity as any document that does not contain at least one term from each set will be excluded from the search results (see Hammerstrøm et al. 2010). This limitation is unavoidable given the time constraints of the study and as such will be acknowledged as a limitation of the study. While the ‘NOT’ operator could be used in the second set to exclude projects for research and development and projects for knowledge translation, Hammerstrøm et al. (2010) note that ‘NOT’ should be used only with extreme caution because it heightens the risk of excluding
relevant records inadvertently. As such, documents presenting the results of projects for research and development, and knowledge translation will be excluded manually.

Hammerstrøm et al. (2010) also note the importance of searching reference lists of identified studies for additional materials. This snowballing process goes some way to ensuring that studies using different terms to describe relevant concepts are identified by the literature search (Hammerstrøm et al. 2010). A snowballing process will be undertaken in which PPE initiatives referenced- and studies cited- in the review documents will be scanned for possible inclusion in the review. Should the snowballing search lead to PPE examples that are not written-up in academic journals but represent interesting or novel PPE organisational models these will be included in the review (with appropriate assessment of their rigor). This is important because many PPE projects are undertaken without academic involvement and the outright exclusion of all such PPE projects would bias the study and undermine the veracity of the resulting framework. Because the intention of this study is to give an up-to-date account of PPE organisational models, the search will be limited to studies published since 2004.

Full identification of all relevant information requires a combination of electronic searching and hand searching (Hammerstrøm et al. 2010; Lefebvre et al. 2008). Because hand searching is labour intensive, Hammerstrøm et al. (2010) recommend manual scanning of the most current issues of journals in which a large number of relevant studies have been found. This ensures the inclusion of studies that may not yet have been indexed (Hammerstrøm et al. 2010). In this study, searches will be conducted for existing reviews in the Campbell Library, as well as the Cochrane Library. These reviews will be used to identify any additional documents, as well as to ensure that saturation has been reached. Records will be kept of all
search terms, combinations, databases and results (see Lefebvre et al. 2008). The literature search should result in a list of articles, papers and reports on which the review and synthesis will be based (Tranfield et al. 2003). The search strategies for each database used will be included in an appendix using a database worksheet template as recommended by the Campbell Collaboration (Hammerstrøm et al. 2010).

The search strategy will be documented in full and reported in the review. For each search conducted I will record the search strategy, as well as the search set numbers and the number of records retrieved (Hammerstrøm et al. 2010). The number of records retrieved will be recorded in the ‘results’ section of the review (Hammerstrøm et al. 2010).

**Additional interviews**

It is anticipated that an additional layer of key informant interviews could be necessary to inform this systematic review process. Should additional information for guiding the review process be judged necessary (after the first stage of review), telephonic or in-person semi-structured interviews with key informants will be conducted. These interviews would be used to inform the search strategy for the literature review. In addition, key stakeholders may provide valuable feedback on the organisational typology of PPE that is developed as a part of this review. Furthermore, should the initial search reveal any new or ongoing PPE initiatives that have not yet been published, interviews with key stakeholders could provide crucial information, thereby enabling the inclusion of these PPE initiatives in the review. These will focus on the organisational models of PPE in South Africa. Interviews will not be recorded but extensive notes will be taken and these notes will be reviewed and recorded electronically as soon as possible after completion of the interview. The notes from Phase 2 interviews with PPE participants will be analysed and synthesised along with the documents.
identified by the systematic review. Interview guides for interviews with knowledgeable colleagues, to be held in Phase 1 can be found in Appendix 1. This guide will be further developed on the basis of Phase 1 of this study. Furthermore, the interview is semi-structured and as such, will be adapted to some extent as the interview takes place. An interview guide for interviews with key PPE stakeholders and participants, to be conducted as part of Phase 2 can be found in Appendix 2.

Should these interviews be undertaken, written consent will be attained. The consent form can be found in Appendix 3 below. An information sheet including a summary of the study, and the researchers’ information will be disseminated beforehand. This information sheet can be found in Appendix 4 below. Confidentiality will not be applicable as no questions of a personal or sensitive nature will be discussed.²

**Review selection and inclusion criteria**

There is little consensus regarding how the appraisal of study quality for systematic reviews of both qualitative and quantitative evidence, and there is no simple hierarchy of evidence quality that applies to all research methods and sources of evidence (Mays et al 2005). Furthermore, most review methodology guidelines focus on reviews that aim to establish effectiveness of interventions or cost-effectiveness. However, research in the field of HPSR is expanding the purview of health system research to include methodologies that are able to tackle topics such as the financing, organisation, delivery and use of health systems, and the factors that underlie the failure or success of health systems with regarding to achieving population health goals and producing wider social value (Gilson 2012). This review seeks to

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² In conducting this study it became clear that the information on organisational models of PPE initiatives for health available in the literature was sufficient, and it was decided that interviews to further inform the typology would not be necessary at this time. As such, no interviews were conducted in either phase of this study.
synthesise the available information on PPE with respect to organisational models and does not aim to establish the effectiveness of these various models. As such, the inclusion criteria for documents will not include the strength of evidence for effectiveness presented in the document. The inclusion criteria for this review are based predominantly on whether the document in question contains sufficient information that is relevant and appropriate to the study aim. The inclusion criteria for documents can be found in Table 1 below.

Articles to be included in this study will be limited to those published since 2004. This choice reflects the need to ensure that the final report provides an up-to-date account of PPE organisational models and recognition of the fact that research on PPE is conducted in the context of an ever-changing policy and regulatory environment. In addition, because of up-swing in interest in PPE in recent years, this cut-off point is unlikely to exclude many studies.

Only articles that provide sufficient information on the organisational model of the PPE in question will be included. The sufficiency of the information included will be determined on the basis of the coding guide. Documents that provide information pertinent to the organisational model of the PPE in questions will be included in the review. However, due to the lack of detailed accounts of PPE organisational models in the literature, it may be necessary to include documents that only give information on the outcomes of the PPE, or the implementation process of the PPE project. In such cases, snow-balling and reference tracking will be used to identify the missing information. However, snow-balling and citation tracking is only possible if the original article contained sufficient particulars of the PPE in

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3 In conducting the systematic review it became apparent that many documents identified through the search strategy contained only limited information on the relevant PPE project. Because the exclusion of these documents would have eliminated a number of relevant and interesting PPE projects, these documents were included and snow-balling and citation-tracking used to identify documents containing further information on the PPE in question. As such, the final inclusion criteria was broader than that described here.
question, such as the name of the PPE, or the name of PPE partners and the location of the PPE. As such, articles that do not include this information will be excluded. Articles identified through snowballing and citation tracking will be included. PPE projects based in countries other than the Southern African region will be excluded.

Table 1: Inclusion criteria

<table>
<thead>
<tr>
<th>Issues to Consider</th>
<th>Inclusion Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>nature of the intervention</td>
<td>All PPE initiatives for financing and/or delivery of healthcare will be included. All documents that contain sufficient information on the organisational model and financing of the PPE will be included. Available information must include the source of funding, and the number and type of project functions transferred to the non-state party. Documents that contain insufficient information will be included on the condition that the information available is sufficient to allow for identification of the PPE in question in articles identified through snowballing and citation-tracking. PPE initiatives at all levels of the health system will be included, and all types of patients/users, providers and financers will be included.</td>
</tr>
<tr>
<td>geographic area</td>
<td>PPE initiatives implemented in Southern Africa will be included.</td>
</tr>
<tr>
<td>language of publication</td>
<td>Due to resource constraints, only documents in English will be included.</td>
</tr>
<tr>
<td>period of publication</td>
<td>January 2004 to current</td>
</tr>
<tr>
<td>inclusion of grey literature</td>
<td>Grey literature will be included</td>
</tr>
<tr>
<td>study designs</td>
<td>All study designs, and non-study material such as annual reports will be included.</td>
</tr>
</tbody>
</table>

(adapted from Hammerstrøm et al. 2010)

Data extraction

Deciding what data to abstract can be a difficult task (Thomas and Harden 2008). For this reason, the initial review of the literature will be used to assist in determining the themes relevant to a description and classification of the organisational structure of a PPE. As mentioned above, a coding guide will be developed on the basis of the initial broad literature review, and refined through interviews and test-applications. During Phase 1 of the research, the identified documents will be scanned in order to determine the analytical themes or coding categories used to describe and analyse the organisational models of PPE initiatives. These codes will form the basis of the analysis of the documents to be included in the review. In order to ensure the appropriateness of the coding guide, a few key documents to be
included in the review will be analysed using the coding guide. Necessary modifications or inclusions will be made.

In order to reduce human error and bias, a data extraction form will be used (see Tranfield et al. 2003). A preliminary example of the data extraction form can be found in Appendix 6 below. However, the data extraction sheet will be further developed on the basis of the scoping review. The data extraction sheet will allow of the categorisation of the various PPE projects identified through the review according to key organisational characteristics and will be used to guide the analysis. The data extraction sheet will serve two functions, it will be used to guide the analysis, and facilitate data management. A codebook will be developed containing categories that reflect the broad themes, or analytical themes, of PPE organisational models and variables within those categories (Mouton 2012).

Background reading for this project has indicated that possible code categories include the apportioning of risk between partners; the division of responsibilities; financing sources; the extent to which the goals and values of the various partners are shared, incentives, contracting and payment mechanisms (Roehrich et al. 2014); the number and type of project functions transferred to the non-state party (World Bank Group 2014); and the societal sphere from which partners originate (such as academic, civil society or industry) (Widdus 2005).

It is suggested that the data extraction process should involve the coding of each document by more than one researcher, and that codes derived from a single text by multiple coders should be triangulated to ensure that the coding strategy is both sufficiently detailed and sufficiently precise to capture all the relevant information correctly (Cooper 2010; Mouton 2012). Because this strategy is precluded by the resources available for this project, two alternative
strategies will be used to ensure the validity of the results. Firstly, the supervisor of this thesis will offer advice and guidance in the formation of the coding strategy and coding sheet. Secondly, each document will be coded by the reviewer twice to ensure that all the relevant information is captured correctly in the coding sheet.

Data analysis and synthesis: Narrative synthesis with thematic analysis

Narrative synthesis

Once the systematic search has been completed and all relevant documents identified, the process of analysing and synthesising the data will begin. All materials will analysed in the same way.

The term ‘synthesis’ refers to “the stage of the review when the evidence extracted from the individual sources in brought together” (Mays et al. 2005; p. 7). A narrative approach will be used to analyse and synthesise the data from the systematic review and transcripts from interviews with PPE participants. Narrative synthesis is a common method for the synthesis of research in systematic reviews (Rodgers et al. 2009). The use of narrative synthesis is fitting for the aims of this research for two reasons. Firstly, traditional narrative reviews present findings from published studies and other sources without attempting to transform these findings into a common metric for further analysis (Mays et al. 2005). However, a narrative synthesis is an approach that can be used to synthesise evidence from multiple sources, going beyond simple analysis, and allowing the researcher to summarise and interpret the evidence (Mays et al. 2005). Secondly, the use of a narrative approach to data synthesis is prescribed for studies in which the review questions necessitate the inclusion of
Part A: Dissertation protocol

evidence from a large range of study-types and non-research evidence (Mays et al. 2005). A narrative review is an apt approach for the synthesis of mixed sources of evidence (Mays et al. 2005), facilitating the incorporation of diverse forms of evidence into the systematic review (Rodgers et al. 2009). As such, a narrative synthesis well suited given the goals of this review.

Thematic analysis

Narrative approaches to data synthesis commonly utilise thematic analysis of the evidence (Mays et al. 2005; Popay et al. 2006). The strengths of thematic analysis consist in its capacity to draw conclusions across heterogeneous studies on the basis of common elements (Lucas et al. 2007), making it particularly apt for use in the current study. Thematic analysis will be used to analyse the results of the systematic literature review (Phase 2). This method involves the identification of key, or primary, concepts from studies and the translation of these concepts into generic terms that reflect similar concepts described in different language in different texts, the translated concepts are then used to explore similarities and differences between texts (Thomas and Harden 2008; Popay et al. 2006).

The first step in the thematic synthesis consists of the coding process (Thomas and Harden 2008). A line-by-line coding process will be used. A line-by-line coding process facilitates the translation of concepts from one text into a generic code that encompasses all the primary documents (Thomas and Harden 2008). The line-by-line coding process also constitutes the first step in synthesising the data under review (Thomas and Harden 2008). The review articles will be read and information relating to the organisation and financing of the PPE will be noted. In a thematic analysis the themes identified are based on the aim of the review (Mays et al. 2005). Codes will be assigned wherever the document describes some aspect of
the organisational model of the project. Coding will continue until all information relevant to the organisational structure of the PPE under review has been identified.

Codes that pertain to similar aspects of organisational structure will be grouped into themes (Aveyard 2010), with each theme constituting an aspect of organisational structure, such as funding, division or responsibility between parties, or aims and goals. The thematic categorisation of codes will continue until all codes have been categorised. At this stage, the veracity of the analysis will be confirmed by locating the codes in the context of the review articles to ensure that they have been accurately categorised, and by ensuring that each category or theme is representative of all the codes subsumed within it (Aveyard 2010). This process will increase the rigour of the analysis, which is vital given than the coding process will not be triangulated between researchers.

A key task in the synthesis of literature is the translation of study-specific ideas into generic concepts (Thomas and Harden 2008). Translation can be achieved through the use of line-by-line coding, and the organisation of these codes into descriptive themes (Thomas and Harden 2008). This review aims not merely to synthesise information contained in the literature but rather to offer a novel interpretation of the findings that represent the field as a whole. As such, the next stage in the data analysis will involve going beyond themes identified in the primary texts to generate new knowledge based on a synthesis of the evidence under review (Thomas and Harden 2008). For the purposes of this review, this stage will consist of the development of the typological organisation of PPE projects in Southern Africa. This stage of the process is “dependent on the judgement and insights of the reviewers” (Thomas and Harden 2008; p. 7). Aveyard (2010) recommends a close examination of the themes that have been developed and the possible connections between them. The connections between codes
in the original documents will be used to inform this process, as such, the thematic analysis will be enhanced by triangulation with original documents at each stage of the process (Aveyard 2010). The framework to be developed will be inferred from a synthesis of the information contained in all the primary texts under review.

There is concern that thematic analysis lacks transparency as a result of a failure to distinguish between data-driven approaches and theory-driven approaches (Thomas and Harden 2008). The approach described herein uses a combination of both approaches but does so in a way that is fully transparent and replicable. The initial review of the broader literature will facilitate the construction of a theory: a theoretical set of analytical themes that are hypothesised to capture the information in the primary texts under review. The coding process of discovering descriptive themes in the texts themselves will be data-driven. These descriptive themes will then be synthesised using the set of analytical themes established during the initial stages of the review.  

### Rigour

In order to ensure the reliability of the study results methodological rigour must be maintained during each stage of the research including the literature search and the data analysis. Mays et al. (2005) suggest mechanisms for ensuring rigour in systematic reviews. These include clarity in describing the aim of the review, explicit and comprehensive description of the methods – such that another researcher could repeat the review using the same methods, justification of the methodological choices made, and, finally, ensuring that

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4 In conducting this study it became clear that the scope of the study was such that the data extraction and analysis process described here would involve the analysis of more information than would be possible to present in the findings. As such, a more a simplified thematic analysis process was utilised.
the sources of evidence used in the review are appropriate to the review question (Mays et al. 2005).

**Literature search**

With respect to the literature search, a number of mechanisms will ensure rigour of the study. Firstly, the triangulation of the search strategy and coding guide with information from knowledgeable colleagues will have a positive effect on the rigour of this study. Secondly, the use of multiple databases will assist in guarding against publication bias (Hammerstrøm et al. 2010). Similarly, the inclusion of grey literature will not only guard against publication bias, but will also ensure that PPE initiatives that do not have an academic component are nonetheless included in the review.

Objective selection criteria will be used and the inclusion or exclusion of documents will be overseen by the project supervisor. Nonetheless (for the reasons described above), since grey literature that is not necessarily peer-reviewed will also be included in this study, it may at times be difficult to judge the quality of the study methodologies. Since an additional reviewer is beyond the scope of this project, there is some opportunity for subjectivity in the selection of evidence to be included. This is acknowledged as a limitation and efforts will be made to guard against subjectivity in the selection of material. In addition, because the inclusion criteria of this study stipulates that only documents that provide sufficient information on the organisational model of the PPE under consideration will be included, the decision to exclude documents may be subjective and open to interpretation of the researcher. This might result in a selection bias of the documents to be included in the review. This risk will be mitigated through the development of the coding guide mentioned above. Documents that provide information on the relevant codes will be included in the review.
Unfortunately the inclusion of data presented in languages other than English is beyond the scope of this review. As such, language bias will undoubtedly affect the study results. This is acknowledged as a limitation of this study.

**Data analysis**

A detailed account of the techniques used in the narrative synthesis and thematic analysis has been provided above in order to allow readers to assess the quality of the methodology employed in this study and to increase the validity and generalisability of the study results. As mentioned above, rigour with regard to the coding of evidence will be ensured through advice and guidance from the supervisor of this thesis during the development of the coding strategy and coding sheet, and through coding each document twice to ensure that all the relevant information is captured correctly in the coding sheet. Furthermore, as has been noted, during the analysis process, codes will be located within original documents before being categorised under themes, thereby ensuring that they have been accurately categorised, and that the theme is adequately representative of the code subsumed within it (Aveyard 2010).

**Ethical considerations**

It is possible that this study will involve interviews with a few key stakeholders. In order to ensure that the data included in the report does not violate the autonomy of participants, a consent form will be utilised. Aside from the protection of the autonomy of the interviewees, there are no further ethical considerations. It will not be necessary to maintain the
confidentiality of participants as no sensitive or personal information will be discussed and participants will only be consulted in their professional capacity.5

**Risks and benefits**

There are no direct benefits for participants in this study. However, PPE participants interviewed in Phase 2 of this study might enjoy some minimal benefit when the study results are disseminated to them upon study completion. The benefits of this study more broadly are significant: the study will further knowledge of PPE in Southern Africa, and enable further research into the effectiveness of these initiatives.

This is a low risk study. Because all interview participants are stakeholders within the field of public-private engagement for health, there is little risk of a power-imbalance developing between the researcher and study participants. Overall, the benefits of this study outweigh the risk of possible harms.

**Study limitations**

This study has a number of limitations, some of which are already highlighted above. Firstly, there is a risk of selection bias. Because a scoping study methodology does not stipulate the quality of studies to be included in the review (Arksey and O'Malley 2005), and allows for the inclusion of information from sources that are not peer-reviewed, there is a risk that the quality of the data will be sub-standard. Although this is a significant risk, in the relatively new field of PPE for health, the value of including information that has not been peer-reviewed outweighs this potential risk. In addition, because the review does not aim to assess

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5 As noted above, stakeholder interviews were not included after assessment of their usefulness and the availability of literature after Phase 1 of this research. This protocol in Part A therefore reflects the original design as planned in the early phases of the research – Part B and C reflect the method as was conducted.
the relative value of any particular PPE organisational model, the inclusion of data that has not been peer reviewed will not unduly affect the value of the study. Lastly, the literature search will be limited to databases to which UCT has access. This may result in the exclusion of some relevant studies if the actual article cannot be accessed.

**Timeline**

The review will begin in November 2014. Due to the relatively narrow scope of this review, and the likely scope of available evidence, this review will involve an intensive rapid process. If necessary, interviews will be conducted between November 20th and December 20th in order to ensure that interviews are completed before the festive season. The final write-up will begin in February 2015 and be completed in March 2015.

<table>
<thead>
<tr>
<th>Component</th>
<th>Activity</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part A: Protocol</strong></td>
<td>Subject formulation</td>
<td>August 2014</td>
</tr>
<tr>
<td></td>
<td>Draft</td>
<td>September 2014</td>
</tr>
<tr>
<td></td>
<td>Edits</td>
<td>September 20th to November 1st</td>
</tr>
<tr>
<td><strong>Part B: Literature Review</strong></td>
<td>Scoping review and refining search strategy</td>
<td>November 1st to November 20th</td>
</tr>
<tr>
<td></td>
<td>Interviews with knowledgeable colleagues</td>
<td>November 20th to November 25th</td>
</tr>
<tr>
<td></td>
<td>Systematic literature search</td>
<td>November 25th to December 10th</td>
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<tr>
<td></td>
<td>Interview with key PPE stakeholders</td>
<td>December 10th to December 30th</td>
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<tr>
<td></td>
<td>Data extraction and analysis</td>
<td>December 30th to January 15th</td>
</tr>
<tr>
<td><strong>Part C: Journal Article</strong></td>
<td>Drafts</td>
<td>January 15th to February 10th</td>
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<tr>
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<td>Intension to Submit</td>
<td>February 10th</td>
</tr>
<tr>
<td></td>
<td>Submission</td>
<td>March 16th</td>
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</tbody>
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(Source: Author)

**Budget**

This study is self-funded. Aside from the incidental costs mentioned below, no additional resources will be required. The principle investigator declares no conflict of interest.
Table 3: Budget

<table>
<thead>
<tr>
<th>Category</th>
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<td>Notebooks</td>
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<td>Petrol</td>
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</tr>
<tr>
<td>Total</td>
<td></td>
<td>R 1 140</td>
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</tbody>
</table>

(Source: Author)

Dissemination

The results of the study will be disseminated in thesis format as well as in the form of a summary article intended for publication in a suitable journal with a readership of public and private sector practitioners, financers and policy makers. Findings are also likely to be shared at private health sector industry conferences such as the Board of Healthcare Funders annual conference, or, failing this, shared with key stakeholders, decision-makers, and NGOs and NPOs for health. In addition, the findings of the study will be shared with study participants including knowledgeable colleagues and PPE participants.
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Part A: Dissertation protocol

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Appendices

Appendix 1: Interview with knowledgeable colleagues/key informants (Phase 1)

Approach

Interviewees will be presented with the information sheet prior to the interview. Consent will be obtained using the consent form in Appendix C.

Interviewees will be presented with a list of key concepts for the organisational models of PPE for health in Southern Africa, and the search strategy developed on the basis of the initial scoping review.

The search strategy and key concepts will be discussed with respect to the extent to which they are in keeping with the interviewee’s experience of PPE organisational models in Southern Africa.

Extensive notes will be taken and these will be electronically recorded as soon as possible after completion of the interview.

Interview guide

What is your experience with PPE in Southern Africa?

Having examined the search strategy, would you recommend the inclusion of any additional terms?

In your experience, are other terms or phrases used to describe these concepts in other Southern African countries?

Would you recommend the inclusion of any additional variations on terms for health service provision or health financing?

Do you think these codes will capture the various aspects of PPE organisational models?
Would you like to share any further information?
Appendix 2: Interview with public-private engagement participants (Phase 2)

Approach

Interviewees will be presented with the information sheet prior to the interview.

Consent will be obtained using the consent form in Appendix C.

Interviews will be guided by the information on the organisational model of the PPE in questions obtained during the literature search.

The interview will be used to gather any information not available from the literature search.

Extensive notes will be taken and these will be electronically recorded as soon as possible after completion of the interview.

Interview guide

Is the primary goal of the PPE health service delivery or health financing?

What were the original goals of the project?

Are the goals shared between all partners?

If not, where/how do the goals differ between partners?

What values drive the project?

To what extent are the values shared between partners?

Is the PPE community-based?

How is the community involved?

Was the target community involved in the development of the project?

Is the community involved in management of the project

How is the project financed?

Is donor funding involved?

Is the project self-financing?
Part A: Dissertation protocol

How is the risk apportioned between partners in the project?

What are the incentives of the various partners?

What contracting and payment mechanisms are employed?

How many and what type of project functions are transferred to the non-state party?

In which sector/s are the various partners based (academic, civil society or industry)?

Do you consider the PPE to be successful?

What are the main impacts of the PPE?

Is there anything further you would like to share?
Appendix 3: Consent form for public-private engagement participants and key informants

University of Cape Town

Eleanor Beth Whyle: Minor Dissertation: Masters in Public Health: University of Cape Town

An Organisational Typology of Public-Private Engagement for Health in Southern Africa: A Systematic Review

Introduction

Health system functioning in Southern Africa is regularly inhibited by a lack of sustainable resources for health. Government expenditure on health is largely insufficient, and reliance on external and donor resources is high. Increasing engagement between public and private sectors is key to improving health system delivery in this context.

Increasingly governments in developed and low-and-middle income countries alike are using private sector involvement in the developing, financing and provision of health services. Despite the growing popularity of public-private engagement (PPE) for health, and the broad acceptance of PPE as an integral component of health systems, empirical research on the topic remains rare. The possibility of definitive answers to many questions surrounding PPE best practice is precluded by the dearth of information available on the topic.

This study aims to go some way towards rectifying this lack of information by developing a framework for understanding variations in organizational models of PPE for health in Southern Africa. The study will take the form of a comprehensive and systematic review of the available literature. The aim of the study is two-fold. Firstly it is hoped that making the
information on the organizational structure of PPE for health readily available will spur further interest among stakeholders in engaging in such initiatives. Additionally, this research will constitute a first step towards developing an understanding of how PPE initiatives for health might be organised to maximise effectiveness and sustainability.

The primary question of this review is as follows: What are the various organisational models for engagement between state and non-state providers for health in Southern Africa.

You are being asked to participate in this research by answering a few questions regarding the organisational models of PPE initiatives for health in Southern Africa on the basis of your experience in the field. I will not ask you to share any personal information with me. The interview will not take longer than one hour and will take approximately 30 minutes.

The interview will not be recorded but I will make extensive notes during the interview. I will share the results of the research with you upon completion of the study. Aside from this, you will not benefit from participating in the study.

You will not be provided any incentive to participate for remuneration for your participations. However, I very much appreciate your time. Please feel free to ask any questions at any time before, during or after the interview.

Contact details
University of Cape Town,
The Faulty of Health Sciences
Human Research Ethics Committee
E 52, Room 24, Old Main Building,
Groote Schuur Hospital,
Observatory, 7925
Telephone: +27 21 406 6492
Fax: +27 21 406 6411

Student Supervisor:

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School of Public Health and Family Medicine
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Student Researcher:

Eleanor Beth Whyle
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Vredehoek
Cape Town
Cell: 082 820 6809
Home: 021 462 3811
E-mail: eleanorbethwhyle@gmail.com
You have a right to contact the University of Cape Town, Faculty of Health Sciences Human Research Ethics Committee (HREC) if you have any questions or concerns about your participation in this research.

The Human Research Ethics Committee is situated in the Old Main Building of Groote Schuur Hospital, Floor E52, Room 23, Observatory, 7925.
Tel: +27 21 406 6492

Principle Investigator:  Dr Jill Olivier
Researcher:   Eleanor Beth Whyle
Name of Organization: University of Cape Town

Consent

I__________________________________ have been invited to participate in research regarding the organizational models of public-private engagement for health in Southern Africa.
I have read the foregoing information. I consent voluntarily to participate in this study interview.
Signature of Interviewee _________________
Date ____________________________

I _________________________________ confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant (if
any) have been answered to the best of my ability. I confirm that the individual has not been coerced into giving consent, and that consent has been given voluntarily.

A copy of this form has been provided to the participant.

Signature of Researcher /person taking the consent__________________________

Date ___________________________
Appendix 4: Information sheet for stakeholder interviews

An Organisational Typology of Public-Private Engagement for Health in Southern Africa: A Systematic Review

I am a post-graduate student at the University of Cape Town studying towards my Masters in Public Health, Health Systems. I would like your consent to interview you regarding organizational models of public-private engagement (PPE) initiatives for health in Southern Africa. You are being asked to participate in this study due to your wealth of knowledge on the topic. This interview will be used to supplement and support the literature review.

Purpose of the research

This aim of this study is to propose a framework by which to understand and analyse the organisational models of PPE for health. I hope that the results of this study will be useful to policy makers, practitioners and project managers who are involved in managing or building a PPE for health in Southern Africa. Further I expect that this research will constitute an imperative step towards the ultimate goal of an investigation of the interplay between organizational model and intervention effectiveness. Such a study is vital for evidence-based policy in the field.

Type of research intervention

This interview will be conducted either in person or telephonically. I will ask you questions regarding the organisational model of the PPE you are involved in. I will not take up more than 1 hour of your time.

Voluntary participation

Participation in this interview is entirely voluntary.
Procedures

If you consent to be interviewed, I will confer with you regarding a date and time (and, if the interview is in-person, a location) that is most convenient for you. Following the interview, you will have the opportunity to revoke any information you shared with me, or to stipulate if and how you are comfortable with the information being used. After the interview I will write-up a set of notes containing the information you shared with me. If you would like, I can share these notes with you so that you can be sure they accurately reflect your statements.

Confidentiality

The information you share with me will not be kept confidential. However, after the interview you will get the opportunity to revoke any information you have shared, or to ask that I not use any particular piece of information, or that a particular piece of information not be attributed to you.

Who to Contact

If you have any questions or concerns, please feel free to contact me.

Eleanor Beth Whyle: 082 820 6809
eleanorbethwhyle@gmail.com

Further contact details

University of Cape Town,
The Faculty of Health Sciences
Human Research Ethics Committee
E 52, Room 24, Old Main Building,
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Student Researcher:

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4 Clive Street
Vredehoek
Cape Town
Cell: 082 820 6809
Home: 021 462 3811
E-mail: eleanorbethwhyle@gmail.com
Part A: Dissertation protocol

You have a right to contact the University of Cape Town, Faculty of Health Sciences Human Research Ethics Committee (HREC) if you have any questions or concerns about your participation in this research.
Appendix 5: Diagrammatic representation of study phases

**Phase 1**
- Scoping review
- Thematic analysis to identify search terms
- Interviews with knowledgeable colleagues and/or industry experts
- Finalization of data extraction form and search strategy

**Phase 2**
- Systematic literature review on the basis of search strategy developed in phase 1
- Article selection
- Interviews with PPE stakeholders
- Data extraction of literature and interview material
- Data analysis and synthesis

**Phase 3**
- Formalisation of PPE organisational framework
- Presentation of results
## Appendix 6: Data extraction sheet

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(Source: Author)
Part B: Literature Review

A typology of models for public-private engagement in health: Key themes in understanding public-private engagement in practice

Eleanor Beth Whyle

Student Number: WHYELE001

MPH: Health systems
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Abstract

Public-private engagement (PPE) is an increasingly common phenomenon worldwide. The aim of PPE is to utilise the resources of the private sector to achieve public health goals. However, due to the exponential growth of these mechanisms in recent years, much ambiguity and confusion surrounds the models or types of PPE and how these differ from each other. This paper presents the results of a broad scoping study examining the various models of PPE. The study identified seven models of PPE. A typology of PPE models is presented with a focus on organisational aspects, and an example from the Southern African context presented for each PPE type. The paper interrogates the distinctions between PPE types with regards to organisational characteristics and discusses the theoretical benefits these particularities are intended to give rise to. Key themes, constituting important considerations in the analysis or implementation of any PPE model with a focus on organisational characteristics, are drawn out. Further conceptual clarity regarding PPE types is necessary not only in order to facilitate evaluative research of the various models, but also because the potential benefits of each model are realised as a result of organisational particularities, and as such an improved conceptual understanding of PPE models will ensure that these theoretical benefits are realised.
Background

The role of the non-state sector in delivery of health care and related services is significant (Bennett et al. 2005). In every country, the delivery of healthcare involves some form of public-private collaboration (McKee et al. 2006). In contexts where health care is delivered entirely through public means, other inputs, such as support services and pharmaceuticals, are privately sourced (McKee et al. 2006). Particularly in low and middle income countries (LMICs), the private sector represents an important source of care for poor or vulnerable groups (Bustreo et al. 2003; Makinen et al. 2000; Patouillard et al. 2007).

In recent years the trend towards greater private sector involvement in healthcare provision and financing, driven by insufficient public resources and poor performance of the public sector, is increasingly apparent in both developed and LMIC contexts (Lim 2004). There are numerous operational advantages to working with pre-existing, self-sustaining health organisations that have already achieved coverage of certain populations, or are well-placed to expand coverage (Patouillard et al. 2007). Non-state providers are often perceived by users to be more responsive to user preferences, and are often more geographically accessible than public providers (Bennett et al. 2005).

Governments are increasingly recognising the private health sector as a neglected resource and are interested in improving engagement with private providers to increase the coverage and quality of health services and mitigate the harms caused by ill-regulated private sectors (Peters et al. 2004). Interventions have been developed to address the technical and efficiency failures associated with private sector delivery, while simultaneously taking advantage of the potential for involving private providers to achieve public health goals (Patouillard et al.
2007). However, evidence for policy-makers, implementers and analysts regarding public-private engagement (PPE) in the health sector is limited.

PPE can be defined as deliberate and systematic collaboration, in accordance with national health priorities, between the state and the private health sector (IFC 2011). For the purposes of this study, the ‘private sector’ is understood to include all health providers and financers working outside the direct control of the state (Foster 2012) including for-profit and not-for-profit entities. This paper gives an overview of PPE models, along with examples from the Southern African context, with the aim of eliminating the conceptual ambiguities that pervade analysis of PPE. In addition, key themes and considerations regarding the implementation or analysis of various PPE mechanisms are discussed. Peters et al. (2004) suggest that strategies for PPE can be categorised into three groups: administrative approaches (regulation and training); public empowerment approaches (informing and educating the public); and, market-based approaches (influencing the behaviour of the private sector to promote the public interest). The focus of this scoping review is on market-based approaches. This choice was made partly as a result of the need for clarity regarding the types of market-based engagement (many of which share key features but are conceptually distinct in important ways), and partly due to the growing interest in innovative mechanisms for market-based engagement with the non-state health sector.

**Method: Scoping review**

This paper presents the results of a scoping review of mechanisms for public PPE in health care provision and financing. Scoping studies allow for mapping of key concepts and themes within a field of interest (Arksey and O'Malley 2005; Mays et al. 2001). The aim of this review is to examine and conceptually map PPE mechanisms and gain an understanding of
the available literature. The results of this search have been used to develop a typology of PPE mechanisms. The typology can be understood as a conceptual framework comprising of abstract representations or ideal types that will facilitate the classification of PPE initiatives on the basis of how closely they resemble these ideal types, thus clarifying the organisational differences between existing cases (Wendt et al. 2009). This scoping review was conducted to inform a more extensive systematic review (which is reported in Part C that follows).

The scoping review was conducted over a two-month period in 2014-2015. Four reference databases were searched: Scopus, AfricaWide, PubMed and Web of Science. The search was limited to the last ten years (2004-current) and to publications in English. No geographical limitations were imposed in this phase, although more extensive attention was placed on texts relating to Southern Africa. Search terms included broad terms for engagement between public and private sectors and terms for non-state sectors, such as ‘private sector and non-governmental organisation’. These were combined with the Boolean operator ‘AND’ with terms describing the delivery and financing of health care. Due to the broad search strategy, the number of search results was large. Title and abstract scanning of search results in each database facilitated the exclusion of articles relating to PPE initiatives for research and development, medical education and health information systems. In addition, outcome-focused papers describing PPE performance, the cost of projects or cost-effectiveness of a particular PPE initiative, and governance or administrative aspects of PPEs were excluded. Articles describing PPE initiatives in which the state partner was not a national, provincial or local state health authority or department were also excluded (such as PPE initiatives for health driven by the military other government departments), as were articles with a methodological focus, those focusing on the personal experiences of PPE actors, and those in which PPE is mentioned only in the conclusion as a recommendation.
290 documents were selected and collated in an EndNote database for ease of data management and to facilitate closer reading. After removal of duplicates the number of documents for review was 231. After an initial analysis, an iterative search process was used in which significant or important citations from key texts were identified, and the article they referenced included in the scoping review. At times the citation tracking process led to articles published prior to 2004 but that constituted a significant addition to the available literature. In order to ensure a thorough conceptual understanding of various PPE models, these documents were included.

Documents were read and data extracted in relation to two main topics: the various types and models of PPE prevalent in the literature (and the defining factors of these types); and key themes and considerations in the organisational design of PPE models.

A trend identified through the scoping study is the varied terms used to describe similar PPE models and the level of overlap and ambiguity between PPE types. As presented here, this ambiguity remains to a certain extent, but PPE types have been distinguished on the basis of important organisational differences, and the terms chosen to describe them represent the terms most commonly used in the literature. A typology of common PPE models is presented here with the aim of clarifying the organisational differences between them. Examples from Southern Africa are given for each PPE. The examples selected are those that best represent the type (rather than those that demonstrate variations within a type). A secondary consideration in selecting the examples was the amount of information available, since a fair degree of specificity is necessary to demonstrate the organisational characteristics of the model. Lastly, because the review included no geographical limitations, examples from the
Southern African context were selected in order to ensure the relevance of the review to local decision-makers.⁶

Results

Seven distinct PPE models were found in the current literature. Figure 1 below presents the various PPE models identified, along with key characteristics of each. Table 1 gives concise descriptions of the various PPE models, including definitions of the public-private partnership (PPP) sub-types identified through the scoping study. Each PPE model will be further elucidated below.

<table>
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<tr>
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<tr>
<td>Public-Private Partnership</td>
<td>The social marketing approach uses commercial sector marketing and communication approaches to 'sell' products of a high social or public health value, or to bring about behaviour change among a target population. Commonly use CBOs, NGOs, or public sector facilities to distribute products and often involve product subsidy and rely on external funding.</td>
<td>A long-term partnership between the state and a private consortium in which contracted services include infrastructure, non-clinical operations and clinical operations delivered to a specified segment of the population.</td>
</tr>
<tr>
<td>Social Marketing</td>
<td>Long-term contractual arrangement for the development, financing and/or provision of public infrastructure (and sometimes services), in which risk and management responsibility are shared.</td>
<td>This is a long-term contract in which the design, building financing and non-clinical operation of a facility, in accordance with public authority requirements is contracted to a private consortium.</td>
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⁶ In the original research planning for this scoping review, it was considered that key informant interviews might be necessary to fill possible data gaps. However, after initial rounds of review, it was clear that the available literature was sufficient complete in a rigorous manner, and that stakeholder perceptions of different modes of PPE would not necessarily enhance the objectives of this review. However, the use of key-informant interviews to further elucidate the specifics of PPE models may be an important avenue for future research.
## Part B: Literature Review

<table>
<thead>
<tr>
<th>Sector-Wide Approach</th>
<th>Public-Private Mix Approach</th>
<th>Franchise</th>
<th>Co-location Public-Private Partnership</th>
<th>Global Public-Private Partnership</th>
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<tr>
<td>An MoH-led formal, sustained cooperative agreement with civil society and donors in which all parties are obligated to pool available resources and work together in accordance with jointly approved and negotiated national sectoral strategies and expenditure frameworks to improve population health outcomes and facilitate national development.</td>
<td>A PPM approach consists of initiatives to increase collaboration and improve relationships between all forms of health care providers providing care for a particular disease</td>
<td>The public authority uses contracting arrangements to harmonise the activities of a network of providers, supporting the providers through branding and bulk drug purchasing, while strictly controlling the quality, quantity, and package of services provided and disallowing cream-skimming.</td>
<td>A long-term partnership through which a portion of a public hospital's premise is granted for use by a private provider, sharing infrastructure and support services but operating as distinct facilities, in return for payment and specified benefits to the public party.</td>
<td>A collaborative relationship, transcending national boundaries, in which both government and non-government entities provide financing and participate in decision-making through a mutually agreed upon division of labour, so as to achieve a shared goal. GPPPs are commonly three-way partnerships including international donors, recipient governments and NGOs or corporations.</td>
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<td>Voucher Programmes</td>
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<td>Using demand-side subsidies with defined benefits to transfer purchasing power for specified goods and services to poor and vulnerable groups.</td>
<td>Public financing of privately delivered health services through grants to providers or public insurance covering private sector services</td>
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<tr>
<td>Contracting-out</td>
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<td>A public authority delegates responsibility for the provision or management of a service on behalf of the state in exchange for a fee, using a contract that specifies the type, quantity, and time period of the services to be provided.</td>
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### Public-private partnership

We look first at PPP, a particular type of PPE, which is a dominant focus within the available literature (we find six distinct PPP sub-types). PPP is a broad term (Thomason and Rodney 2009) for a relatively common (Ciccone 2010; Engel et al. 2013; Roehrich et al. 2014) type of PPE arrangement.
The World Bank Institute defines PPP as “a long-term contract between a private party and a government agency for providing a public asset or service, in which the private party bears a significant risk and management responsibility” (World Bank Institute 2012; p. 11). As such, PPPs are characterised by shared decision-making and risk-bearing, close collaboration, and are organised around a formal, highly specified contract (Reddy and Mary 2013; Roehrich et al. 2014; Widdus 2005). The PPP contract forms the foundation for the partnership; defining

| Public-Private Mix | - Non-contractual  
|                  | - Collaborative  
|                  | - Vertical disease focus  
|                  | - Involves actors from all sectors |
| Public-Private Partnership | - Highly collaborative  
|                      | - Risk-sharing  
|                      | - Long-term  
|                      | - Contractual  
|                      | - Shared decision-making |
| Contracting Out | - Contractual  
|                  | - Short term  
|                  | - ‘Buying’ services |
| Sector-Wide Approach (SWAp) | - Non-contractual  
|                        | - Shared decision-making  
|                        | - Centred around national sectoral strategies  
|                        | - Pooled funding |
| Social Marketing | - Use private sector marketing and communication tools  
|                    | - Increase uptake of public goods  
|                    | - Usually involve subsidisation |
| Vouchers | - Demand-side financing  
|           | - Defined benefits  
|           | - Targeted groups |
| Financial Support | - Public financing of private sector  
|                    | - Through grants or public insurance  
|                    | - Non-contractual |
the relationship between parties, specifying their respective rights and responsibilities and allocating risks (World Bank Institute 2012).

One of the primary advantages of PPPs is that they allow for a transfer of risk from the government to a private provider, and optimal risk allocation is the primary mechanism by which PPPs are seen to increase ‘value for money’ (Bing et al. 2005; World Bank Institute 2012). Risk-sharing also ensures mutual commitment to successful outcomes (Sekhri et al. 2011). Risk refers to “unpredictable variation” and according to the World Bank Institute should be allocated to whichever partner is best able to manage it (2012; p. 153). Managing risk involves controlling the likelihood of the risk occurring – for example through project management expertise; controlling the impact of an unforeseen occurrences on the project; and absorbing the additional costs of an unforeseen occurrence – through third party insurance, or by passing increased costs onto consumers (World Bank Institute 2012).

The private sector, due to its management capacity, speedy access to capital and responsiveness, is better able to absorb most kinds of risk. As such, a PPP, in theory, presents a win-win situation for both partners (Ciccone 2010). The optimal allocation of risk within a partnership would determine: the allocation of functions (the partner that is best able to absorb the risks associated with a certain function will also be responsible for that function of the project), payment mechanisms (which ensure that functions are performed appropriately and secure the financial risk on the side of the private partner), and performance measurement (World Bank Institute 2012).

**Private finance initiative**

Types of PPP can be distinguished on the basis of the extent to which services and facilities are bundled under one contract (Barlow et al. 2013). At one end of the spectrum lies the
private finance initiative (PFI) model, commonly referred to as the ‘UK model’ as a result of its popularity in that country (Ciccone 2010; Cruz and Marques 2013; Roehrich et al. 2014). In this arrangement, only infrastructure and non-clinical service management are bundled into a contract with a private provider (Cruz and Marques 2013). At the other end of the spectrum lies the Alzira model in which infrastructure, non-clinical services, and clinical services including primary and tertiary care delivery are bundled under a single contract (Cruz and Marques 2013).

The PFI model, also commonly referred to as the ‘accommodation-only’ model, or the ‘design, build, finance, operate (DBFO) model’, is a model in which responsibility for building of infrastructure, facilities management (such as building maintenance) and non-clinical services is transferred to the private partner (Barlow et al. 2013; McKee et al. 2006; Thompson and McKee 2004). Along with Thompson (2004), this model will be discussed here under the name ‘private finance initiative’ (PFI) because one of the primary reason for governments to engage in PFI is supposedly to gain access to private financing for public facilities (McKee et al. 2006).

In the PFI model a “public agency contracts a private partner to design, build, finance and operate a hospital facility” (Hellowell 2013; p. 78). The contract does not extend to provision or operational management of clinical services. In other words, specialist investors organise the finance and construction of the facility and are responsible for the ongoing maintenance of the facility (Hellowell 2013). By bundling financing, building and facility management under one contract the state is able to streamline incentives and create maximum efficiencies, since the long-term contract ensures it is in the interest of the private partner to keep building costs to a minimum while ensuring the long-term longevity of the infrastructure.
Under a PFI arrangement, a long-term payment structure is used in which the public sector pays the private partner over the course of the contract (Barlow et al. 2013), usually thirty years (McKee et al. 2006). Contracts are awarded through a competitive bidding process, and the successful contractor will enter into three distinct contracts – with a bank for project financing; with a construction company for infrastructure construction; and, with a facilities management to manage the facility over the lifetime of the contract (McKee et al. 2006). A key aim of the PFI model is to transfer risks away from the private sector; meaning that appropriate contract design is vital in a PFI arrangement, since the risk allocation is stipulated by the contract (Bing et al. 2005).

**Case example of PFI: Inkosi Albert Luthuli Hospital, Kwa-Zulu Natal, South Africa**

The Inkosi Albert Luthuli Hospital is an example of a reportedly successful PFI arrangement from South Africa (Dambisya and Modipa 2009), and represents the first health sector PFI in the country (Wadee et al. 2004). The PFI consisted of a 15 year, R4.5 billion contract, signed in 2001 after five months of negotiation, with Impilo Consortium, the private partner (Dambisya and Modipa 2009; Nyagwachi 2008; Wadee et al. 2004). The PFI was not designed to finance the construction of the hospital, which remained the responsibility of the provincial Department of Health, but rather to exploit the capacity of private partners to mobilise capital for the provision and maintenance of hi-tech medical equipment and technology (Dambisya and Modipa 2009; Wadee et al. 2004). Other responsibilities transferred to the private partner were: facility management, selected hospital upgrades, and, operational management of the hospital’s IT system (Marek et al. 2005; Nyagwachi 2008; Seemela 2008). As such, operational risks for the project were transferred to the private
partner (Nyagwachi 2008). The contract stipulated that the cost to government, which included a management fee, would be deferred over the duration of the contract, and that ownership of all privately financed assets would revert to the ownership of the provincial department at the end of the contract period (Wadee et al. 2004).

**Public-private integrated partnership**

Public-private integrated partnerships (PPIPs) – another innovative form of PPP (Sekhri et al. 2011) – harness private sector financing and expertise by combining or bundling the renewal of health system infrastructure with the delivery of clinical services in a partnership between the state and a consortium of health financers and providers (Cruz and Marques 2013; Hellowell 2013; Sekhri et al. 2011). This model is also sometimes referred to as a ‘combined PPP’ (Hellowell 2013). The arrangement consists of a long-term contractual agreement in which the private partner finances, builds/renovates infrastructure and delivers medical services to a particular population group for a specified length of time (Sekhri et al. 2011). Financial, operational and clinical standards are stipulated by a formal contract, and, combined with performance-based payment mechanisms, are intended to create a high level of accountability of the private partner to the state partner (Sekhri et al. 2011). It is hoped that increased efficiency will arise from the vertical bundling of infrastructure management and clinical services, as well as improve accessibility and quality of services (Cruz and Marques 2013). Not only are PPIPs expected to deliver services that are cost-neutral to users, but ideally the services delivered should also be of a higher quality and quantity (Sekhri et al. 2011). The government retains ownership of all assets (Sekhri et al. 2011).
Case Example of PPIP: Phalaborwa Hospital – Lesotho, South Africa

An example of the PPIP model is the partnership between the South African, Limpopo Department of Health and Social Services, and a private consortium for the finance, design, upgrade, refurbishment, maintenance and operation of the Phalaborwa Hospital in Limpopo (Dambisya and Modipa 2009; PPP Unit 2012). The upgraded facility will be operated as a private hospital because there is a public hospital nearby (PPP Unit 2012). However, the agreement includes an arrangement for the referral of patients on the Government Employees Medical Scheme to the Phalaborwa hospital to be charged a discounted rate (PPP Unit 2012). In addition the agreement will be a source of revenue for the provincial health department as the private partner will pay an annual concession fee (PPP Unit 2012).

Alzira model

The Alzira Model can be usefully understood as an innovative type of PPIP arrangement (Hellowell 2013). However, the inclusion of the model here as a type of PPP is justified by the fact that it is commonly described as such in the literature (Barlow et al. 2013; Cruz and Marques 2013; McKee et al. 2006; Thompson and McKee 2004). The growing popularity of the model (Barlow et al. 2013; Marriott 2014; Thomason and Rodney 2009) constitutes another reason for categorising the Alzira model as PPP type in its own right.

The Alzira model is an arrangement that allows primary health care services to be bundled together with secondary- and tertiary-level services delivered through the PPP (Cruz and Marques 2013). The model extends the clinical operation component of a PPIP from hospital care to a full package of primary, secondary and tertiary care services (Barlow et al. 2013). This arrangement shifts the burden of risk to the private partner, but it can also create a more efficient health system by enabling the private partner to control the flow of patients from
primary to tertiary facilities, treating less severe cases out-of-hospital (Barlow et al. 2013; Coelho and O'Farrell 2011; Cruz and Marques 2013) A capitation fee payment mechanism is used in which the state partner prospectively pays a fee for each member of the catchment population (Barlow et al. 2013; Thompson and McKee 2004).

**Case example of the Alzira model: The Tsepong-Lesotho public-private integrated partnership**

In the Tsepong-Lesotho PPIP, Africa’s largest healthcare PPP, and the first Alzira model PPP in Africa (Marriott 2014), a private provider, Tsepong (a consortium of funders, providers and community groups led by Netcare), was selected through a competitive tender (Coelho and O'Farrell 2011) and contracted to build and operate a large 425-bed national referral hospital (Queen Elizabeth II), an adjacent primary health care clinic, and three filter clinics (Coelho and O'Farrell 2011; de Bruin 2009; Makholwa 2011). Tsepong was responsible for co-financing (with the government), building and maintaining the infrastructure, as well as delivering both primary and tertiary healthcare services, and managing all non-clinical services (Coelho and O'Farrell 2011; de Bruin 2009; Sekhri et al. 2011).

The contract between the Lesotho government and Tsepong defines the type and number of services, payment mechanisms, and also includes stipulated performance indicators and penalties (Coelho and O'Farrell 2011). In addition, an independent contract management body monitors performance on behalf of the government through quarterly audits (Coelho and O'Farrell 2011; Sekhri et al. 2011). Furthermore, the hospital is expected to obtain independent accreditation, and a loss of accreditation constitutes grounds for termination of the contract (Sekhri et al. 2011). After 18 years, the health facilities will be handed back to the Lesotho government (Cruz and Marques 2013; Makholwa 2011). The partnership aims to
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increase the number of services provided while maintaining costs and quality, without increasing the amount patients are expected to pay out-of-pocket (Sekhri et al. 2011). However, despite the theoretical scope for achieving efficiency and outcome gains through this model, there is concern in the case of the Tsepong-Lesotho project, inadequate contracting has resulted in a projected that exceeds expected costs for the government and allows excessive returns on investment for the private partner (Marriott 2014).

**Franchising**

Franchising, or ‘social franchising’, is a type of PPP (Barlow et al. 2013; Chambers et al. 2013; Marek et al. 2005; McKee et al. 2006) in which private providers join a branded franchise, supported by training, advertising and supplies (Montagu 2002), and agree to maintain certain quality standards in exchange for the increased business that being part of the franchise will bring (Madhavan and Bishai 2010). The public sector issues a franchise to a for-profit organisation, on condition of strict control by a public authority (Barlow et al. 2013). The aim of the arrangement is to create a commercial relationship of a franchise network that benefits participating providers (for example by increasing patient numbers) and then leverages these benefits for the public good by ensuring increased quality, decreased cost, or greater accessibility of services (Montagu 2002). Ministries of health can potentially use franchising to harmonise a network of service providers sharing a common goal (Perrot 2006). This allows the public authority to ensure consistent quality of service provision (Perrot 2006). Franchising encourages private partners to follow guidelines, thereby ensuring that a higher quality of care is provided (Bennett et al. 2005) and disallowing private partners from refusing treatment to any individual (Barlow et al. 2013). Any member of the population must have access to any service offered at the facility and public authorities retain strict control (Barlow et al. 2013).
**Case Example of Franchising: New Start Zimbabwe**

In Zimbabwe, the Ministry of Health in 1999, with funding from USAID and technical assistance from Population Services International, began a national Voluntary Counselling and Testing (VCT) franchise, New Start (Marek et al. 2005). Service quality standards are ensured through agreements between PSI-Zimbabwe and the health centres, and the quality of care is monitored through mystery client surveys (Marek et al. 2005). In addition, both initial and follow-up training of service providers is used to maintain quality standards. The programme now consists of a network of 12 centres, located in high-traffic areas throughout the country (Marek et al. 2005).

**Co-location public-private partnership**

A co-location arrangement is a type of PPP (Dambisya and Modipa 2009; Hellowell 2013; McIntyre 2010; Nyagwachi 2008; Shuping and Kabane 2007) that occurs when a private hospital is located within or on the premises of a public hospital, with the two possibly sharing some infrastructure and support services, but largely operating as distinct facilities with limited involvement of the private partner in providing public services (Brown and Barnett 2004). Co-location PPPs involve payment from the private to the public sector for the use of the premises, in addition to other specified benefits to the public sector such as maintenance arrangements (Hellowell 2013; Shuping and Kabane 2007). The public and private partners operate similar services but collaborate rather than compete, allowing the public sector to raise revenue, and the private sector to generate profit (Shuping and Kabane 2007). Co-location arrangements allow for some degree of cost and resource sharing, for example through the shared use of expensive medical equipment to which the public facility
might otherwise have lacked access, facility upgrades, and shared support services (Brown and Barnett 2004; Marek et al. 2005).

**Case example of co-location: The Pelonomi and Universitas Hospitals co-location project**

The Pelonomi and Universitas Hospitals co-location project in Bloemfontein South Africa is a partnership between the Free State Provincial Department of Health (DoH) and Community Hospital Management (CHM) (of which Netcare is a shareholder) in which the provincial department made underutilised public hospital space available to the private partner through a 20 year concession agreement (de Bruin 2009; Shuping and Kabane 2007). The Free State Government contracted with Netcare CHM for the upgrade and refurbishment of the entire hospital in exchange for the concession of one ward of the hospital to be used by Netcare to provide services to private patients using their own staff and equipment, with the shared use of intensive-care unit facilities and operating theatres (de Bruin 2009; Marek et al. 2005). In exchange for the use of the public facility (Cruz and Marques 2013), the private partner committed an initial capital injection for the design, finance and operation of the existing facility – R43 million over sixteen and a half years – as well as R38 million for upgrades (Dambisya and Modipa 2009), in addition to a percentage of turnover (Shuping and Kabane 2007). When the project expires, the ward will be returned to the ownership of the state (Shuping and Kabane 2007).

**Global public-private partnership**

Global PPPs (GPPPs) tend to be understood somewhat differently to the standard PPP model and are not simply PPPs with an out-of-country private partner. Ciccone describes GPPPs as a model defined by shared decision making and “a mutually agreed upon, well-defined
division of labour such that all stakeholders contribute and benefit equally” (2010; p. 48). Key differences between PPPs and GPPPs include the three-way nature of most GPPP partnerships (Buse and Walt 2000a) and the risk-sharing focus of PPPs which is largely absent from the GPPP literature. GPPPs usually involve the corporate sector in partnerships between international donors and recipient states (Buse and Walt 2000a), and are commonly associated with notably large volume financial donations (Buse and Walt 2000b). Examples of GPPPs include the Global Alliance for Vaccines and Immunisation (GAVI), Roll Back Malaria, the Stop TB Partnership, and the Global Fund for Aids, TB and Malaria (GFATM) (Widdus 2005).

**Case example of GPPP: African Comprehensive HIV/AIDS Partnership Botswana ARV Programme**

The African Comprehensive HIV/AIDS Partnership (ACHAP) and Botswana ARV programme partnership is an example of the ‘big push’ Global PPP model. The programme was characterised by a large infusion of funding, drugs and technical assistance over a short period of time in order to achieve an immediate and lasting impact (Distlerath and Macdonald 2013). Funded by global donors – Merck and the Bill and Melinda Gates Foundation each dedicated US$50 million over five years (2000 to 2005) (Distlerath and Macdonald 2013; Ramiah and Reich 2006) – the partnership launched one of the earliest and most successful antiretroviral programmes in Sub-Saharan Africa (Ramiah and Reich 2005). Distlerath and Macdonald (2013) contend that ACHAP successfully leveraged private sector management resources in a government-led implementation process. The programme constitutes a highly collaborative partnership because the Government of Botswana was included as an equal partner in the project, and not only as a grantee of funds (Ramiah and Reich 2005; Ramiah and Reich 2006). However, while the signed agreement listed the state as an equal
programme partner, ACHAPs board of directors – which held ultimate responsibility for organisational decisions, including authorising budgets, approving proposals and providing strategic direction (Distlerath and Macdonald 2013) – did not include government representatives, arguably undermining the decision-making power of the government (Ramiah and Reich 2006). In addition to financing the programme, donor partners provided technical support, under the understanding that private sector knowledge and management capacity could make a significant contribution to the fight against HIV/AIDS (Ramiah and Reich 2006) and can enhance local capacity by transferring managerial, technical and leadership skills to local stakeholders (Distlerath and Macdonald 2013). The programme’s model emphasised engagement with the state to build institutional capacity within the government (Ramiah and Reich 2005).

In addition to PPPs, other forms of public-private engagement exist in which partners from the government sector, together with partner(s) from the for-profit sector of non-governmental organisations (NGOs), interact with the intention of achieving a mutual benefit or goal (Dambisya and Modipa 2009).

**Contracting out or outsourcing**

Although the use of contracts is a common element of the PPPs already discussed, contracting out forms a distinct PPE type, and there are important differences between PPP arrangements and standard contracting out arrangements. However, these distinctions are not always clear, and in many instances the term PPP is used to describe traditional contracting out arrangements. These distinction will be further elucidated in the discussion section of this paper.
In a standard contracting arrangement, a public authority delegates responsibility for the provision or management of a public service to a distinct entity giving the non-state partner overall management authority in delivering a particular service on behalf of the state in exchange for a fee, on the basis of a contract that specifies the type, quantity and time period of the services to be provided (Jacobs et al. 2010; Jayasinghe 2009; Perrot 2006; Waters et al. 2003).

Contracting is one method of combining public funds with private provision, thus allowing resource allocation decisions to remain in the public sphere, while simultaneously ensuring efficient service provision (Waters et al. 2003). The model involves purchasing services from a non-state party to deliver health or management services to a specified population, using a contract agreement to specify the type, quantity, quality and duration of service provision, or the expected changes in health outcomes (Lagarde and Palmer 2009; Peters et al. 2004).

This type of engagement can increase access and utilisation of health services (Lagarde and Palmer 2009) because it allows for a focus on measurable results, increases managerial autonomy, harnesses private sector expertise, and increases the effectiveness and efficiency of services through competition (Lagarde and Palmer 2009). In addition to quality improvements, contracting can expand the coverage of non-state actors by making government funds available to private providers (Bennett et al. 2005).

**Case example of contracting out: part-time district surgeons**

Contracting with part-time district surgeons (PDS) – private practitioners operating side-by-side public and private practices – for the provision of curative primary care services within a defined geographical area is a long-standing practice in the South African context (Kula and
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Fryatt 2014; Marek et al. 2005; Palmer 2003; Palmer and Mills 2003; Wadde et al. 2004). The model presents a solution to shortage of general physicians willing to work in the public sector, particularly in rural areas (Marek et al. 2005; Mills et al. 2004; Palmer 2003; Palmer and Mills 2003). Under this model a fee-for-service payment mechanism is used and the contract specifies the list of services to be provided (Doherty 2011; Kula and Fryatt 2014; Marek et al. 2005; Mills et al. 2004; Palmer and Mills 2005). Contracts vary in duration from very short-term – month-to-month – to longstanding – until the physician’s retirement (Palmer 2003; Palmer and Mills 2005).

PDS contract arrangements are initiated by provincial authorities and tend to be characterised by limited supervision and under-use of sanctions (Marek et al. 2005; Mills et al. 2004; Palmer 2003; Palmer and Mills 2005). The arrangement is fairly relational; no quality standards are included in the contract, the behaviours that would invoke sanctions were ill-defined, and monitoring was very limited (Marek et al. 2005). Commonly, there is no genuine competition for contracts, particularly in areas where there are no other general practitioners to provide the necessary services (Palmer and Mills 2005). As a result, few disciplinary mechanisms are available to provincial authorities in enforcing the terms of the contract. While the contracts are understood to be legally binding (Palmer and Mills 2005), practitioners are commonly governed by community ties, professional ethics, a desire to work in the public interest, interpersonal relationships with purchasers, and a sense of mutual dependency, rather than by the terms of the contract (Marek et al. 2005; Palmer and Mills 2005).
**Sector-wide approach**

A sector-wide approach (SWAp), is a type of relational contractual arrangement (Perrot 2006). The term refers to sustainable collaboration between various health care actors, including district and central governments, private sector stakeholders, international donors and NGOs working towards shared objectives based on government policy and strategy (Mugisha et al. 2005). All public and private institutions that are financed, managed or regulated by the national Ministry of Health are included in a SWAp (Peters and Chao 1998). Participating donors cede the right to select which projects to finance, in exchange for participation in the development of a sectoral strategy and resource allocation decisions (Cassels 1997). Under a SWAp all parties undertake to respect the national health policy – which they have jointly approved – and agree to pool financial resources under the management of the MoH (Perrot 2004). The arrangement works on the basis of a negotiated agreement and the strength of the agreement derives from the relationship between the partners and their co-dependency in pursuit of their common and individual goals, rather than from the imposition of penalties (Perrot 2006).

Multiple donor projects put an excessive administrative burden on the state, and can lead to duplication of efforts, uneven coverage and a lack of sustainability (Theobald et al. 2005). In addition, vertically delivered projects are said not to adequately influence government policy or achieve health systems strengthening (Theobald et al. 2005). Cassels (1997) observes that the SWAp strategy developed as a result of donor concern regarding the effectiveness of aid, and government frustration with the managerial load of disparate vertical projects. The aim of a SWAp is to ensure that the government has control over the spending of all available resources and is able to coordinate development partners in accordance with national policy (Sundewall and Sahlin-Andersson 2006).
A SWAp usually has the following characteristics: A medium-term, collaborative programme of work (including projections of resource availability and medium-term expenditure plans unifies all partners), government plays a leadership role, and all partners share a commitment to work towards increasing reliance on government financial management systems (Cassels 1997; Pearson 2010). In other words, government takes the lead in developing a coherent policy and corresponding expenditure framework for the whole sector, and government, donors and civil society organisations partner to fund and implement the policy (Theobald et al. 2005).

The potential benefits of a SWAp are said to be numerous if effectively implemented. SWAps can increase government ownership of all health sector activities, and strengthen government planning, implementation and monitoring capacity (Theobald et al. 2005). In addition, the SWAp can reduce the burden on the state of administering various vertical, donor-driven programmes (Cassels 1997). Unifying donors and public-sector authorities in decision-making, planning and implementing procedures results in a transference of technical and administrative capacity to the state, and ultimately reduces state reliance on donors.

**Case example of SWAp: Zambia SWAp**

Zambia implemented a SWAp in 1992 with the aim of “making all funds available for any activity or goal that is included in the strategic plan” (Sundewall and Sahlin-Andersson 2006; p. 282), making it the first country in the world to implement a SWAp (Chansa et al. 2008). The SWAp remains the government’s umbrella institution for all donor and government health sector activities under the framework set out in the strategic plan (Chansa et al. 2008). The Zambian National Health Strategic Plan includes NGO activities (including the Churches
Medical Association of Zambia, a local NGO) and some private sector activities, and all stakeholders are invited to participate in policy formulation (Jeffreys et al. 2003). While the Zambian policy documents envision a leadership role for the government in which government assumes a larger responsibility for planning, administration and monitoring, in reality there is not always agreement among partners regarding the level of financial control necessary to enable strong ownership on the part of the government (Sundewall and Sahlin-Andersson 2006), and central-level implementation of the SWAp has proven problematic since 1998 (Jeffreys et al. 2003). Furthermore, Chansa et al. (2008) found that the SWAp had not succeeded in unifying donor funds under a common framework.

Social marketing

Social marketing involves using private sector marketing strategies to attempt to change behaviours of the population, improve availability of health-related products, and increase uptake of public health services (Meadley et al. 2003; Patouillard et al. 2007). The model uses commercial market practices to increase coverage of health products or services (Patouillard et al. 2007), or change behaviours in the interest of a public good (Madhavan and Bishai 2010). Social marketing interventions usually use promotional activities such as branding, labelling, pre-packaging and subsidising of products (Bennett et al. 2005; Patouillard et al. 2007). Some may exploit existing commercial distribution networks, but others engage with public programmes, NGOs and CBOs to facilitate product distribution (Bennett et al. 2005; Meadley et al. 2003). Donor funded social marketing programmes aim to reduce unmet need for certain services by creating demand, and improving access and affordability of products among low-income or vulnerable groups (Sharma and Dayaratna 2005). Social marketing programmes commonly include subsidisation of the marketed products to ensure accessibility to low-income purchasers (Sharma and Dayaratna 2005).
Case example of social marketing: Population Services International social marketing for condoms in Southern Africa

Population Services International (PSI) uses social marketing to promote the use of condoms in Zambia, Malawi, Namibia, Zimbabwe and South Africa. These projects use branding, slogans and imagery delivered through radio, magazine and newspaper adverts to market the female condom (Meekers and Richter 2005). The Zambia Social Marketing Programme, initiated in 1992 by PSI, promotes the use of Maximum brand male condoms, and CARE brand female condoms, through intensive radio and television-based mass media campaigns and public service announcements (Agha 2001; Van Rossem and Meekers 2007). The CARE campaign also used female peer educators to inform potential customers and heavily subsidised the cost of the product (Agha 2001). Although the state’s role in the programme is unclear, the programme is run by the Society for Family Health (SFH) (a not-for-profit non-governmental provider of health services) which operates in line with the health priorities of the Government of Zambia, and is an affiliate of PSI which works in partnership with the Zambian Ministry of Health (PSI 2015).

In Zimbabwe in 1997, in collaboration with the National Aids Coordination Programme, and Zimbabwe National Family Planning Council, PSI undertook a female condom social marketing promotion and distribution programme in urban areas (Meekers and Richter 2005). The project was funded by USAID and DFID (Meekers and Richter 2005). In South Africa, PSI, through an affiliate organisation, the SFH is involved in social marketing for condoms to complement the public sector’s condom distribution efforts (Beksinska et al. 2012). SFH uses branding, along with other social marketing techniques, to increase distribution of male
condoms – under the Lovers Plus and Trust brands – and female condoms under the Care brand (Beksinska et al. 2012).

Public-private mix

Public-private mix (PPM) approaches involve linking all health care providers and organisations, from public and private sectors, in pursuit of a common public health goal (Daniel et al. 2013) with the aim of increasing collaboration and improving relationships between providers from various sectors (Kaboru 2012). PPM initiatives usually have a vertical, disease-specific focus (Kaboru 2012). The PPM approach is most commonly used to increase case detection, treatment rates and patient follow-up in the fight against Tuberculosis (Daniel et al. 2013; Gidado and Ejembi 2009; Haq et al. 2012; Lal et al. 2011a; Lal et al. 2011b; Naqvi et al. 2012). The idea behind a PPM approach is to expand aspect to key health services by engaging for-profit and not-for-profit health care providers in service delivery (Rao et al. 2011) with a clear distribution of tasks between different providers (Kaboru 2012). Studies have shown that using a PPM approach to engage all relevant providers can effectively harness available capacity to expand coverage, improve access and reduce the financial burden of care on patients (Lal et al. 2011b).

Case example of PPM: The Global Fund to Fight AIDS, Tuberculosis and Malaria – public-private mix for TB in Angola

GFATM is a major provider of funding for national TB programmes throughout the LMIC contexts (Lal et al. 2011b). GFATM encourages the use of PPM approaches within national TB programmes by requiring countries applying for funding to set up national level collaborative relationships with diverse stakeholders, such as patients and civil society organisations and health care providers from all sectors, for the delivery of grass-roots TB
services (Lal et al. 2011b). Angola has received GFATM grants to scale-up PPM for TB (Lal et al. 2011b). The National DoH implements a vertical TB programme through a PPM approach, by engaging with a diverse array of providers country-wide (Lal et al. 2011b). Commonly, many providers external to the national TB programme manage a significant proportion of patients in need of TB care (Lal et al. 2011b). By engaging with all relevant providers though the PPM approach, the GFATM hopes to harness available capacity, expand coverage, and reduce cost to patients (Lal et al. 2011b).

**Vouchers**

Voucher programmes – sometimes referred to as ‘consumer-led, demand-side financing schemes’ (Ensor 2004) – provide users with purchasing power in the form of vouchers, redeemable for specified health services or products at selected health facilities or providers (Ensor 2004; Patouillard et al. 2007). These schemes transfer purchasing power for defined goods and services to specified groups, usually the poor (Ensor 2004). Voucher programmes for health service delivery subsidise particular services through the provision of vouchers to targeted groups, commonly through health facilities (Worrall et al. 2005), which can be used to purchase health-related goods or services (Marek et al. 2005). The private sector commonly plays a key part in voucher schemes (Worrall et al. 2005) which typically strive to achieve a good balance between the two to ensure wide coverage, foster ample competition, and encourage consumer choice (Madhavan and Bishai 2010). This mechanism of financing targets vulnerable populations with the intention of improving access to services while simultaneously increasing consumer choice, promoting competition among providers and improving quality of services (Ensor 2004; Mills 2014). In addition, vouchers programmes facilitate individuals in attaining care from non-state providers (Bennett et al. 2005) which can satisfy user preferences and/or relieve the burden on state facilities.
**Case example of Vouchers: Emergency contraception voucher programme - Zambia**

In the Zambia Emergency Contraception (EC) voucher programme potential users of EC were given emergency contraceptive pill (ECP) vouchers together with counselling and education on the use of emergency contraceptives (Marek et al. 2005). The voucher could be redeemed, through either the health counsellor or participating providers for a pack of ECPs (Marek et al. 2005; Skibiak et al. 2001). Voucher cards also included important information about taking EC (Skibiak et al. 2001). Participating providers included both public and private providers, but while the vouchers could be redeemed for ECPs free of charge at the public provider, private providers were permitted to charge a much reduced price (Marek et al. 2005). The voucher programme simultaneously removed cost-related and information-related barriers to EC use by both targeting vulnerable individuals (young women) and subsidising the cost of ECPs. In addition, competition between providers was promoted and users were able to access ECP from the provider of their choice allowing them to avoid the public health facilities where they felt judged, and mistrusted the quality of services (Skibiak et al. 2001).

**Financial support**

Like contracting, financing constitutes an element of many of the PPE models discussed herein, but can also be considered as a market-based PPE type distinct from contracting, franchising, social marketing, and voucher programmes (Loevinsohn and Harding 2005; Peters et al. 2004; Waters et al. 2003). Financing is a model of PPE distinct from contracting and others in that transfer of funds is often through grants, subsidies or tax incentives rather than direct payment, the use of contracts is not a necessary feature of financing arrangements,
and in that the state partner has little decision-making power regarding the type of services delivered and the geographic area covered (Loevinsohn and Harding 2005; Peters et al. 2004; Waters et al. 2003). Financing can be used as a means of PPE either in the form of subsidies to encourage private providers to provide certain services, or provide services to particularly needy population groups, or in the form of public insurance mechanisms that cover specific health services provided in the private sector (Waters et al. 2003). This mechanism can involve using financial instruments (grants, subsidies or tax incentives) to influence the behaviour of private partners (Peters et al. 2004), such as grants to the private sector in response to the application from an NGO requesting that government offer financial support to meet a particular need they have identified (Loevinsohn and Harding 2005). In such an arrangement the NGO makes decisions regarding what services are delivered and how (Loevinsohn and Harding 2005).

**Case example of financial support: Government Employees Medical Scheme – South Africa**

The Government Employees Medical Scheme (GEMS) constitutes a significant source of financial support from the government to the private sector. Launched in 2005, this subsidised health insurance scheme for civil servants aims to increase coverage of medical aid in South Africa (Dambisya and Modipa 2009; Govender et al. 2013). Under GEMS, government subsidises a large portion (seventy-five to one hundred percent) of the medical scheme contribution of government employees (Dambisya and Modipa 2009; Govender et al. 2013). This money, together with the small contribution employees are expected to pay, is pooled under GEMS and transferred to the private sector to purchase care from a designated network of private practitioners and private hospitals (Dambisya and Modipa 2009; Govender et al. 2013). GEMS is the fastest growing medical scheme in South Africa, and has a
maximum potential membership of three million members including dependents (van den Heever 2012). As such, GEMS constitutes a significant and growing transference of funds from the public to the private sector. By facilitating state employees’ access to private health care, GEMS simultaneously satisfies the user preference for private health care, increases medical scheme coverage, and creates a role for the state in encouraging positive competition among insurers (Dambisya and Modipa 2009; Govender et al. 2013). As GEMS grows in size and influence, government can also use strategic purchasing through GEMS to indirectly control the behaviour of private providers.

**Discussion**

The above uncritically describes various models of PPE. The aim of this review was to begin to create a typology of PPE through which to better understand the various PPE models. In order to achieve this aim, this section will firstly endeavour to remove some ambiguity regarding the way terms for various PPE models are used in the literature. Having done so, key themes to understanding, analysing and implementing any PPE mechanism will be briefly discussed. These key themes constitute vital considerations in understanding the organisational structure of any PPE, and issues to consider in seeking to improve PPE outcomes. In doing so, this section will present an overview and critical reflection on the key themes and elements for consideration with regard to PPE establishment and analysis revealed in the literature.

**Clarity of terms**

There is considerable ambiguity in the use of the terms used to describe various models of PPE. Many authors use the term ‘partnership’ to describe any collaboration between parties from distinct sectors or organisations. Strictly speaking, the term ‘partnership’ implies a
commitment of two or more distinct parties to a common goal through the joint provision of resources and expertise, and the sharing of risks (Asante and Zwi 2007). As such, the term can only be applied to PPE models in which risk is transferred from the state partner to a non-state partner.

Similarly, PPPs and other forms of PPE are often discussed under the title ‘privatisation’ and increasing participation of the private sector in public services delivery is commonly referred to as ‘privatisation’ (Cruz and Marques 2013). Ravindran, (2010) for example, describes contracting out, social marketing and PPP as mechanisms of privatisation, suggesting that any transfer by a government of ownership and/or management of government functions from public to private for-profit or not-for-profit organisations constitutes privatisation. Bajpai and Saraya (2010) further suggest that PPPs allow governments little effective control over projects, preventing public partners from ensuring that social objectives are met. These objections are based on a mischaracterisation of the nature of PPE. PPEs do not necessarily constitute privatisation, which consists of irreversible transfer of ownership to the private sector (Cruz and Marques 2013). None of the mechanisms discussed above, including PPPs, involve the irreversible transfer of ownership of government infrastructure or responsibilities to the private sector.

Another example of the need for clarification of terms is Widdus’ paper Public-Private Partnerships: an overview (2005). The paper gives a useful and informative account with a focus on the effects of partnerships. However, the article uses the term ‘PPP’ to describe partnerships including Global Alliance for Vaccines and Immunisation, and the Stop TB Partnership, which are characterised by the involvement of partners from three sectors – including international institutions controlled by government, civil society organisations and
private partners – and consisting of shared objectives, decision-making and risk-bearing. In other words, Widdus is discussing a particular type of PPP, the GPPP. Core characteristics of GPPPs cannot be assumed to be present in all PPP types. Similarly, Hellowell (2013) uses ‘PPP’ interchangeably with ‘PFI’, despite the fact that the term ‘PPP’ includes partnerships that are not based on public access to private financing. McKee et al. describe franchising arrangements as occurring when a “public authority contracts a private company to manage [an] existing hospital” (2006; p. 889). However, this definition clearly lacks any mention of the network arrangement that is the defining feature of the franchising mechanism (Perrot 2006; Peters et al. 2004; Ravindran 2010; Schlein et al. 2013). These examples make clear the need for better clarification and more consistent use of terms describing PPE models. Figure 1 above presented the various PPE models with their key characteristics, in order to demonstrate the distinctions between the various types. Table 1 above gave a concise definition of each PPE model described herein.

Public-private partnerships versus contracting out

A particular distinction that warrants special attention is the distinction between PPPs and contracting out arrangements. While both models rely on contractual obligations between the state and a non-state partner, important conceptual differences have been drawn in the literature.

Roehrich et al. suggest that the primary difference between PPP and contracting out is that PPP consists of a closer, collaborative relationship, with higher levels of state control and involvement, which facilitates the public sector’s access to the “idiosyncratic resources and capabilities” of the private partner that allow for more responsive service delivery (2014; p. 113). Whereas PPP arrangements involve close working relationships between partners that
facilitate a transfer of knowledge and skills between the two, contracting out involves the ‘handing over’ of public sector infrastructure or service provision with limited continued involvement on the part of the public partner (Roehrich et al. 2014). Furthermore, contracting out arrangements differ from PPPs in the extent of resource-sharing involved, the degree of shared decision-making power, and the size or significance of the risks transferred to the private partner. Table 2 illustrates these distinctions more fully.

**Table 2: The distinction between PPP and contracting out**

<table>
<thead>
<tr>
<th></th>
<th>PPP</th>
<th>Contracting Out</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Management and decision-making</strong></td>
<td>Shared-decision making</td>
<td>Transfer of decision-making responsibilities</td>
</tr>
<tr>
<td><strong>Degree of collaboration</strong></td>
<td>Close collaboration, large degree of negotiation and trust</td>
<td>Hierarchical relationship - public sector 'buys' services</td>
</tr>
<tr>
<td><strong>Knowledge transfer</strong></td>
<td>High levels of knowledge transfer</td>
<td>No knowledge transfer due to low levels of collaboration</td>
</tr>
<tr>
<td><strong>Risk-sharing</strong></td>
<td>Always has a risk-sharing component.</td>
<td>Can involve risk-sharing but does not necessarily do so.</td>
</tr>
<tr>
<td><strong>Resource sharing</strong></td>
<td>Sharing of financial, infrastructural and/or human resources</td>
<td>Limited resource sharing aside from transfer of funds</td>
</tr>
<tr>
<td><strong>Payment mechanisms</strong></td>
<td>Always includes some form of performance-based payment</td>
<td>Private partner paid directly by public authority, not necessarily performance-based</td>
</tr>
<tr>
<td><strong>Payment schedule</strong></td>
<td>Private party bears all initial costs and is paid in instalments, moving payments 'off-budget'.</td>
<td>Various</td>
</tr>
<tr>
<td><strong>Service-mix/bundling</strong></td>
<td>Mixed/ bundled services contracted out to a single private partner, streamlining incentives and increasing efficiency</td>
<td>No bundling, each contract involves the provision of a single set of services</td>
</tr>
<tr>
<td><strong>Length of contract</strong></td>
<td>Long-term contract</td>
<td>Generally shorter-term contract</td>
</tr>
</tbody>
</table>

(Source: Author)

Whereas contracting out is a mechanism for combining public finance with private provision, PPP is a mechanism for bundling private finance, management and provision to introduce efficiencies that could not be otherwise realised. As such, another key difference is the extent to which transferred responsibilities are bundled under one contract.
It is hoped that this paper will go some way towards developing conceptual clarity regarding PPE models. A clearer typology of PPE models, in which the particularities of the relationship between partners are clarified, is necessary for evaluating which models work best at achieving different goals in different contexts. It is vital that the implementation of PPE projects is driven by such evidence, and as such, vital that the necessary research is undertaken. However, conceptual clarity regarding the various models of PPE is also necessary to ensure their effective implementation. The theoretical benefits of the various models accrue as a direct result of the organisational characteristics, or partnership arrangements, of the model. If the organisational particularities from which these potential benefits arise are not well understood, there is a substantial risk that the necessary organisational characteristics will not be ensured in the implementation process and, as such, that the theoretical benefits of the project will not be realised in practice. These organisational particularities include accountability mechanisms, the locus of decision-making power, monitoring mechanisms, payment mechanisms, monitoring and reporting structures, and the distribution of the risk burden between partners, inter alia. A clearer conceptualisation of each model and the benefits that can be achieved as a result of the organisational particularities of each model is necessary in order for policy-makers and implementers to ensure that projects are undertaken and carried-out in such a way as to ensure that the potential gains of the model are realised.

**Common themes**

While a clear understanding of the model of PPE to be implemented is vital in ensuring that the full spectrum of potential benefits are realised, this literature review revealed a number of common themes that constitute important factors in ensuring the potential benefits of any PPE model are realised. While these themes do not eradicate the need for a full understanding
of the organisational characteristics of the model in question, they constitute important considerations in ensuring successful engagement with private partners across all PPE models. These themes include risk-transfer, sustainability, power and control, management capacity and trust.

**Risk transfer**

The language of risk is rarely used outside of the PPP literature, despite the fact that risk (or ‘unpredictable variation’) and its appropriate management is deemed important in all PPE mechanisms. Governments have a stewardship function that entails a fundamental responsibility to set the terms for all non-state engagement in the health sector (Bennett et al. 2005). It is therefore the responsibility of governments to ensure wide-spread access to health services. Regardless of the PPE arrangement each a enters into, the state bears this ultimate responsibility. With or without formal contractual mechanisms that shift risk onto the private partner, the public sector ultimately retains all responsibility for inefficiencies in private management and is fully accountable for the delivering of services to the population (Cappellaro and Longo 2011). Donor-funded programmes, for example, are heavily impacted by global financial trends (Kirigia et al. 2011). When economic downturn makes it more difficult for donors to commit resources, states must try to mitigate the effect of the loss of resources, thus bearing substantial financial risk. Similarly, when a global donor commits funding through a SWAp, the risk of the funding drying up prematurely lies ultimately with the public partner. As such, risks associated with project failures and shortcomings can never be entirely transferred to the private partner.

Shared risks result in a mutual commitment to successful outcomes (Sekhri et al. 2011) and it is the risk-sharing involved in PPE initiatives that drive innovation to achieve cost-
efficiencies, because the parties bearing the risk have a greater incentive to manage it efficiently (Barlow et al. 2013). The issue of risk allocation is notably missing from the literature on PPE mechanisms other than PPPs. Decision-makers and implementers should be aware of the risk allocation in undertaking any engagement with the private partner.

Sustainability

The second important point of consideration in ensuring the success of any PPE initiative is sustainability, including mechanisms for the continuation of services when the project reaches its predetermined end, or is terminated prematurely. Ciccone (2010) notes that GPPPs in particular tend to “lack safeguards against donor dependency, which means that systems will likely collapse once the charity dries up” (Ciccone 2010). Furthermore, Streefland (2005) suggests that while private-sector engagement can be beneficial, the ultimate goal must be public health systems with sufficient capacity to meet population health needs. As such, managing the transition back to a purely public model while maintaining output levels is a key concern (Jacobs et al. 2010).

Power and control

The agency problem – the capacity of stakeholders to exercise adequate control over partners - is an issue within all levels of management and across various organisational types (Chambers et al. 2013). Aligning incentives between partners is therefore another key concern, regardless of the type of PPE mechanism utilised. Performance-based financing, and monitoring of service delivery to ensure alignment of incentives, are always present in contract-based PPE initiatives (Lagarde et al. 2009). However, even in PPE initiatives that are not based on explicit contracts, such as a SWAp and financing mechanisms, it is considered vital to ensure that both parties are adequately incentivised to work towards a common goal.
Thomason and Rodney (2009) suggest that for-profit private partners need to be convinced that there are financial incentives in engaging in PPE (Thomason and Rodney 2009). While there is no doubt that financial incentives can be exploited to ensure adequately aligned incentives, it is important to recognise that ideological incentives may go further in ensuring private partners behave in accordance with the public good. Remuneration on the basis of successful service delivery may lead private partners to focus on cost minimisation at the expense of service enhancement (Roehrich et al. 2014). Similarly, relationships built on financial incentives are liable to dissolve when financial realities change. For private parties, engagement with the public sector could facilitate access to data and analysis skills, and enhance credibility and trust (McDonnell et al. 2009). As such, facilitating a better relationships with the government is another possible incentive for private PPE involvement (Sinanovic and Kumaranayake 2010). All mechanisms for aligning incentives between partners ought to be considered in the implementation of PPE initiatives.

**Capacity**

In both contractual and non-contractual PPE initiatives, the capacity of the public sector to effectively manage private partners must be realistically assessed. It is commonly thought that contracts, and competition for these contracts will increase efficiency (Sinanovic and Kumaranayake 2010). However, poor contract design or insufficient capacity to monitor contracts undermine many contracting arrangements (Sinanovic and Kumaranayake 2010). Those considering the initiation of a PPE should be cognisant not only of the possible benefits of the initiative but also of the state’s capacity to support the intervention i.e. to negotiate effectively with non-state partners and engage in such a way as to protect the public interest (Bennett et al. 2005). Asymmetric skill levels between partners may undermine the
success of PPEs, particularly in cases where the strategic planning and negotiating capacity of public partners is limited (Roehrich et al. 2014). Government’s financial, implementation, planning, monitoring, and enforcement capacity is a key consideration in all PPE models including PPPs (Bing et al. 2005; Roehrich et al. 2014), other contractual models (Doherty 2011; Palmer and Mills 2005; Vio 2006), and non-contractual models (Bennett et al. 2005; Janisch et al. 2010; Jeffreys et al. 2003; Madhavan and Bishai 2010; Meadley et al. 2003; Mugisha et al. 2005).

**Trust and relational contracts**

Trust is a key factor in the success of any PPE arrangement, but is particularly important when government capacity is lacking. When engaging with the private sector, the state may be vulnerable as a result of information asymmetry (Lonsdale et al. 2010). Characteristics such as poorly developed institutional capacity, a shortage of administrative and contract development skills, under-developed markets, and corruption affect relationships between state and non-state partners, rendering PPE infeasible or difficult in LMIC contexts (Palmer and Mills 2005; Waters et al. 2003). One significant consideration is the mistrust and tension that exists between state and non-state health sectors in many contexts (Bennett et al. 2005). Such tensions, combined with inexperience in working together can undermine the success of PPE initiatives (Bennett et al. 2005). The literature draws attention to the importance of trust in engagement with non-state partners (Roehrich et al. 2014; Sekhri et al. 2011), which can constitute a useful response to this vulnerability (Lonsdale et al. 2010). Chambers (2013) further notes that alternative means of power might include ideological means, including professional and political ideologies or discursive orders such as occupational ethos and norms of conduct that can be reinforced to ensure appropriate behaviour of partners. These relational means of engagement rely heavily on trust (Perrot 2006). These mechanisms are
appropriate to partnerships where no formal contract is in place, and to circumstances in which government contracting capacity is low.

Furthermore, even when contractual capacity is adequate, PPE arrangements for the health sector ought to facilitate supportive partnerships between different actors with shared goals and values, rather than putting the focus on the judicial and financial aspects of the arrangement (Soeters et al. 2006). As such, contractors ought to be wary of relying solely on the terms of the contract in developing and implementing partnerships. This research suggests that further analysis regarding the most effective mechanisms for PPE governance – especially for PPE projects without a formal contractual component or those implemented in settings where contracting capacity is weak – is an important area for further research.

**Conclusion**

This scoping review identified seven PPE models including PPP, and six PPP sub-types. The paper attempts to develop conceptual clarity regarding the organisational characteristics of these models of engagement with non-state partners. Key organisational particularities (such as accountability mechanisms, mechanisms and conditions of funding, the locus of decision-making power, and the burden of risk), as well as the potential benefits these are thought to enable, were displayed. Examples of each PPE type were given in an attempt to further understanding of the models in theory, and how organisational particularities are brought to bear in practice. In addition to developing a typology of PPE models, and demonstrating a need for increased conceptual clarity in the field, this scoping review revealed five considerations that are key to the successful implementation of all PPE initiatives regardless of model, including risk transfer, sustainability, power and control, capacity and trust.
Although interest in all forms of PPE models has grown in recent years, much of the academic literature concerns the formal, long-term, large-scale partnerships that constitute PPPs. Relatively little attention has been paid to other mechanisms of market-based engagement with the non-state sector. Furthermore, significant ambiguity is prevalent regarding the terms used to describe both PPP types and other models of PPE. There is a need for greater clarity in defining various models of PPE so that researchers can begin to investigate the aspects of various models that make them apt for particular contexts or increase the chances of achieving successful, sustainable projects with positive outcomes for population health. Importantly, the potential benefits of each model are a dependent on the organisational particularities of the model in question. As such, a clearer conceptualisation of each model and the potential benefits that arise as a result of the organisational particularities of each model is necessary in order for policy-makers and implementers to ensure that PPE projects are undertaken in a manner that ensure the potential gains of the model are realised.
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Part B: Literature review


Part B: Literature review


Part B: Literature review


Part B: Literature review


PART C: JOURNAL ARTICLE

MANUSCRIPT

Targeted Journal: Health Policy and Planning

Models of public-private engagement for health services delivery and financing in Southern Africa: A systematic review

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MPH (Health Systems)

1 Instructions for authors in Appendix 5, authors’ contribution and information are also excluded. For the purpose of this thesis, the student is the sole and first author of the work
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Abstract

In low and middle income countries (LMICs), the private sector, including international donors, non-governmental organisations, for-profit providers and traditional healers, plays a significant role in health financing and delivery. The use of the private sector in furthering public health goals is increasingly common. By working with the private sector through public-private engagement (PPE), states can harness private sector resources to further public health goals. PPE initiatives can take a variety of forms and understanding of these models is limited. This paper presents the results of a systematic literature review conducted to establish the types and prevalence of PPE projects for health service delivery and financing in Southern Africa. PPE initiatives identified through the review were categorised according to a PPE typology. The review reveals that the full range of PPE models, eight distinct models, are utilised in the Southern African context. The distribution of the available evidence, including significant gaps in the literature, is discussed, key finding presented, and recommendations are made for researchers, implementers and current and potential PPE partners. It was found that the literature is disproportionately representative of PPE initiatives located in South Africa, and of those that involve for-profit partners and international donors. A significant gap in the literature identified through the study is the scarcity of information regarding the relationship between international donors and national governments. This information is key to strengthening these partnerships, improving partnership outcomes and capacitating recipient countries. The need for research that disaggregates PPE models and investigates PPE functioning in context is demonstrated.

Keywords

Public-private engagement, public-private sector partnership, donor reliance, Southern Africa, health system strengthening
### Key messages:

- A wide range of models of public-private engagement (PPE) is apparent in the Southern African literature.

- The available literature is over-representative of engagements with for-profit partners, engagement with international partners, and PPE initiatives in South Africa, while substantial gaps in the literature include state engagement with the informal sector, in-country not-for-profit organisations, and PPE for health financing.

- Factors influencing the success of PPE initiatives include organisational particularities, interpersonal relationships between partners, and the suitability of the PPE model to the context.

- In evaluating PPE initiatives, it is vital to recognise the differences between various models and the appropriateness of different models to different contexts. Further research is suggested in this regard.


Introduction

The global burden of disease falls most heavily on low-income countries, which struggle to manage this burden with weak health systems (Hanson et al. 2008). Engagement between the public and private sectors is increasingly common and has developed into a general approach to “improving efficiency, effectiveness and responsiveness” of the public sector (Kernaghan 1993). The focus of policy-makers and analysts is no longer devoted solely to how governments can finance and deliver all health services, but now includes how the private sector can be managed so that their activities help meet national health objectives (Mills et al. 2002; Smith et al. 2008).

Despite the rising popularity of public-private engagement (PPE) for health, in-depth empirical investigations and conceptualisations of PPE remain rare (Kernaghan 1993; Roehrich et al. 2014). There are various models for engagement with the private sector (Buso 2004). However, policy-makers give little attention to the question of the best mechanisms by which to utilise private healthcare to achieve national public health goals (Berman 1996). The evidence base on private sector engagements remains weak, and efforts must be made to strengthen it (Hanson et al. 2008).

The aim of the study reported here was to explore the various models of PPE that are being utilised in the Southern African context. This requires a disaggregation of PPE models. As such, a systematic literature review was conducted and the results analysed in accordance with a typology of models of PPE developed on the basis of a preceding scoping review (see Part B). The systematic review aimed to explore the evidence on the types and quantity of PPE initiatives in Southern Africa. This facilitated an analysis of the trends in PPE with
respect to its prevalence, the models being utilised, and the range of partners being engaged with, as well as the identification of gaps in the available evidence and the need for further research. It is hoped that this work will facilitate studies assessing the effectiveness of various forms of PPE, the organisational choices that impact PPE effectiveness and sustainability, and the suitability of different PPE models to various contexts. In addition, this typology of PPE should illuminate the wide range of mechanisms through which public sector actors can utilise private resources, and private sector actors can contribute to public health goals.

Background

Delivery and financing of healthcare is commonly considered to be the sole responsibility of the state, despite the fact that in low and middle income countries (LMICs) a lack of resources hampers governments’ capacity to fulfil this role (Asante and Zwi 2007). The health systems of many LMICs are ‘mixed health systems’ in which public health systems operate alongside a non-state health sector, with market systems often playing a dominant role (Kula and Fryatt 2014; Nishtar 2010). In such systems, insufficient state funding and under-regulation of the private sector combine to undermine the equity and efficiency of the system as a whole (Nishtar 2010).

In most Southern African countries, inadequate public health infrastructure, medicine shortages, and insufficient financial and human resources undermine the state’s capacity to meet population health needs, and low quality of care characterises public sector provision (Asante and Zwi 2007; Foster 2012; Rao et al. 2011; Sekhri et al. 2011). Historically, the state was viewed as the appropriate sole provider of health care, and interaction and collaborations between the public and private sectors was limited (Buso 2004; Kula and Fryatt 2014). The structural adjustment programmes driven by the World Bank/International
Monetary Fund in the 1980s and 1990s, combined with international concern about the government’s capacity to deliver adequate health services, and economic theory regarding the increased efficiency of the private sector, saw cuts in public spending which undermined public sector health provision and resulted in an increased role for the private sector in health care (Buso 2004; Marriott 2009; Munyuki and Jasi 2009; Mussa et al. 2013; Pfeiffer 2004; Pfeiffer et al. 2008; Unger et al. 2006). Many LMICs, including Zambia, Mozambique and Malawi, implemented reforms along these lines (Buso 2004). For these, and other historical reasons, public health care provision in sub-Saharan Africa has, since the early 1980s, been largely characterised by resource scarcity and a contraction of service delivery (Streefland 2005). Only three of the ten countries included in the review – Malawi, Swaziland and Zambia – have met the Abuja target to devote fifteen percent of government expenditure to health (Foster 2012). These shortages are exacerbated by increasing demand for services driven by new health challenges such as HIV (Rao et al. 2011).

In many Southern African countries health spending is supplemented by external donor funding, which flows either through government or private channels (Foster 2012). While South Africa and Angola receive very little donor funding, Malawi and Mozambique are heavily reliant on external funds (Foster 2012). Figure 1 below demonstrates the significance of the private sector across Southern Africa.

The private sector plays a large role in the provision of health services in LMICs (Bennett et al. 2005; Mills 2014; Montagu et al. 2011; Peters et al. 2004) and constitutes an important source of care for the poor (Patouillard et al. 2007). The private health sector consists of a heterogeneous mix of for-profit providers (predominantly formal, accredited in-patient and out-patient providers but also including informal providers operating outside of government
regulation such as traditional healers and drug sellers), non-governmental organisations (NGOs) and not-for-profit organisations (NPOs) both local and international (Hanson et al. 2008; Waters et al. 2003).

Figure 1: Health financing indicators

(Source: Foster 2012, WHO 2015)

Although the appropriateness of mechanisms for private sector engagement is dependent on the type of private provider in question, the focus of this paper is on PPE organisational models, which can be used to engage with for-profit and not-for-profit partners alike. As such, distinctions between types of private-sector partners will not be drawn out. Nonetheless, it is important to bear in mind that the poor are more likely to access lower-quality and informal private health services, and that PPE is less commonly undertaken with private partners that service the poorer segments of the population (Hanson et al. 2008).

Private providers serve populations in both rural and urban areas, are often more geographically accessible than public facilities, are perceived to be more responsive to user preferences, and offer shorter waiting times and greater confidentiality (Bennett et al. 2005;
Berman 1996; Montagu et al. 2011; Patouillard et al. 2007). In Africa, half of all people seeking care turn to private providers (Hanson et al. 2008). About sixty percent of the total health expenditure in Sub-Saharan Africa is private, predominantly out-of-pocket, and about half is spent on private providers (Hanson et al. 2008).

It is apparent from the literature that the private sector presents both strengths and weaknesses with regard to health service provision. An effective private health sector can relieve the burden on the public sector and allow more resources to be spent on the very poor and vulnerable segments of society (Dambisya and Modipa 2009; IFC 2011; Sharma and Dayaratna 2005). However, left unchecked, private provision of health services can increase costs, decrease affordability, lead to a deterioration in quality of services (in both sectors), increase inequity in access to services and, ultimately, undermine population health and social justice objectives (Buso 2004; Doherty 2011; Foster 2012; Rao et al. 2011; Reddy and Mary 2013). Furthermore, there is also concern that the burgeoning of the private sector can weaken the public sector – by contributing to an internal ‘brain-drain’ and furthering inequality in access to care (Streefland 2005).

Despite these concerns, the size and capacity of the private sector in the region suggests that it is neither possible nor desirable for the public sector to shoulder the entire burden of health care provision and financing (IFC 2011). While there is no doubt that market failures occur in the private provision of health, policy-makers can use PPE to attempt to eliminate these failures, so that private resources can be harnessed for public good (Hanson et al. 2008; Marriott 2009).
Policy-makers are increasingly acknowledging the private sector as a resource, and exploring and implementing mechanisms for engaging with the private sector to increase coverage and quality of services by harnessing private financing and expertise to target vulnerable populations and mitigate the harm that arises from ill-regulated private provision and financing of healthcare (Asante and Zwi 2007; Bennett et al. 2005; Patouillard et al. 2007; Peters et al. 2004; Sekhri et al. 2011). “The public and private sectors have different strengths and weaknesses, and a judicious blending of the two can produce optimal results” (Hanson et al. 2008; p. e233). Locally relevant public policies can ensure that private providers make a positive contribution to the system (Nishtar 2010).

The primary objective of PPE is to maximise population benefits given existing limited resources (Buso 2004). However, knowledge and understanding on the mechanisms of engaging with the private sector that work best to improve quality and/or coverage of services is limited (Peters et al. 2004), especially in LMICs (Mills et al. 2004).

**Method**

This systematic literature review was undertaken to explore the available literature addressing the range and quantity of PPE mechanisms being utilised in Southern Africa. Figure 2 below presents a summary of the review process.\(^2\) The systematic review process was strengthened by a preceding scoping review which was undertaken to better define the field and ensure that search terms covering the entire spectrum of PPE models were included. In addition, an iterative process, in which the search strategy was refined on the basis of previous searches, was used (Hammerstrøm et al. 2010; Lefebvre et al. 2008). Both natural language terms and

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\(^2\) Ethics approval for this study was granted by the University of Cape Town, Faculty of Health Science, Human Research Ethics Committee.
standardised subject terms (controlled vocabulary search terms) were included to ensure that relevant documents employing different terminology for the same concept were identified (Hammerstrøm et al. 2010; Lefebvre et al. 2008).

**Figure 2: Systematic review process**

For the systematic literature review presented here, a Campbell Systematic Review methodology was followed to minimise bias in identifying and analysing documents for inclusion and to facilitate the inclusion of a wide variety of evidence types. Because the goal of the study was to investigate various mechanisms for government engagement with the non-state health sector, broad definitions of the non-state sector and of what constitutes engagement were used. The private sector was taken to include any non-state actor in the
health system excluding health system users, and therefore included international and national, for-profit and not-for-profit, formal and informal, individuals and organisations. Following Kernaghan, engagement was taken to include any “relationship involving the sharing of power, work, support and/or information with others for the achievement of joint goals and/or mutual benefits” (1993; p. 61).

In order to capture all current Southern African PPE initiatives for health and minimise bias (see Hammerstrøm et al. 2010), a range of databases, both medical- and business-related, were searched, including: PubMed, Scopus, AfricaWide, EconLit, Web of Science, Business Source Premier, Equinet and PAIS International. The decision to include business-related databases as well as medical databases is justified by the need to ensure that the review includes the full range of available evidence. Some PPE initiatives for health are undertaken as business ventures and are not presented in medical journals. A detailed account of the search criteria for each database can be found in Appendix 3. Search terms and MESH terms were grouped into three categories using Boolean operators to ensure adequate sensitivity and specificity. The first category included ‘Southern Africa’ as well as the names of all individual countries within Southern Africa. In order to ensure a manageable number of search results, the first category of search terms was restricted to titles and abstracts in the larger databases. Trial searches were conducted in each database to establish the necessity of this approach. The second group of search terms included terms relating to the financing and delivery of health care, and the third, terms describing the range of PPE models indentified in the scoping review.

The review is limited to PPE initiatives for health financing and delivery (including human resource management), and excludes PPE initiatives for drug development, research or
human resource training. To be included in the review, the document had to be in English, and discuss at least one particular PPE in Southern Africa. The review focused on literature published since 2004. Documents discussing PPE in general were excluded, as were documents discussing PPE initiatives in areas other than health service delivery or financing, and those in which the state partner was other than a national or provincial ministry of health (MoH), or local government health authority. In keeping with the Campbell review methodology, the review included both peer-reviewed and grey literature (Campbell Collaboration 2014). The inclusion of grey literature in this study will not only guard against publication bias, but will also ensure that PPE initiatives that do not have an academic component are nonetheless included in the review. An objective inclusion criteria was used.

It is not uncommon for PPE initiatives that met the inclusion criteria (that is, were described in documents published after 2004) to have been initiated before then. Furthermore, the most detailed account of the organisational structure of a PPE is commonly reported at or around the time of its inception. As such, it was necessary to expand the scope to include some key documents published prior to 2004 (the oldest document included in this review was published in 1996).

A data extraction form was used to record and synthesise extracted data, and to minimise human error and bias in the data extraction process (see Tranfield et al. 2003). The process of categorising the codes under themes was enhanced by locating the codes within the original texts during thematic analysis. This facilitated more accurate categorisation of codes, and ensured that each theme is sufficiently representative of all the codes subsumed within it (see Aveyard 2010). Data synthesis was conducted according to a typology of PPE models,
developed on the basis of an earlier scoping review of PPE throughout the world (mentioned above). This typology, including definitions and key features, is presented in Appendix 1.

The typology can be usefully understood as a conceptual framework in that it is an organisational device comprising of abstract representations, or ideal types that do not necessarily exist in reality. The usefulness of the typology is dependent on the ways in which individual PPE initiatives can be categorised according to how closely they resemble these ideal types, thus elucidating the differences between existing cases (Wendt et al. 2009). The term ‘typology’ was chosen to highlight the importance of the systematic classification of PPE initiatives as it is this process that is intended to facilitate comparative research (Wendt et al. 2009) and improve understanding more generally.

Figure 3 below gives a diagrammatic representation of the typology. Although the original typology excluded regulation of dual practice (DP) on the grounds that it is a not a market-based PPE model, given the importance of DP and its appropriate regulation in the Southern African context, this type of PPE was included in the systematic review, and the original typology was augmented to include regulation of DP. The typology facilitated a disaggregation of PPE initiatives such that, in keeping with the aim of this paper to facilitate a thorough investigation of modes of engaging with non-state partners for health, an understanding could be garnered of the current state of PPE in Southern Africa regarding the various types and models that are in place. Appendix 2 presents the documents included in this review grouped according to the PPE they reference, as well as key PPE characteristics.
Results

The initial database search identified 1276 documents across all databases. After screening the title and abstracts of each result, 278 documents were selected and exported to EndNote citation manager. Duplicates were removed resulting in a subtotal of 166, ten of which were excluded as a result of the unavailability of full texts. The remaining documents were assessed for appropriateness. Excluded documents fell predominantly into one of five categories: the PPE in question was not for health care financing or provision, the article was hypothetical or mentioned PPE as a recommendation only, the document provided a general discussion but did not reference any particular PPE initiative, the project in question had no explicit state partner, or the article reported an academic study or pilot project not an implemented PPE initiative. 56 documents met the inclusion criteria. An additional 14 were located using citation tracking, resulting in a total of 70 documents for inclusion. A bibliography of documents included in the review can be seen in Appendix 4.

Definitions of the various PPE mechanisms, along with key explanatory and conceptual characteristics can be found in Appendix 1. While definitional and conceptual overlap exists between some models, each PPE type is identified by key characteristics and are distinguishable. A diagrammatic representation of the PPE typology can be seen in figure 3 below.

Prevalence and geographic location of PPE models in the literature

In total 52 individual PPE initiatives, representing eight distinct PPE models, were identified in Southern Africa. PPE models included: social marketing, sector-wide approach (SWAp), contracting out, voucher programme, public-private mix (PPM) approach, dual practice (DP) regulation, financing, and public-private partnership (PPP). In addition, six PPP sub-types
were identified, including franchising, global public-private partnership (GPPP), public-private integrated partnership (PPIP), Alzira model PPP, co-location PPP, and private finance initiative (PFI). This entails that all PPE models identified through the global scoping review are apparent in Southern Africa. Table 1 presents the number of PPE initiatives within each model, and the countries in which they have been identified. This table also gives the number of PPE initiatives identified in each country with international donor or global health initiative (GHI) support.

### Figure 3: Public-private engagement typology

<table>
<thead>
<tr>
<th>Public-Private Engagement (PPE)</th>
<th>Public-Private Mix</th>
<th>Public-Private Partnership</th>
<th>Contracting Out</th>
<th>Sector-Wide Approach (SWAp)</th>
<th>Social Marketing</th>
<th>Vouchers</th>
<th>Financial Support</th>
<th>Dual Practice Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Non-contractual</td>
<td>- Highly collaborative</td>
<td>- Contractual</td>
<td>- Non-contractual</td>
<td>- Demand-side financing</td>
<td>- Public financing of private sector</td>
<td>- Regulatory control of dual practice</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Collaborative</td>
<td>- Risk-sharing</td>
<td>- Short term</td>
<td>- Shared decision-making</td>
<td>- Defined benefits</td>
<td>- Through grants or public insurance</td>
<td>- Between state and public-sector physicians</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Vertical disease focus</td>
<td>- Long-term</td>
<td>- No shared decision-making</td>
<td>- Vertical disease focus</td>
<td>- Targeted groups</td>
<td>- Non-contractual</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Involves actors from all sectors</td>
<td>- Contractual</td>
<td>- ‘Buying’ services</td>
<td>- Involves actors from all sectors</td>
<td>- Defined benefits</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Author)
The systematic review revealed that the extent to which engagement with non-state partners for health is reported in the literature varies dramatically between Southern African countries. In Namibia and Swaziland, only one PPE project was identified in each country, while at the other end of the scale, in South Africa a high number of PPE initiatives are reported - with 19 South African PPE initiatives identified through the search. It is clear from this systematic review that the number of reported PPE initiatives in Southern Africa with external input in the form of funding or technical assistance is high.

Table 1: Prevalence and geographic location of PPE models in the available literature

<table>
<thead>
<tr>
<th>PPE Model</th>
<th>Number Identified</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Marketing</td>
<td>12</td>
<td>Angola, Malawi, Mozambique, Namibia, South Africa, Zambia, Zimbabwe</td>
</tr>
<tr>
<td>Contracting out</td>
<td>8</td>
<td>Botswana, Lesotho, Malawi, Mozambique, South Africa, Zambia</td>
</tr>
<tr>
<td>Global PPP</td>
<td>7</td>
<td>Botswana, Lesotho, South Africa, Swaziland, Zambia</td>
</tr>
<tr>
<td>PPM approach</td>
<td>5</td>
<td>Angola, Malawi, South African, Zimbabwe</td>
</tr>
<tr>
<td>Co-location PPP</td>
<td>4</td>
<td>South Africa</td>
</tr>
<tr>
<td>SWAp</td>
<td>3</td>
<td>Malawi, Mozambique, Zambia</td>
</tr>
<tr>
<td>PFI</td>
<td>3</td>
<td>South Africa</td>
</tr>
<tr>
<td>Voucher Programme</td>
<td>2</td>
<td>Zambia, Malawi</td>
</tr>
<tr>
<td>Financing</td>
<td>2</td>
<td>South Africa</td>
</tr>
<tr>
<td>PPIP</td>
<td>1</td>
<td>South Africa</td>
</tr>
<tr>
<td>Alzira Model PPP</td>
<td>1</td>
<td>Lesotho</td>
</tr>
<tr>
<td>Franchise</td>
<td>1</td>
<td>Zimbabwe</td>
</tr>
</tbody>
</table>

(Source: Author)

The PPE model most extensively reported in the literature was the social marketing model, of which 12 examples were identified in six countries throughout Southern Africa. However, all except one of these PPE initiatives – the Soul City PPE – are driven by international social marketing NGO, Population Services International (PSI), or an affiliate, Society for Family Health (SFH) (Agha 2001b; Beksinska et al. 2012; Chapman et al. 2012; Mathanga et al. 2006; Meekers and Richter 2005; Omona 2009; Van Rossem and Meekers 2007; Wood et al. 2012). The Soul City social marketing campaign is predominantly supported by the South
African National Department of Health (DoH), but also receives funding from the Global Fund to Fight AIDS, Malaria and TB (GFATM); the President’s Emergency Plan for AIDS Relief (PEPFAR), and USAID. As such, none of the social marketing campaigns identified were independent of external support.

Social marketing initiatives use commercial communication and marketing techniques to increase uptake of a product with a public health benefit or to change health-related behaviours (Madhavan and Bishai 2010; Meadley et al. 2003; Peters et al. 2004). The social marketing PPE initiatives identified were predominantly directed at behaviour change associated with condom use and safe sexual practices for HIV/AIDS prevention. These included various branding and advertising techniques for male and female condoms (Agha 2001; Beksinska et al. 2012; Pfeiffer 2004; Van Rossem and Meekers 2007), as well as television programmes aimed at socially desirable behaviour change (Goldstein et al. 2005). Of the 12 social marketing initiatives identified, only four were not HIV/AIDS-related. These included three campaigns to increase access to- and use of- insecticide treated bed-nets, and one campaign, aimed at new mothers, to increase the use of water-treatment products. The prevalence of social marketing PPE initiatives in the literature is in keeping with broader trends through which “social marketing has emerged as the dominant approach to health education and communication in the developing world” (Pfeiffer 2004; p. 77). Condom social marketing, in particular, has become the cornerstone of many AIDS education and prevention campaigns in sub-Saharan Africa (Pfeiffer 2004).

Contracting out was the second most prevalent PPE type reported in the literature, with eight contracting out initiatives identified in six countries. Contracting out consists of the delegation of a health-related responsibility by the state to a private partner in exchange for a
fee (Lagarde et al. 2009; Mills and Broomberg 1998). A contract is used to specify the type, quantity, quality and duration of the services contracted-out (Lagarde et al. 2009; Mills and Broomberg 1998). The contracted out services mentioned in the literature were primarily medical services in hospitals, clinics and through private physicians, but also included medical services contracted out to mining companies and NGOs. 3

Another PPE type prevalent in the literature is the GPPP. A GPPP is a collaborative, three-way partnership, including international donors and recipient governments, usually funded by a multinational health initiative through a substantial disbursement of funds, in which both government and non-government entities participate in decision-making through a mutually agreed upon and well-defined division of labour (Buse and Walt 2000a; Ciccone 2010; Widdus 2005). The GPPPs identified in the Southern African literature are predominantly aimed at HIV prevention and care – such as the African Comprehensive HIV/AIDS partnership (ACHAP), and the Khayelitsha ART programme (with Medicine Sans Frontiers and the Global Fund) – or at the detection and treatment of women’s cancers – Pink Ribbon, Red Ribbon (with PEPFAR and the Gates Foundation). A particularly interesting GPPP identified in the literature is the Apparel Lesotho Alliance to Fight AIDS (ALAFA), in which the Lesotho MoH, along with USAID, the Department for International Development (DFID) and international clothing companies, partnered with the Lesotho garment industry to provide HIV services and improve working conditions within the industry, and boost sales through ‘fair-trade’ marketing campaigns.

The Alzira model example identified through the review, in which the Lesotho Government contracted with Tsepong (a private consortium) is noteworthy as being reportedly the first of

3 It is important to note that contracting out for non-clinical services, such as laundry, security and housekeeping services, is common (IFC 2008), but such initiatives are excluded from this review which focuses on PPE for health service delivery and financing.
its kind in Africa and presented as a flagship PPP model by the International Finance Corporation (IFC) (Marriott 2014). The Alzira model is characterised by a contractual arrangement that combines the building of facilities with the operating of non-clinical services and clinical services including primary care provision for a defined population in return for capitated payment (Barlow et al. 2013; Cruz and Marques 2013).

**The levels of involvement of out-of-country partners in Southern African PPE initiatives reported in the literature**

A particularly interesting issue brought to light by the review is the extent to which reported PPE initiatives in Southern Africa are driven by out-of-country partners. Table 2 below presents the prevalence of international partners in Southern African PPE initiatives. Of the 52 PPE initiatives identified, 18 (thirty-five percent) were independent of support from international partners.

<table>
<thead>
<tr>
<th>Country</th>
<th>No. of PPE initiatives identified</th>
<th>No. and % with external partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Africa</td>
<td>19</td>
<td>5 (26%)</td>
</tr>
<tr>
<td>Malawi</td>
<td>7</td>
<td>7 (100%)</td>
</tr>
<tr>
<td>Zambia</td>
<td>7</td>
<td>6 (86%)</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>5</td>
<td>4 (80%)</td>
</tr>
<tr>
<td>Mozambique</td>
<td>4</td>
<td>3 (75%)</td>
</tr>
<tr>
<td>Botswana</td>
<td>3</td>
<td>3 (100%)</td>
</tr>
<tr>
<td>Lesotho</td>
<td>3</td>
<td>2 (66%)</td>
</tr>
<tr>
<td>Angola</td>
<td>2</td>
<td>2 (100%)</td>
</tr>
<tr>
<td>Namibia</td>
<td>1</td>
<td>1 (100%)</td>
</tr>
<tr>
<td>Swaziland</td>
<td>1</td>
<td>1 (100%)</td>
</tr>
</tbody>
</table>

(Source: Author)

South Africa is an outlier to this trend with only five of the 19 PPE initiatives identified having out-of-country partners. This indicates that the South African PPE initiatives reported in the literature tend to be more self-sufficient than elsewhere in Southern Africa. Of the 33
PPE initiatives identified in Southern African countries excluding South Africa, only four, or twelve percent, did not receive financial or technical support from out-of-country partners.

**Public-private engagement initiatives independent of out-of-country support**

The South African example indicates that a wide range of PPE models can be implemented in the Southern African context without external support – given the right health systems environment. South Africa’s reported in-country PPE initiatives include two contracting out arrangements (the part-time district surgeon approach and public-private work-place partnerships), four co-location PPPs, three PFIs, a PPM approach to child survival, two financing arrangements, one PPIP, and the remunerated work outside the public sector (RWOPS) approach to management of DP.

Co-location arrangements represent a particularly useful mechanism for private-sector engagement. A co-location arrangement is a long-term partnership through which a portion of a public hospital's premises is granted for use by a private provider, in return for payment and specified benefits to the public party (Hellowell 2013; Shuping and Kabane 2007). These types of arrangements present an opportunity for revenue generation as well as infrastructural management for public hospitals (Marek et al. 2005). The arrangement also facilitates private hospital provision to those who can afford it, easing the burden on the public hospital. The literature revealed four co-location PPPs in South Africa, while none were reported in the rest of Southern Africa although similar arrangements are known to exist.

Similarly, no private-finance arrangements were reported outside of South Africa. A PFI is a long-term contract in which the design, building financing and non-clinical operation of a facility is contracted to a private consortium (Hellowell 2013; McKee et al. 2006). PFIs offer
an opportunity to shift the risk of the construction of new health infrastructure onto a private partner, as well as make the cost of the project on the public sector easier to bear by distributing payments over the course of the contract (Hellowell 2013). In addition, by bundling constructing and facility maintenance, the arrangement can create positive incentives and improve efficiency.

Contracting out, discussed above as a model prevalent in the literature throughout the region, is another model that is found to be commonly employed without the support of out-of-country partners. In addition to the South African examples – which include the delegation of service provision to NGOs, mining companies, and private physicians – contracting out arrangements independent of out-of-country support, were found to be used in Zimbabwe and Lesotho. In South Africa, part-time district surgeons (PDS) are commonly used to provide care in remote or rural locations (Palmer 2003). Contracting of individual physicians was also found in Mozambique where the state contracts with expatriate doctors to supplement inadequate human resources for health (Vio 2006). As such, contracting with private physicians to provide services in underserved areas is an important mechanism of improving service coverage and access to care.

The regulation of DP, identified in South Africa, Zambia and Mozambique, can similarly increase the number of doctors willing to work in remote or rural locations (Berman and Cuizon 2004). As such it is surprising that the contracting of individual physicians, and regulations facilitating and controlling dual practice are not more common in the Southern African context.
Involvement of international organisations in Southern African PPE initiatives reported in the literature

Most of the PPE initiatives identified received either financial or technical support from GHIs or international donors. The systematic review identified a wide range of international donors and organisations contributing financial and technical support to PPE initiatives in Southern Africa. Table 3 presents the most prevalent of these organisations and the number of PPE initiatives they are reportedly involved with. By far the most prevalent global health partner is PSI. PSI is a global health organisation focusing on family planning, HIV/AIDS, and maternal and child health (PSI 2015). The organisation is characterised by a belief that services and products are most effective when combined with robust communication and distribution efforts (PSI 2015). PSI was identified as a global partner in 12 Southern African PPE initiatives – 11 social marketing initiatives and one voucher programme for insecticide treated bed-nets. PSI lists large international donor organisations – including USAID, DFID, GFATM, The Bill and Melinda Gates Foundation, and the United Nations International Children’s Emergency Fund (UNICEF) – among its key development partners.

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Occurrence of PPE involvement identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Services International</td>
<td>12</td>
</tr>
<tr>
<td>Department for International Development</td>
<td>6</td>
</tr>
<tr>
<td>United States President’s Emergency Plan for AIDS Relief</td>
<td>5</td>
</tr>
<tr>
<td>The Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
<td>4</td>
</tr>
<tr>
<td>Bill and Melinda Gates Foundation</td>
<td>3</td>
</tr>
<tr>
<td>Roll Back Malaria</td>
<td>2</td>
</tr>
<tr>
<td>Society for Family Health</td>
<td>2</td>
</tr>
<tr>
<td>World Health Organisation</td>
<td>2</td>
</tr>
<tr>
<td>George W. Bush Foundation</td>
<td>2</td>
</tr>
</tbody>
</table>

(Source: Author)
A noteworthy result of the review is the apparent lack of formal contracting arrangements in PPE initiatives supported by international donors. Thirty-four of the PPE’s identified in the review received support from international organisations. However, in only nine of these (twenty-seven percent) was a formal contract or memorandum of understanding apparent from the evidence. By way of comparison, of the 18 PPE initiatives without out-of-country partners identified in the literature, 14, or seventy-eight percent, involved formal contractual agreements or memoranda of understanding between primary partners. While this is not to say that no formal or informal contractual mechanisms were utilised in the externally-supported PPE initiatives identified, it does entail that information on the details of the relationship, the degree of accountability between partners, and the mechanisms used to achieve an appropriate level of accountability, is not available for use by future policy-makers and implementers.

**Discussion: Mapping the evidence, key findings, and recommendations**

The systematic review presented here reveals a disproportionate amount of evidence on PPE according to geographic location and types of partners; the evidence on PPE in South Africa was found to be disproportionately large, and PPE initiatives with for-profit partners, and those with international NGO partners, were found to be more commonly reported than examples of state engagement with in-country not-for-profit and informal provider partners. A surprising lack of evidence on state support for health financing initiatives aimed at the poor was also identified. Further research is suggested on topics including the nature of the relationship between governments and international partners, and the viability of particular PPE models in the Southern African context. In keeping with the ultimate aim of this review to enable further research regarding the models of PPE that are best suited to various
contexts, evaluative research is suggested that disaggregates PPE types and investigates PPE functioning in context. Key findings of this review include the wide range of potential partners in PPE for health and the resources they contribute, the context-dependent nature of PPE models, and the importance of trust and interpersonal relationships to PPE success.

**Potential partners and the resources they contribute**

At the outset of this review potential non-state partners for PPE initiatives were presumed to be for-profit or not-for-profit health sector actors. However, the review suggests that the range of potential partners in PPE for health includes actors not traditionally considered part of the health sector. These include academics, community-based organisations (Flynn 1996; Stren and Green 2005) and churches (Mazzeo and Makonese 2009); as well as industry actors, such as mining companies (Sinanovic and Kumaranayake 2006; Sinanovic and Kumaranayake 2010), the garment industry (Kenworthy 2014), and telecommunication and consultancy companies (Ndlovu et al. 2014).

In addition, although much of the available literature focuses on the material and technical resources that can be harnessed through PPE, the review revealed that private partners also represent a source of intangible resources that can be harnessed for the public good. These include the increased privacy and anonymity offered by certain types of private providers (Skibiak et al. 2001), and cultural acceptability, such as is presented by traditional healers (Ae-Ngibise et al. 2010). These intangible resources present a significant potential contribution to PPE initiatives. Collaboration with such providers can allow the public sector to wield these important resources in the public interest and policy-makers should remain cognisant of both the tangible and intangible capital that can be harnessed through PPE.
Geographic distribution of available literature

While the literature reports on 19 individual PPE initiatives in South Africa, evidence of PPE initiatives elsewhere is less prevalent, and, in some cases, starkly so. In both Namibia and Swaziland, the systematic review revealed only one PPE initiative in each country, and only two PPE initiatives were reported in Angola. It is unlikely that these figures are an accurate reflection on the prevalence of state engagement with non-state partners in these countries. It is more likely that these results are driven by systematic under-reporting, or that the modes of PPE being used were such that they could not be captured in this review. The fact that this systematic review used phrases relating to existing PPE models as search terms may have resulted in a failure to capture more uncommon or innovative PPE mechanisms. As such, further empirical research into the extent of PPE, and the types of PPE used, in these contexts is strongly recommended.

More generally, PPE models particular to the Southern African context may not have been captured by this review. Models of PPE specific to the Southern African context may present important lessons for other LMICs and efforts should be made to generate evidence in this regard. These considerations also raise the important question of the extent to which PPE models, and their successful implementation, are context-dependent. The literature suggests that best practice for PPE implementation is “situation specific” (World Bank Institute 2012; p. 11). The success of PPE initiatives is dependent on government’s capacity to negotiate, develop, implement and manage contracts and collaborative initiatives (Chopra et al. 2009; Jeffreys et al. 2003; Kula and Fryatt 2014; Marriott 2009; Sheaff et al. 2013). Some PPE models are more capacity-intensive than others. PFIs, for example, are particularly capacity-hungry, requiring extensive contract negotiation and management capacity, and having a high participation cost for the public sector (Bing et al. 2005). As such, the review indicates that
those considering the implementation of a PPE initiative should begin with a realistic appraisal of their capacity to manage the relationship, and should consider whether an alternative PPE model with a lower participation cost for the public sector might achieve the same, or similar, outcomes.

Other contextual factors that have been said to impact the success of PPE initiatives include human resource management capacity, financial management capacity, and the capacity of the state to impose sanctions, (Mugisha et al. 2005; Sheaff et al. 2013; Vio 2006). In addition, the nature of the private health care market, and the extent to which non-state partners are financially dependent on the state may impact the success of PPE initiatives (Palmer and Mills 2005; Sheaff et al. 2013). It is hoped that the PPE typology presented here will facilitate further research into the contextual factors influencing PPE outcomes, and comparative and evaluative studies surrounding which PPE models are best suited to different contexts.

The literature review also indicates the need for further investigation into the viability in the rest of Southern African of PPE models found to be used in South Africa. The South African PPE initiatives identified in the literature were largely independent of out-of-country support. In particular, co-location arrangements and PFIs are utilised in South Africa to harness private resources for public health goals, but were not identified elsewhere in Southern Africa. These PPE models may not be well suited to the Southern African context, but, given the potential gains they present it, may be worthwhile to investigate the feasibility of implementing PPE initiatives of this sort elsewhere in Southern Africa. Further research is suggested in this regard.
In addition, it is possible for Southern African countries to learn from the experiences of other African countries in implementing innovative PPE models. For example, contracting with the non-state sector, in particular faith-based organisations (FBOs), is common throughout Africa (Boulenger et al. 2012; Boulenger et al. 2009) and can utilise models of engagement not identified in this search, such as designating faith-based health facilities as public sector institutions, and co-ownership of health facilities by faith-based providers and the state (Olivier and Wodon 2012). These models indicate the potential for Southern African countries to learn from the experiences of countries elsewhere in Africa, and a need for further research regarding the viability of such models in the Southern African context.

**Scarcity of evidence of state engagement with in-country NPOs**

The distribution of results indicated by this review may have been influenced by the types of providers that governments in different contexts commonly engage with. This review revealed only four PPE initiatives in which the non-state partner was an in-country NGO, without international organisation affiliation or funding. It is unlikely that these results reflect the actual levels of PPE with in-country NGOs. Rather it can be presumed that such partners lack sufficient resources to ensure that their work and the results thereof are reported. Engagement with not-for-profit providers presents an important opportunity for achieving population health gains, particularly for low-income countries. As such it is vital that information on the mechanisms used to engage with not-for-profit providers, and evaluations of these mechanisms, are available to policy-makers.

**State engagement with the informal sector**

This systematic review aimed to capture evidence of PPE with both formal and informal providers. However, no literature on engagement with the informal health sector was
identified in the review. In low-income countries, the informal private sector – comprising providers who have not been formally trained and operate outside the purview national regulations – tends to be large (Peters et al. 2004). Pharmacy vendors and traditional healers constitute a primary source of health care in many African countries (Peters et al. 2004) and the World Health Organisation encourages the inclusion of traditional healers in health programmes (Ae-Ngibise et al. 2010). The lack of evidence of PPE with informal providers is particularly concerning given that it is these providers that are most commonly utilised by the poorest segments of the population (Hanson et al. 2008). While it is recognised that the difficulties inherent in engaging with informal providers may result in very few engagements of this sort being undertaken (Hanson et al. 2008), it is also possible that such initiatives are under-reported. Engaging with informal providers constitutes a significant challenge that must be undertaken in order to ensure patient safety and quality of services (IFC 2011; Peters et al. 2004). Further research is necessary to establish the extent of state engagement with informal providers, and the factors that enable and inhibit such engagement.

**Regulation of dual practice**

The regulation of DP presents a similar challenge. DP involves health workers working in both public and private sectors simultaneously (García-Prado and González 2011). The practice occurs to various extents in both developed and LMIC contexts (García-Prado and González 2011), including countries with regulatory restrictions against the practice (Ferrinho et al. 2004). DP can lead to improvements in the delivery of health services, but may also have undesirable effects on health systems (García-Prado and González 2011). Internationally, DP is seen as a system-wide solution to limited resource availability in the public health sector (Wadee and Khan 2007). In LMICs, where there are insufficient incentives for doctors to work in the public sector, DP may facilitate government retaining
physicians in the public sector at a lower cost, because providers can supplement their income in the private sector (Ashmore and Gilson 2015; Ferrinho et al. 2004; García-Prado and González 2011).

However, in LMICs it is not uncommon for DP to increase absenteeism by incentivising physicians to work less than their contracted number of hours in the public sector as a result of the demand for their services in the private sector (Ashmore and Gilson 2015; García-Prado and González 2011). In addition, private-sector work may decrease public sector job-satisfaction, and exacerbate the internal ‘brain drain’ (Ashmore and Gilson 2015; Ferrinho et al. 2004). DP can also worsen public/private inequalities because providers may provide better quality care in their private practices (Madhavan and Bishai 2010). As such, the practice must be adequately regulated and regulations must be enforced (Ashmore and Gilson 2015). Effective and well-targeted regulations will help to retain physicians in the public sector while mitigating the ill-effects of dual practice (Marek et al. 2005).

The literature revealed evidence of attempts to regulate this practice from only three of the ten countries under review. In South Africa, regulations to limit DP, known as the remunerated work outside public services (RWOPS) policy requires physicians to apply for the privilege of undertaking dual practice, limits the number of hours physicians work outside of public services, and stipulates that private sector work must be done outside the hours for which the applicant is paid by the public sector (Ashmore and Gilson 2015; Benatar 2014; Moorman 2001). Similar restrictive regulations are in place in Zambia – where only senior physicians are permitted to engage in DP – and an outright ban is in place in Mozambique (Berman and Cuizon 2004; Russo et al. 2014).
However, the evidence suggests that the implementation and effectiveness policies to manage DP is problematic. In Zambia, DP regulations are ill-enforced and regularly flouted, and in Mozambique the ban is selectively applied and commonly ignored (Berman and Cuizon 2004; Russo et al. 2014). In South Africa, there is concern that absenteeism has increased as a result of the policy, and that DP privileges are being abused by health practitioners (Ashmore and Gilson 2015; Benatar 2014). Given the likely prevalence of the practice throughout the region (García-Prado and González 2011; Russo et al. 2014), and the evident difficulty of controlling the practice, the lack of reporting on the mechanisms and effectiveness of regulation of dual-practice is worrisome.

State support for health financing for the poor

This systematic review sought to include PPE initiatives for health financing. However no such initiatives were identified through the review. Community-level prepayment plans have been recommended as a complement to government financing, particularly in sub-Saharan Africa (Waters et al. 2003). However, sub-Saharan African governments have failed to respond appropriately to international pressure for the institution of national policies that support community health insurance (CHI) (De Allegri 2009). CHI can increase access to care and prevent impoverishment as a result of ill-health among poor, vulnerable and informally employed populations (De Allegri et al. 2009). Low enrolment has been identified as the primary factor inhibiting the growth of CHI schemes in Sub-Saharan Africa (De Allegri et al. 2009; Kalk 2008). Even very small contributions are a considerable financial burden for the very poor that constitute the target population of CHI schemes (Kalk 2008). As such, governments can, and should, support these schemes through subsidies (De Allegri et al. 2009; Kalk 2008).
However, despite the fact that voluntary pre-paid plans are extensive in Southern Africa (Marek et al. 2005) only one instance of PPE for health financing was identified in the review. The Government Employees Medical Scheme (GEMS) in South Africa is a heavily subsidised, voluntary health insurance scheme, but is restricted to government employees and as such does not target the poor, vulnerable or informally employed (Govender et al. 2013). Particularly in countries such as Namibia and South Africa, where the private health insurance industry is strong (Foster 2012), there may be room for expansion of PPE for CHI. Further research into the factors inhibiting state involvement in CHI and similar schemes is suggested.

**Mechanisms to structure relationships between governments and international donors**

This review revealed a lack of information regarding the contractual mechanisms (formal or informal) in GPPPs and other PPE initiatives between states and international donors, international NGOs and GHIs. Of the seven GPPPs identified, information regarding the formalisation of the relationship between development partners and government was available for only two. The relationship between ACHAP and the government of Botswana is described as a “formal operational agreement” (Distlerath and Macdonald 2013; p. 5), and the Khayelitsha ART programme involves informal relational contracts with implementing partners and a formalised grant agreement between the Western Cape DoH, and GFATM (Hodes and Naimak 2011). This lack of information is concerning from an academic perspective in that it disallows the development of a body of knowledge regarding how states do, and should, engage with out-of-country partners. However, it is also concerning to the extent that, if this lack of evidence is indicative of a limited use of formal or informal mechanisms to structure relationships between partners, such arrangements may inadvertently
shift the balance of power away from state players and ultimately undermine the capacity of the collaboration to make a positive contribution.

Contracts, or memoranda of understanding (MOUs), can facilitate clarity regarding risk allocation, division of responsibilities, performance requirements and termination provisions, inter alia (World Bank Institute 2012). The involvement of international actors in national health systems raises significant questions about accountability (Brugha 2009). Accountability within PPE initiatives between national governments and international organisations is difficult to achieve (Buse and Walt 2000b) and the growing dominance of GPPPs raises serious questions about how to ensure accountability on the part of global partners (Ciccone 2010). While all GHIs include MoH partners, the role of these partners and their capacity to influence decisions is unclear (Buse and Walt 2000b). Without formal agreements detailing the expectations and responsibilities of each partner, it is difficult for national governments to hold global partners to account in achieving desired outcomes and upholding the public interest.

This is particularly concerning when the financial dependence of the state on an international partner further undermines the power of the public partner to dictate terms (Buse 2003) and gives donors increased decision-making power (Ciccone 2010). An asymmetric division of power is inevitable when the public sector is financially reliant on a global partner (Ciccone 2010). Furthermore, the influence of donors is not always in keeping with national public health priorities, national social values or health system strengthening. The involvement of international donors has at times been problematic in terms of a lack of alignment with country needs and priorities, the distortion of recipient countries’ national health policy (Biesma et al. 2009), the creation of expensive parallel bureaucracies for donor management
and increasing the burden on already fragile health systems (Brugha 2009), exacerbation of
the ‘internal brain-drain’, as well as decreased domestic health sector spending (Biesma et al.
2009; Carter et al. 2006; Lancet 2009). As such, investigation into how best to structure
relationships between international donors and national governments in order to ensure that
PPE arrangements empower state partners and strengthen health systems is vital.

Sector-wide approach as an accountability mechanism

SWAps present a potential means of improving accountability between governments and
donors. A SWAp is an MoH-led formal, long-term cooperative agreement with civil society
and donors in which all parties pool available resources and work in accordance with jointly
approved national sectoral strategies and expenditure frameworks to improve population
health outcomes and facilitate national development (Cassels 1997; Perrot 2006). SWAps
utilise formalised, relational mechanisms, in the form of a negotiated agreement between
actors, that describe the roles and responsibilities of each actor in the joint venture (Perrot
2006). All three SWAps identified in this review – Malawi, Zambia and Mozambique SWAp
arrangements – utilised MOUs to formalise relations between partners (Jeffreys et al. 2003).
Donors involved in the SWAp cede the right to select vertical projects to finance (thereby
allowing government to ensure expenditure of funds is in line with national policies), in
exchange for the opportunity to influence the development of a sectoral strategy and
resource-allocation decisions (Cassels 1997). All partners are obligated to work under the
framework of the government’s strategic vision for the health sector (Mugisha et al. 2005).
As such, SWAps aim to facilitate accountability of international partners and donors to
national priorities.
However, the achievement of this aim is commonly undermined by a lack of donor commitment. In Mozambique, for example, 11 years after the implementation of the SWAp, only fourteen percent of health sector funding was channelled through the SWAp, while fifty-five percent was utilised in vertical un-integrated programmes (Mussa et al. 2013). In 2003, six years after the implementation of the SWAp, Government’s capacity to absorb donor funds was still considered low, as was management, implementation, planning and monitoring capacity, and there was little consistency between the national medium-term expenditure frameworks and the activities of major international donors (Jeffreys et al. 2003).

The Malawi SWAp is undermined by a similar lack of capacity as a result of extreme under-staffing; financial management systems within the MoH are weak and undermine donor’s willingness to commit financial resources to basket funding (Jeffreys et al. 2003). The Malawi SWAp also faces a lack of commitment on the part of key donors (Jeffreys et al. 2003). GFATM is a major financial supporter of the Malawi SWAp, but the disbursement of funds is conditional and therefore cannot be depended on in the long term (Carter et al. 2006). Similarly, in Zambia it was found that despite the SWAp, administrative structures and development programmes remain, to a large, extent vertical and project focused (Sundewall and Sahlin-Andersson 2006). In general, vertical measures remain the default approach to international aid (Unger et al. 2006) and aid initiatives frequently bypass government health plans and priorities (Marriott 2009). As such, the SWAp approach commonly fails to create an appropriate level of accountability on the part of international partners to national priorities. No literature was identified in this review regarding how best to ensure accountability between international donors and national governments, or how to improve SWAp functioning.
The effects of imbalanced power relations between governments and international donors on the social value of the health system?

The value of a national health system exceeds the health gains it produces. “The design given to political institutions such as health systems governs the notions of morality and justice prevailing in society” (Rothstein 1998; p. 160). An effective health system is a core social institution, and recognition that a strong health system is an essential component of a just and equitable society is growing (Backman et al. 2008). Trusted and strong national health systems can contribute to wider social values including nation building and social cohesion (Chopra et al. 2009; Gilson 2003; Streefland 2005). However, because GHIs work in many countries simultaneously, funds are commonly disbursed in a manner that is not tailored to the epidemiological or cultural contexts of the recipients (Biesma et al. 2009). In addition, the disbursement of donor funds can be subject to value-based conditions, such as PEPFAR grants, for example, which at times have been dependent on explicit opposition of prostitution (Carter et al. 2006). As such, reliance on donor funding can inhibit the ability of health systems to be representative of national priorities or values (Biesma et al. 2009), undermining national ownership. Research ought to be conducted into the effects of donor involvement on national health systems ownership, social cohesion and the social value of the health system. Furthermore, international partners should be cognisant of the social value of the health system in their engagement with national partners.

Sustainability of PPE initiatives with international donors

An important function of contracts (whether formal or informal) and accountability mechanisms, is the stipulation of provisions for termination of relations (see World Bank Group 2014). Termination provisions include defining the contract term, making provisions for handover of functions and stipulating the circumstances under-which the relationship can
be prematurely terminated (World Bank Institute 2012). Sustainability entails the ability of national health systems to assume full responsibility for programmes without an adverse effect on programme outcomes (Ooms 2006). The question of how to manage the transition back to purely public provision is one that requires careful consideration and should (but rarely does) constitute a key concern in programme development (Jacobs et al. 2010). As such, these are vital considerations for the sustainability of programmes developed and implemented with donor support.

This is especially so because, when funding for programmes is donor-driven it cannot be depended on, as was demonstrated by the effects of the 2008 global financial crisis which had negative consequences for donor supported health programmes (Hodes and Naimak 2011; Kirigia et al. 2011). Development assistance is temporary and precarious and donor-funded programmes are commonly created without guarantee that funding will continue in the long term (Ciccone 2010; Ooms et al. 2008). The literature review revealed no studies on how best to ensure sustainability of donor-funded programmes and no information regarding mechanisms for management of the transition back to public funding and provision. Furthermore the extent to which more formalised relationships between partners would mitigate these risks is as yet unclear.

**How can international partners contribute to PPE management capacity strengthening?**

One potential mechanism by which international partners can mitigate the risks of the unsustainable nature of donor driven programmes may be to work to build the PPE management capacity of local and government partners. In this way, when donor-driven
programmes come to an end, government partners could use PPE with in-country actors to ensure the continued provision of services.

Adequate regulation of the private sector requires significant stewardship and regulatory capacity on the part of the state (Nishtar 2010). Similarly, the use of PPE in the health system necessitates substantial administrative capacity on the part of the government to develop, manage and enforce contracts and regulatory procedures, and create agreements that protect public health (Bennett et al. 2005; Marriott 2009). Poor contract design and insufficient monitoring capacity commonly undermine contracting arrangements in the health sector (Sinanovic and Kumaranayake 2010), and it is not uncommon for government to agree to contractual terms that result in an unfavourable distribution of risk, or that allow for sanctions that the government is, in actuality, unable to impose (Doherty 2011).

One potential way for international donor organisations to contribute in a meaningful and sustainable manner to health systems development in Southern Africa might be to increase the transfer of partner management capacity between international and state partners. Nishtar (2010) suggests that the role of GHIs should be expanded to include engagement with countries to maximise the workload of a broad range of providers, thereby building a sustainable workforce while strengthening regulatory capacity. Collective development and implementation of programmes that involve government, health providers and NGOs may facilitate skills transfer, local ownership and sustainability (Hodes and Naimak 2011). However evidence of the effects of collaboration with GHIs on the strength of health systems is limited (McCoy 2009). Further research regarding factors that facilitate such knowledge transfer, as well as the effectiveness of PPE management capacity transference as a mechanism of health system strengthening, is suggested.
Relational contracts and trust

In conducting the extended research suggested above, it will be important to remain cognisant of the role played by informal, relational and trust-based mechanisms for structuring relationships between partners. A central aim of this review was to facilitate evaluative research of the comparative strengths of various PPE organisational models. At the outset of the review, as a result of background reading, the organisational factors assumed to be relevant to the success of PPE projects included directly observable organisational characteristics such as the distribution of risk between partners, funding sources and payment mechanisms, the division of responsibilities, incentives, contracts and monitoring arrangements, and the bundling of services, etc. While the systematic review confirmed that these features can influence the success of PPE arrangements, the review also illuminated the importance of intangible features of relationships between partners to successful PPE.

The mechanisms by which partners exert control can be formal – utilising formal contracts and financial incentives, or informal/relational – using interpersonal relationships, industry norms, reciprocity, values and trust to manage the behaviour of partners (Chambers et al. 2013; Kernaghan 1993; Perrot 2006; Thomson et al. 2009). Interpersonal relationships between partners often play a significant role, sometimes more so than contractual or monitoring mechanisms (Palmer and Mills 2005). The degree to which each partner perceives that other partners are committed and engaged in the project, affects their own willingness and commitment – described by Thomson et al. (2009) as an “I-will-if-you-will” mentality. As such, trust and a perception of ‘fair dealing’ constitute important control mechanisms (Thomson et al. 2009).
The relationship between government and the non-state health sector in LMICs has historically been, and in many contexts remains, marred by tension and mistrust (Bennett et al. 2005). This mistrust, combined with limited PPE management capacity can undermine PPE initiatives. On the other hand, however, PPE can empower non-state actors to make a genuine contribution to health sector governance (Kernaghan 1993) and strong interpersonal relationships and shared ideologies may decrease the capacity required on the part of the state to ensure successful PPE initiatives. If trust can be achieved and maintained, it can significantly reduce the transaction costs of collaboration (Thomson et al. 2009). Relational approaches to PPE may also be more sustainable than traditional contractual approaches (Thomson et al. 2009). Furthermore, such approaches may also be much better suited in contexts where capacity for developing, negotiating, implementing and enforcing formal contracts is low, as is the case in many LMICs (Palmer and Mills 2005). This review has illuminated the importance of the role of relational contracts, norms of behaviour and trust in PPE project development and implementation, and the feasibility of using these mechanisms to improve the performance of PPE initiatives is an area that should be explored further.

Next steps: Evaluating PPE models in context

One of the primary aims of this review was to facilitate evaluative research that examines the effectiveness of various PPE models in context. PPE initiatives are heterogeneous; the various PPE models discussed here have distinct strengths and weaknesses, and their successful implementation will depend on the suitability of the model to the context in which it is implemented, among other factors. The need for further research into the suitability of various PPE models in various contexts is underlined by a particularly troubling PPE example identified in the review. The Tsepong/Lesotho PPE for the Queen Mamohato Hospital in Maseru reportedly constitutes the first Alzira model PPE initiative in Africa.
(Marriott 2014). The partnership has been described by the IFC as a flagship model to be replicated elsewhere in Africa because it represents an innovative DBFO arrangement that includes the delivery of primary and tertiary medical services bundled under one contract (Marriott 2014). In theory, the model allows the private partner to create efficiencies by controlling the flow of patients from primary to tertiary level services (Coelho and O'Farrell 2011).

However, despite the IFC playing the role of contract advisor to the Lesotho Government, serious flaws in the contract design have led to rapidly increasing costs borne by the public partner. Higher than expected use of the facilities, as well as issues with human resource retention, have resulted in annual costs of US$67 million per year, diverting the country’s resources away from urgently needed primary care in rural areas (Marriott 2014). In addition, the contract allows Tsepong a twenty-five percent return on equity, compared to a (profitable) international norm of between thirteen and eighteen percent for similar projects (Marriott 2014). The imbalance of power in the contract negotiation was reportedly inadequately managed by the IFC which failed to make up for insufficient operational management capacity on the part of the state (Marriott 2014). The PPE initiative has been described as a “dangerous diversion of scarce public funds from primary healthcare services in rural areas” (Marriott 2014; p. 1).

This example demonstrates the need for caution in engaging with private partners for health. It should also constitute a call for further research into the contextual factors that facilitate or undermine the success of various PPE initiatives. Research is needed to guide decision-makers in deciding which PPE models are most likely to be successful in their context and
the steps that can be taken by implementers to ensure PPE success. It is hoped that the study presented here will go some way to facilitating such research.

Summary

This literature review revealed substantial gaps and, in some cases, a disproportionate distribution of the available literature on PPE in Southern Africa. In particular the available literature disproportionately presents evidence on PPE initiatives in South Africa, is biased towards reporting on PPE initiatives involving for-profit partners and those involving international donors, and demonstrates a lack of coverage on public-sector engagement with informal partners. Significant gaps in the available literature are also apparent with regard to state involvement in health financing mechanisms targeted at the poor and informally employed, as well as mechanisms to improve the regulation of DP. In addition, information regarding the nature of relationships between international donor organisations and national governments, and how these relationships can be strengthened to ensure sustainability of donor-funded programmes and the empowerment of state-partners, is limited. Further research into the context-dependency of PPE models, as well as the viability of implementing models used in South Africa and Africa in general, in Southern African contexts, is recommended. The review revealed that partners in PPE for health need not be limited to health sector actors, and that non-state partners can contribute intangible and tangible resources to public health goals. In addition, the review indicates that trust and interpersonal relationships should be considered alongside organisational particularities as key determinants of PPE success. On the basis of this review it is recommended that any PPE initiative should begin with a realistic appraisal of the state’s PPE management capacity, and international partners should strive to make a contribution to PPE management capacity strengthening. Further, it is recommended that Southern African governments should
consider investing in CHI schemes through PPE, and that, particularly in South Africa and Namibia, the engagement of the private health insurance sector in PPE for CHI should be explored.

It is hoped that the research presented here will facilitate further studies that acknowledge the heterogeneous nature of PPE, and in doing so create evidence that can be used to improve PPE functioning. Further it is an ambition of this paper to facilitate increased involvement of the private sector in public health by illuminating the wide variety of potential models for engagement with the state. Given the prevalence of PPE and the capacity of engagement with non-state partners to improve population health and contribute to health systems strengthening, it is vital that the evidence base guiding policy-makers in their decisions regarding which PPE models to utilise, and how best to implement them, is strengthened.
References

Ae-Ngibise K, Cooper S, Adiibokah E, et al. 2010. ‘Whether you like it or not people with mental problems are going to go to them’: A qualitative exploration into the widespread use of traditional and faith healers in the provision of mental health care in Ghana. *International Review of Psychiatry, 22*: 558-567.


*BMC International Health and Human Rights*, **11**: 1-10.


Appendices

Appendix 1: Definitions of public-private engagement models

<table>
<thead>
<tr>
<th>PPE Models</th>
<th>Social Marketing</th>
<th>Sector-Wide Approach</th>
<th>Public-Private Mix Approach</th>
<th>Voucher Programmes</th>
<th>Contracting-out</th>
<th>Dual Practice Regulation</th>
<th>Financing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public-Private Partnership</td>
<td>Long-term contractual arrangement for the development, financing and/or provision of public infrastructure (and sometimes services), in which risk and management responsibility are shared.</td>
<td>The social marketing approach uses commercial sector marketing and communication approaches to 'sell' products of a high social or public health value, or to bring about behaviour change among a target population. Commonly SM programmes use CBOs, NGOs, or public sector facilities to distribute products. Often involve product subsidy to ensure affordability and rely on external funding.</td>
<td>An MoH-led formal, sustained cooperative agreement with civil society and donors in which all parties are obligated to pool available resources and work together in accordance with jointly approved and negotiated national sectoral strategies and expenditure frameworks to improve population health outcomes and facilitate national development.</td>
<td>A PPM approach consists of initiatives to increase collaboration and improve relationships between all forms of health care providers providing care for a particular disease</td>
<td>Using demand-side subsidies with defined benefits to transfer purchasing power for specified goods and services to poor and vulnerable groups.</td>
<td>A public authority delegates responsibility for the provision or management of a service on behalf of the state in exchange for a fee, using a contract that specifies the type, quantity and time period of the services to be provided.</td>
<td>The development and enforcement of regulations, policy and other mechanisms to prevent or control public sector health providers working in the private sector.</td>
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</table>

Key Characteristics
### Public-Private Partnership Types:

All PPPs are: long term, formal contractual arrangements, highly collaborative, involve a transfer of risks

<table>
<thead>
<tr>
<th>Private Finance Initiative or (DBFO)</th>
<th>Public-Private Integrated Partnership</th>
<th>Alzira Model</th>
<th>Franchise*</th>
<th>Co-location Public-Private Partnership</th>
<th>Global Public-Private Partnership</th>
</tr>
</thead>
</table>
This is a long-term contract in which the design, building, financing and non-clinical operation of a facility, in accordance with public authority requirements is contracted to a private consortium.

A long-term partnership between the state and a private consortium in which contracted services include infrastructure, non-clinical operations and clinical operations delivered to a specified segment of the population.

The Alzira model is characterised by a contractual arrangement that combines the building of facilities with the operating of non-clinical services and clinical services including primary care provision for a defined population in return for capitates payment.

The public authority uses contracting arrangements to harmonise the activities of a network of providers, supporting the providers through branding and bulk drug purchasing, while strictly controlling the quality, quantity and package of services provided and disallowing cream-skimming.

A long-term partnership through which a portion of a public hospital's premise is granted for use by a private provider, sharing infrastructure and support services but operating as distinct facilities, in return for payment and specified benefits to the public party.

A collaborative relationship, transcending national boundaries, in which both government and non-government entities provide financing and participate in decision-making through a mutually agreed upon and well-defined division of labour, so as to achieve a shared goal. All partners contribute and benefit equally.

GPPPs are commonly three-way partnerships including international donors, recipient governments and NGOs or corporations.

<table>
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<th>Key Characteristics</th>
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<tbody>
<tr>
<td>Utilises private financing mechanisms</td>
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<td>Includes upgrading/building as well as non-clinical facility management</td>
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<td>---</td>
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<tr>
<td>3-way subcontract structure (finance, build/procure, manage)</td>
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</tbody>
</table>

* The term 'franchising' is also sometimes used to refer to contracting-out of hospital management.

(Source: Author)
### Appendix 2: Summary of documents under review

<table>
<thead>
<tr>
<th>Type of PPE</th>
<th>Country</th>
<th>Name of PPE</th>
<th>Relevant documents in review</th>
<th>Author(s) &amp; Year of Publication</th>
<th>Year established</th>
<th>Out-of-country partner?</th>
<th>Partners</th>
<th>Contractual or Non-contractual</th>
<th>Risk Transfer &amp; Sustainability</th>
<th>Decision-making responsibility &amp; Power</th>
</tr>
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<tr>
<td>Social Marketing</td>
<td>Mozambique</td>
<td>Jetto Condom Social Marketing PSI</td>
<td>Condom social marketing, Pentecostalism, and structural adjustment in Mozambique: A clash of AIDS prevention messages</td>
<td>2004: Pfeiffer, J.</td>
<td>1994</td>
<td>Mozambique MoH</td>
<td>PSI (int NGO)</td>
<td>National</td>
<td>International</td>
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<td>Social Marketing</td>
<td>Namibia</td>
<td>ITN Social Marketing</td>
<td>Social marketing and the fight against malaria in Africa: population services international (PSI) and insecticide treated nets (ITNS)</td>
<td>2009: Omona, Julius</td>
<td>1994</td>
<td>Namibia MoH &amp; Social Services</td>
<td>PSI, int NGO; Roll Back Malaria (global health initiative)</td>
<td>National</td>
<td>International</td>
<td>Programmes tailored to needs of MoH</td>
</tr>
<tr>
<td>Social Marketing</td>
<td>Angola</td>
<td>ITN Social Marketing</td>
<td>Social marketing and the fight against malaria in Africa: population services international (PSI) and insecticide treated nets (ITNS)</td>
<td>2009: Omona, Julius</td>
<td>1994</td>
<td>Govt of Angola</td>
<td>PSI, int NGO; Roll Back Malaria (global health initiative)</td>
<td>National</td>
<td>International</td>
<td>Programmes tailored to needs of MoH</td>
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<td>Social Marketing</td>
<td>Zambia</td>
<td>Care Female Condoms</td>
<td>Intention to use the female condom following a mass-marketing campaign in Lusaka, Zambia</td>
<td>2001: Agha, Sohail</td>
<td>1997</td>
<td>Zambia MoH</td>
<td>PSI (int NGO), USAID</td>
<td>National</td>
<td>International</td>
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Part C: Journal article manuscript
<table>
<thead>
<tr>
<th>Location</th>
<th>Condoms</th>
<th>The reach and impact of social marketing and reproductive health communication campaigns in Zambia</th>
<th>Author(s)</th>
<th>Year</th>
<th>Organization(s)</th>
<th>Source of funding</th>
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<tbody>
<tr>
<td>Zambia</td>
<td>Maximum Condoms</td>
<td>2007: Van Rossem, Ronan Meekers, Dominique</td>
<td>1992: Zambia MoH, PSI (int NGO), Society for Family Health (local NGO, PSI affiliate)</td>
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<td></td>
<td>Care Female</td>
<td>Factors associated with use of the female condom in Zimbabwe</td>
<td>2005: Meekers, Dominique Richter, Kerry</td>
<td>1997</td>
<td>Zimbabwe National AIDS Coordination Program, Zimbabwe National Family Planning Council</td>
<td>PSI (int NGO), USAID, DFID</td>
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<tr>
<td>South Africa</td>
<td>Lover's Plus Trust Care</td>
<td>Progress and challenges to male and female condom use in South Africa</td>
<td>2002: Bekinska, Mags E. Smit, Jennifer A. Mantell, Joanne E.</td>
<td>National DoH</td>
<td>Society for Family Health (local NGO, PSI affiliate)</td>
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<td>Malawi</td>
<td>ITN Social Marketing</td>
<td>2006: Mathanga, Don P. Campbell, Carl H. Taylor, Terrie E. Barlow, Robin Wilson, Mark L.</td>
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<tr>
<td>Socially marketed insecticide-treated nets effectively reduce Plasmodium infection and anaemia among children in urban Malawi</td>
<td>1998: Omana, Julius</td>
<td>Malawi MoH</td>
<td></td>
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<tr>
<td>PSI (int NGO)</td>
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<td>Malawi MoH</td>
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<tr>
<th>Malawi</th>
<th>WaterGuard</th>
<th>2012: Wood, Siri Foster, Jennifer Kols, Adrienne</th>
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<tbody>
<tr>
<td>Understanding why women adopt and sustain home water treatment: Insights from the Malawi antenatal care program</td>
<td>2002: Malawi MoH</td>
<td>Malawi MoH</td>
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<tr>
<td>PSI (int NGO), USAID</td>
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<td>Malawi MoH</td>
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</table>

<table>
<thead>
<tr>
<th>Malawi</th>
<th>Malawi SWAp</th>
<th>2007: Simwaka, Bertha Nhlema Bello, George Banda, Hastings Chimizizi, Rheeab Squire, Bertel Sb Theobald, Sally J.</th>
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<tbody>
<tr>
<td>PSI (int NGO)</td>
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<td>DFID, Global Fund, USA Govt, Govt of Norway,</td>
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<td>Govt-driven programme of work, strengthens collaboration with non-state players</td>
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<td>Malawi Ministry of Health and Population</td>
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<tr>
<td>Study Title</td>
<td>Year</td>
<td>Authors</td>
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<tr>
<td>Assessing the use of an essential health package in a sector wide approach in Malawi</td>
<td>2011</td>
<td>Bowie, Cameron Mwase, Takondwa</td>
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<tr>
<td>Mapping of Sector Wide Approaches in Health</td>
<td>2003</td>
<td>Jeffreys, Emma Walford, Veronica Pearson, M</td>
</tr>
<tr>
<td>Engendering the bureaucracy? Challenges and opportunities for mainstreaming gender in Ministries of Health under sector-wide approaches</td>
<td>2005</td>
<td>Theobald, S. Tolhurst, R. Elsey, H. Standing, H.</td>
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<tr>
<td>Impact Evaluation of the Sector Wide Approach (SWAp), Malawi</td>
<td>2010</td>
<td>Pearson, Mark</td>
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<td>Global Fund investments in human resources for health: innovation and missed opportunities for health systems strengthening</td>
<td>2014</td>
<td>Bowser, Diana Sparks, Susan Powers Mitchell, Andrew Bossert, Thomas J. Barnighausen, Till Gedik, Guln Atun, Rifat</td>
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<tr>
<td>Vertical funding, non-governmental organizations, and health system strengthening: perspectives of public sector health workers in Mozambique</td>
<td>2013</td>
<td>Mussa, Abdul H. Pfeiffer, James Gloyd, Stephen S. Sherr, Kenneth</td>
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**Mozambique**

**Mozambique SWAp**

<table>
<thead>
<tr>
<th>Year</th>
<th>Mozambique MoH</th>
<th>Govts of Norway, Switzerland, EU, UK, Ireland</th>
<th>Partners sign memorandum of understanding to formalise agreement.</th>
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<tr>
<td>Part C: Journal article manuscript</td>
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<td><strong>Zambia</strong></td>
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<td><strong>Zambia SW Ap</strong></td>
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<tr>
<td><strong>Mapping of Sector Wide Approaches in Health</strong>&lt;br&gt;2003: Jeffreys, Emma Walford, Veronica Pearson, M</td>
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<tr>
<td><strong>Exploring SWAps contribution to the efficient allocation and use of resources in the health sector in Zambia</strong>&lt;br&gt;2008: Chansa, Collins Sundewall, Jesper McIntyre, Di Tomson, Goran Forsberg, Birger C.</td>
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<tr>
<td><strong>Mapping of Sector Wide Approaches in Health</strong>&lt;br&gt;2003: Jeffreys, Emma Walford, Veronica Pearson, M</td>
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<tr>
<td><strong>Translations of health sector SWAps—A comparative study of health sector development cooperation in Uganda, Zambia and Bangladesh</strong>&lt;br&gt;2006: Sundewall, Jesper Sahlin-Andersson, Kerstin</td>
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<tr>
<td><strong>Flexible SWAps for Strategic Policy-making: Reflections on the Zambian Experience</strong>&lt;br&gt;2007: van Donge, Jan Kees</td>
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<tr>
<td><strong>Global PPP</strong></td>
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<td><strong>Pink Ribbon Red Ribbon</strong></td>
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<tr>
<td><strong>Innovative public-private partnership: a diagonal approach to combating women’s cancers in Africa</strong>&lt;br&gt;2013: Oluwole, Doyin Kraemer, John</td>
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</table>

<p>| <strong>Health policy and priority setting conducted under strong MoH leadership.</strong> |
| <strong>All activities undertaken in accordance with national strategic plan. Aims to build national leadership for health systems stewardship.</strong> |
| <strong>Use signed memorandum of understanding to formalise agreement.</strong> |
| <strong>Funds used in accordance with national policies</strong> |
| <strong>Emphasised country ownership and leadership of the project.</strong> |</p>
<table>
<thead>
<tr>
<th>Botswana</th>
<th>ACHAP Botswana</th>
<th>Saving Mothers Giving Life</th>
<th>2014: Kruk, Margaret E. Rabkin, Miriam Grépin, Karen Ann Austin-Evelyn, Katherine Greeson, Dana Masvawure, Tsitsi Beatrice Sacks, Emma Rose</th>
<th>2011</th>
<th>Zambia MoH, PEPFAR, Every Mother Counts (int NGO), American College of Obstetricians &amp; Gynaecologists</th>
<th>Contractual arrangement with non-governmental implementing partners but not with MoH</th>
<th>No Plan for sustainability or expansion</th>
<th>Implementing partners 'support' MoH district health teams. Activities closely aligned with national health strategies. Central-level involvement and ownership low, but support high.</th>
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</thead>
<tbody>
<tr>
<td>Country</td>
<td>Project방송</td>
<td>Description</td>
<td>Year(s)</td>
<td>Sponsor(s)</td>
<td>Notes</td>
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<td>Lesotho</td>
<td>ALAMA</td>
<td>A Manufactur(RED) Ethics: Labor, HIV, and the Body in Lesotho's &quot;Sweat-free&quot; Garment Industry</td>
<td>2014</td>
<td>Kenworthy, Nora J.</td>
<td>USAID, DFID, Gap, Levi [existence of a contract between ALAMA and MoH not specified, but designation of the project as a PPP implies a formal contractual arrangement]</td>
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<tr>
<td>South Africa</td>
<td>Khayelitsha ART Programme</td>
<td>Piloting antiretroviral treatment in South Africa: The role of partnerships in the Western Cape's provincial roll-out</td>
<td>2011</td>
<td>Hodes, R. Naimak, T. H.</td>
<td>WC Provincial Govt MSF, Global Fund Informal, relational social contract between implementing partners. Formal grant agreement between Global Fund and WC DoH. Close collaboration between MSF and local govt led to high degree of ownership</td>
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<td>Swaziland</td>
<td>Becton, Dickson &amp; Company HCW Wellness Centres</td>
<td>HIV-related public-private partnerships and health systems strengthening</td>
<td>2009</td>
<td>Papkalla, Ute Kupfer, Gesa</td>
<td>Govt of Swaziland International Council for Nurses, PEPFAR, Becton, Dickson &amp; Co. Focus on national buy-in and ownership to ensure sustainability</td>
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<td>Mozambique</td>
<td>Expatriate Specialist MD Contracting</td>
<td>Management of expatriate medical assistance in Mozambique</td>
<td>2006</td>
<td>Vio, Ferruccio</td>
<td>Mozambique MoH Swiss Development Cooperation, Bilateral agreements with developing country govs Formal contractual agreement MoH responsible for selection, supervision and assessment of physicians.</td>
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<tr>
<td>Country</td>
<td>Project</td>
<td>Description</td>
<td>Year</td>
<td>Counterparty</td>
<td>University or Contract</td>
<td>Sustainability Issues</td>
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<td>Botswana</td>
<td>TeleMedicine PPP</td>
<td>Scaling up a Mobile Telemedicine Solution in Botswana: Keys to Sustainability</td>
<td>2014: Ndlovu, K., Littman-Quinn, R., Park, E., Dikai, Z., Kovarik, C. L.</td>
<td>Govt of Botswana, MoH, 5AM Holdings</td>
<td>University of Pennsylvania</td>
<td>Formal contractual arrangement awarded through tender process.</td>
<td>System hosted at MoH to ensure continued MoH ownership</td>
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<tr>
<td>Malawi</td>
<td>CHAM</td>
<td>Promoting universal financial protection: contracting faith-based health facilities to expand access - lessons learned from Malawi</td>
<td>2013: Chirwa, Maureen L., Kazanga, Isabel Faedo, Giulia Thomas, Stephen</td>
<td>Malawi MoH, Christian Health Association of Malawi</td>
<td>Development partners</td>
<td>Formal contractual agreement through Service Level Agreement</td>
<td>Insufficient risk transfer through payment mechanisms undermined sustainability</td>
<td>Inadequate monitoring and information asymmetry decreased power of the state contractor</td>
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<tr>
<td>Lesotho</td>
<td>Lesotho Clinics</td>
<td>Contracts in the real world: Case studies from Southern Africa</td>
<td>2005: Palmer, N., Mills, A.</td>
<td>Lesotho Govt, local construction consortium, private sector commercial company</td>
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<tr>
<td>Lesotho</td>
<td>Lesotho Clinics</td>
<td>The performance of different models of primary care provision in Southern Africa</td>
<td>2004: Mills, Anne Palmer, Natasha Gilson, Lucy McIntyre, Di Schneider, Helen Sinanovic, Edina Wadee, Haroon</td>
<td></td>
<td></td>
<td>Formal sub-contracting arrangement, legally binding and well defined. However, disputes often settled through relational mechanisms due to contextual factors</td>
<td>Reimbursed per input - low risk transfer.</td>
<td>Low levels of competition for contract.</td>
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<td>Zimbabwe</td>
<td>Trends and opportunities in public-private partnerships to improve health service delivery in Africa</td>
<td>2005: Marek, Tonia O’Farrell, Catherine Yamamoto, Chiaki Zable, Ilyse</td>
<td>Hwange Colliery Hospital</td>
<td>No specification of reimbursement rates - low risk transfer</td>
<td>No contractually obligated monitoring of quality of services.</td>
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<td></td>
<td>Capital flows in the health care sector in Zimbabwe: Trends and implications for the health system</td>
<td>2009: Munyuki, Elijah Jasi, Shorai</td>
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<tr>
<td>South Africa</td>
<td>Contracts for primary care in South Africa’s Part-Time District Surgeon System</td>
<td>2003: Palmer, N</td>
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<td></td>
<td>Trends and opportunities in public-private partnerships to improve health service delivery in Africa</td>
<td>2005: Marek, Tonia O’Farrell, Catherine Yamamoto, Chiaki Zable, Ilyse</td>
<td>Provincial DoH, private general practitioners</td>
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<td></td>
<td>Public–private interactions on health in South Africa: opportunities for scaling up</td>
<td>2014: Kula, Nothemba Fryatt, Robert J.</td>
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<td>Monitoring through monthly reports. Low levels of competition for contracts undermines state power to enforce sanctions.</td>
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<td>Public–private partnership</td>
<td>Quality of tuberculosis care provided in different models of public-private partnerships in South Africa</td>
<td>No date</td>
<td>Provincial TB Programme, NGO for CB-DOTs</td>
<td>NGOs commonly receive donor funding</td>
<td>Formal agreement through memorandum of agreement/</td>
<td>NGOs must follow national guidelines and submit standardised</td>
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### Public Private Partnership

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<tr>
<th>Category</th>
<th>Description</th>
<th>Year</th>
<th>Study Details</th>
<th>Relationship Details</th>
<th>Notes</th>
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<tr>
<td>The motivations for participation in public-private partnerships for the provision of tuberculosis treatment in South Africa</td>
<td>2010: Sinanovic, Edina Kumaranayake, Lilani</td>
<td></td>
<td></td>
<td>Very informal relationship, no written agreement or formal contract in place.</td>
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<tr>
<td>Quality of tuberculosis care provided in different models of public-private partnerships in South Africa</td>
<td>Since 1973: Provincial TB Programme, Mining companies</td>
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<td>Reimbursement per patient day - low risk transfer</td>
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<td>Africa Model PPP</td>
<td>Lesotho</td>
<td>Tsepong-Lesotho PPP for Health Care</td>
<td>A critical test case</td>
<td>2011: Makholwa, Andile</td>
<td>Empowerment benefits</td>
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<td></td>
<td>The Lesotho Hospital PPP experience: catalyst for integrated service delivery</td>
<td>2011: Coelho, Carla Faustino O'Farrell, Catherine Commander</td>
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<tr>
<td>Co-location PPP</td>
<td>South Africa</td>
<td>Capital flows in the health sector in South Africa: Implications for equity and access to health care</td>
<td>2009: Dambisya, Yoswa M Modipa, Sehlapelo I</td>
<td>Limpopo DoH, Clinix Renal Care</td>
<td>Formal contractual agreement</td>
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<tr>
<td></td>
<td></td>
<td>Introducing Public Private Partnerships in South Africa</td>
<td>2007: RSA National Treasury,</td>
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<td></td>
<td>Independent Practitioners Association</td>
<td>Public–private interactions on health in South Africa: opportunities for scaling up</td>
<td>2014: Kula, Nothemba Fryatt, Robert J.</td>
<td>Gauteng DoH, Independent Practitioners Association</td>
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<td>Public-private partnerships</td>
<td>2001: Moorman, J</td>
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<td>Ellisras Hospital</td>
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<td>2009: Dambisya, Yoswa M Modipa, Sehlapelo I</td>
<td>Limpopo DoH, private partner</td>
<td>Formal contractual agreement</td>
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<td>as and Pelonomi Hospitals</td>
<td>Public–private interactions on health in South Africa: opportunities for scaling up</td>
<td>2014: Kula, Nothemba Fryatt, Robert J.</td>
<td>Free State DoH, Community Hospital</td>
<td>Formal contractual agreement</td>
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<tr>
<td>Public-Private Partnerships: A Case Study of the Pelonomi and Universitas Hospital Co-Location Project</td>
<td>2007: Shuping, S, Kabane, S</td>
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<tr>
<td>Empowerment Benefits</td>
<td>2009: de Bruin, Wilma</td>
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<td>Public Private Partnership (PPP) at Inkosi Albert Luthuli Central Hospital</td>
<td>KZN Department of Health,</td>
<td>KwaZulu Natal DoH, Impilo Consortium</td>
<td>Formal Contractual Agreement 15 Year Concession</td>
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<tr>
<td>Trends and Opportunities in Public-Private Partnerships to Improve Health Service Delivery in Africa</td>
<td>2005: Marek, Tonia, O’Farrell, Catherine, Yamamoto, Chiaki, Zable, Ilyse</td>
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<td>2009: Dambisya, Yoswa M Modipa, Sehlapelo I</td>
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<td>Gauteng DoH,</td>
<td>Formal contractual agreement</td>
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<tr>
<td>South Africa</td>
<td>Public-private Interactions in the South African health sector: Experience and perspectives from national, provincial and local levels</td>
<td>2004: Wadee, Haroon Gilson, Lucy Blauw, Duane Erasmus, Ermin Mills, Anne</td>
<td>2011</td>
<td>Gauteng DoH,</td>
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<tr>
<td>Zambia</td>
<td>Ghana and Zambia: Achieving Equity in the Distribution of Insecticide-Treated Bednets through Links with Measles Vaccination Campaigns</td>
<td>2005: Grabowsky, Mark Farrell, Nick Chimumbwa, John Nobiya, Theresa Wolkon, Adam Selanikio, Joel</td>
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<td>National Malaria Control Centre, local NGO implementing partners</td>
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<td>Public-Private Mix</td>
<td>Zimbabwe</td>
<td>Experiences of collaboration, coordination and efficiency in the delivery of HIV/AIDS home-based care in Zimbabwe</td>
<td>2009: Mazzeo, John Makonese, Loveness</td>
<td>Zimbabwe National Aids Council, CARE Zimbabwe, PLAN, St Gerards Catholic Church (local NGOs)</td>
<td>DFID, AUSAid</td>
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<tr>
<td>South Africa</td>
<td>Integrated C-IMCI Child Survival Project</td>
<td>Using partnership approach to reduce mortality and morbidity among children under five in Limpopo province, South Africa</td>
<td>2012: Sivhaga, Kennedy Hlabano, Boniface Odhiambo, Penina Ochola</td>
<td>African Medical and Research Foundation (AMREF), NDoH, PDoH, NGOs, CBOs, etc</td>
<td>Limpopo DoH has formal memorandum of understanding with AMREF</td>
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<tr>
<td>Healthy Cities</td>
<td>Healthy cities: toward worldwide health promotion</td>
<td>1996: Flynn, Beverly Collora</td>
<td>No date</td>
<td>DoH, NGOs, Academics,</td>
<td>WHO</td>
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<td>Dual Practice Regulation</td>
<td>Boundary workers and the management of frustration: a case study of two Healthy City partnerships</td>
<td>2005: Stren, Ruth Green, Judith</td>
<td>CBOs</td>
<td>2013: Jacobstein, R.</td>
<td>Banja La Mstogolo (BLM, Marie Stopes International Affiliate), Christian Health Association of Malawi, NDoH</td>
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<td>Malawi</td>
<td>Lessons from the recent rise in use of female sterilization in Malawi</td>
<td>1992</td>
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<td>Female Sterilization Services</td>
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<td>Public-private partnerships</td>
<td>2001: Moorman, J</td>
<td>NDoH, PDoH</td>
<td>Practitioners required to sign a contract to remain accountable to the head of department tasked with performance management.</td>
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<td>South Africa</td>
<td>Professional competence and professional misconduct in South Africa</td>
<td>2014: Benatar, S.</td>
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<td></td>
<td>Human Resources for Health</td>
<td>2007: Wadee, H. Khan, F.</td>
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<td></td>
<td>A review of non-financial incentives for health worker retention in east and southern Africa</td>
<td>2007: Dambisya, Yoswa M</td>
<td></td>
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<td>'Going private': a qualitative comparison of medical specialists' job satisfaction in the public and private sectors of South Africa</td>
<td>2013: Ashmore, John</td>
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<td>Zambia</td>
<td>Multiple public-private jobholding of health care providers in developing countries</td>
<td>2004: Berman, Peter Cuizon, Dexter</td>
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<td>Dual practice regulation</td>
<td>Mozambique</td>
<td>Negotiating markets for health: an exploration of physicians’ engagement in dual practice in three African capital cities</td>
<td>2014: Russo, Giuliano McPake, Barbara Fronteira, Inês Ferrinho, Paulo</td>
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<td>The Khanya Programme</td>
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<td>2013: Nxumalo, Nonhlanhla Goudge, Jane Thomas, Liz</td>
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<td>2007: Dambisya, Yoswa M</td>
<td>Govt of South Africa</td>
<td>Formal contractual agreements with private providers, but indirect (through GEMS, not directly from Govt to providers).</td>
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<td>2009: Dambisya, Yoswa M Modipa, Sehlapelo I</td>
<td>Govt of South Africa</td>
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<td>New Start VCT Franchise</td>
<td>Trends and opportunities in public-private partnerships to improve health service delivery in Africa</td>
<td>2005: Marek, Tonia O’Farrell, Catherine Yamamoto, Chiaki Zable, Ilyse</td>
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<td>Capital flows in the health sector in South Africa: Implications for equity and access to health care</td>
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<td>2012: PPP Unit</td>
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(Source: Author)
## Appendix 3: Search strategy

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<td>AfricaWide</td>
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<td>Scopus</td>
<td>20/01/2015</td>
<td>( ALL ( &quot;public-private partnership&quot; OR &quot;public-private sector partnership&quot; OR &quot;public-private mix&quot; OR &quot;part-time district surgeon&quot; OR contracting OR &quot;sector-wide approach&quot; OR &quot;social enterprise&quot; OR &quot;social franchising&quot; OR &quot;social marketing&quot; OR &quot;private finance initiative&quot; OR vouchers OR &quot;conditional cash transfers&quot; OR &quot;rural practice&quot; OR &quot;health insurance&quot; OR &quot;insurance, health&quot; ) ) AND ( TITLE-ABS-KEY ( &quot;southern africa&quot; OR angola OR botswana OR lesotho OR malawi OR mozambique OR namibia OR &quot;south africa OR zambia OR zimbabwe&quot; ) ) AND ALL (( health systems OR health systems research OR health service* OR community health service* OR health care delivery OR health service accessibility OR health care policy OR delivery of health care OR health care planning OR health care access OR health care cost OR health care quality OR public health service* OR health policy OR health care organization OR health care system* OR health insurance OR health care finance* OR health program OR public health OR health-care finance* ) ) AND ( LIMIT-TO ( PUBYEAR, 2014 ) OR LIMIT-TO ( PUBYEAR, 2013 ) OR LIMIT-TO ( PUBYEAR, 2012 ) OR LIMIT-TO ( PUBYEAR, 2011 ) OR LIMIT-TO ( PUBYEAR, 2010 ) OR LIMIT-TO ( PUBYEAR, 2009 ) OR LIMIT-TO ( PUBYEAR, 2008 ) OR LIMIT-TO ( PUBYEAR, 2007 ) OR LIMIT-TO ( PUBYEAR, 2006 ) OR LIMIT-TO ( PUBYEAR, 2005 ) OR LIMIT-TO ( PUBYEAR, 2004 ) )</td>
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<td>(TS=(health systems OR health systems research OR health service* OR community health service* OR health care delivery OR health services accessibility OR health care policy OR delivery of health care OR health care planning OR health care access OR health care cost OR health care quality OR public health service* OR health policy OR health care organization OR health care system* OR health insurance OR health care finance* OR health program OR public health OR health-care finance*)) AND (TS=(&quot;public-private partnership&quot; OR &quot;public-private sector partnership&quot; OR &quot;public-private mix&quot; OR &quot;part-time district surgeon&quot; OR contracting OR &quot;sector-wide approach&quot; OR &quot;social enterprise&quot; OR &quot;social franchising&quot; OR &quot;social marketing&quot; OR &quot;private finance initiative&quot; OR vouchers OR &quot;conditional cash transfers&quot; OR &quot;dual practice&quot; OR &quot;health insurance&quot; OR &quot;insurance, health&quot;)) AND (TS=(southern Africa OR angola OR botswana OR lesotho OR malawi OR mozambique OR namibia OR south Africa OR zambia OR zimbabwe))</td>
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Part C: Journal article manuscript

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</tr>
</tbody>
</table>

(Source: Author)
Appendix 4: Bibliography of documents identified in the systematic review


Dambisya YM. 2007. A review of non-financial incentives for health worker retention in east and southern Africa. Health Systems Research Group, Department of Pharmacy, School of Health Sciences, University of Limpopo, South Africa.


KZN Department of Health. Public Private Partnership (PPP) at Inkosi Albert Luthuli Central Hospital. Inkosi Albert Luthuli Central Hospital: Province of KwaZulu-Natal.


Sinanovic E, Kumaranayake L. 2006b. Quality of tuberculosis care provided in different models of public-private partnerships in South Africa. *Int J Tuberc Lung Dis, 10*: 795-801.


Appendix 5: Instructions for authors: Health Policy and Planning

INFORMATION FOR AUTHORS

*Health Policy and Planning*’s aim is to improve the design and implementation of health systems and policies in low- and middle-income countries through providing a forum for publishing high quality research and original ideas, for an audience of policy and public health researchers and practitioners. HPP is published six times a year.

HPP has a double-blinded peer-review policy. All papers, in each of the categories described below, are peer reviewed.

Specific objectives are to:

Attract high quality research papers, reviews and debates on topics relevant to health systems and policies in low- and middle-income countries;

Ensure wide geographical coverage of papers including coverage of the poorest countries and those in transition;

Encourage and support researchers from low- and middle-income countries to publish in *HPP*;

Ensure papers reflect a broad range of disciplines, methodologies and topics;

Ensure that papers are clearly explained and accessible to readers from the range of disciplines used to analyse health systems and policies; and

Provide a fair, supportive and high quality peer review process.

Health Policy and Planning welcomes submissions of the following types: original articles, review papers, methodological musings, research in practice, commentaries, and papers in our series 'How to do (or not to do)...' [for example, see Hutton and Baltussen, *HPP*, 20(4): 252-9] and '10 best resources' [for example, see David and Haberlen, *HPP*, 20(4): 260-3].
Authors should pay close attention to the factors that will increase likelihood of acceptance. As well as the high overall quality required for publication in an international journal, authors should address HPP's readership: national and international policy makers, practitioners, academics and general readers with a particular interest in health systems and policy issues and debates in low- and middle-income countries. Manuscripts that fail to set out the international debates to which the paper contributes, and to draw out policy lessons and conclusions, are more likely to be rejected or returned to the authors for redrafting prior to being reviewed. In addition, economists should note that papers accepted for publication in HPP will consider the broad policy implications of an economic analysis rather than focusing primarily on the methodological or theoretical aspects of the study.

Public health specialists writing about a specific health, policy, challenge or service should discuss the relevance of the analysis for the broader health system. Those submitting health policy analyses should draw on relevant bodies of theory in their analysis, or justify why they have not, rather than only presenting a narrative based on empirical data.

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Manuscripts must be submitted online. Once you have prepared your manuscript according to the instructions below please visit the online submission website. Instructions on submitting your manuscript online can be viewed here.

Manuscripts containing original material are accepted for consideration with the understanding that neither the article nor any part of its essential substance, tables, or figures has been or will be published or submitted for publication elsewhere. This restriction does not
apply to abstracts or short press reports published in connection with scientific meetings. Copies of any closely related manuscripts should be submitted along with the manuscript that is to be considered by HPP. HPP discourages the submission of more than one article dealing with related aspects of the same study.

Should you require any assistance in submitting your article or have any queries, please do not hesitate to contact the editorial office at hpp.editorialoffice@oup.com During the online submission procedure, authors are asked to provide: a) information on prior or duplicate publication or submission elsewhere of any part of the work; b) a statement of financial or other relationships that might lead to a conflict of interest or a statement that the authors do not have any conflict of interest; c) a statement that the manuscript has been read and approved by all authors (see also section on authorship below); d) the name, address, telephone and fax number of the corresponding author who is responsible for negotiations concerning the manuscript. The manuscript must be accompanied by copies of any permissions (see heading Permissions below) to reproduce already published material, or to use illustrations or report sensitive personal information about identifiable persons.

All papers submitted to HPP are checked by the editorial office for conformance to author and other instructions all specified below. Non-conforming manuscripts will be returned to authors.

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All persons designated as authors should qualify for authorship. The order of authorship should be a joint decision of the co-authors. Each author should have participated sufficiently in the work to take public responsibility for the content. Authorship credit should be based on
substantial contribution to conception and design, execution, or analysis and interpretation of data. All authors should be involved in drafting the article or revising it critically for important intellectual content, must have read and approved the final version of the manuscript and approve of its submission to this journal. An email confirming submission of a manuscript is sent to all authors. Any change in authorship following initial submission would have to be agreed by all authors as would any change in the order of authors.

SUBMISSION

Please read these instructions carefully and follow them closely to ensure that the review and publication of your paper is as efficient and quick as possible. The Editorial Office reserve the right to return manuscripts that are not in accordance with these instructions.

All material to be considered for publication in Health Policy and Planning should be submitted in electronic form via the journal's online submission system. Once you have prepared your manuscript according to the instructions below, instructions on how to submit your manuscript online can be found by clicking here. 

LANGUAGE EDITING PRE-SUBMISSION

OUP offers pre-submission language editing through Oxford Language Editing, a service for researchers all over the world. Language editing, particularly if English is not your first language, can be used to ensure that the academic content of your paper is fully understood by the journal editors and reviewers. Visit http://www.oxfordlanguageediting.com to find out more about the freelance editors available and the different services offered. Please note that edited manuscripts will still need to undergo peer-review by the journal.

LANGUAGE EDITING PRE-SUBMISSION
OUP offers pre-submission language editing through Oxford Language Editing, a service for researchers all over the world. Language editing, particularly if English is not your first language, can be used to ensure that the academic content of your paper is fully understood by the journal editors and reviewers. Visit [www.oxfordlanguageediting.com](http://www.oxfordlanguageediting.com) to find out more about the freelance editors available and the different services offered. Please note that edited manuscripts will still need to undergo peer-review by the journal.

MANUSCRIPT TYPES AND PREPARATION

original articles

review papers

methodological musings

research in practice

commentaries

papers in our series 'How to do (or not to do)..' [for example, see Hutton and Baltussen, HPP, 20(4): 252-9] and '10 best resources' [for example, see David and Haberlen, HPP, 20(4): 260-3].

ORIGINAL RESEARCH

Manuscripts should preferably be a maximum of 6000 words, excluding tables, figures/diagrams and references.

The title page should contain:

Title - please keep as concise as possible and ensure it reflects the subject matter;

Corresponding author's name, address, telephone/fax numbers and e-mail address;

Each author's affiliation and qualifications;

Keywords and an abbreviated running title;
2-4 Key Messages, detailing concisely the main points made in the paper;

Acknowledgements

A word count of the full article.

The manuscript will generally follow through sections: Abstract (no more than 300 words), Introduction, Methods, Results, Discussion, Conclusion, References. However, it may be appropriate to combine the results and discussion sections in some papers. Tables and Figures should not be placed within the text, rather provided in separate file/s.

In the acknowledgements, all sources of funding for research must be explicitly stated, including grant numbers if appropriate. Other financial and material support, specifying the nature of the support, should be acknowledged as well.

Figures should be designed using a well-known software package for standard personal computers. If a figure has been published earlier, acknowledge the original source and submit written permission from the copyright holder to reproduce the material. Colour figures are permitted but authors will be required to pay the cost of reproduction.

All measures should be reported in SI units, followed (where necessary) by the traditional units in parentheses. There are two exceptions: blood pressure should be expressed in mmHg and haemoglobin in g/dl. For general guidance on the International System of Units, and some useful conversion factors, see 'The SI for the Health Professions' (WHO 1977).

Statistics:

For the reporting of statistical analyses please consider the following additional points:

Focus the statistical analysis at the research question.
Report simple analyses first, then only more sophisticated results.

Provide information about participation and missing data.

As much as possible, describe results using meaningful phrases (E.g., do not say "beta" or "regression coefficient", but "mean change in Y per unit of X"). Provide 95% confidence intervals for estimates.

Report the proportions as N (%), not just %.

Report p values with 2 digits after the decimal, 3 if <0.01 or near 0.05. E.g., 0.54, 0.03, 0.007, <0.001, 0.048. Do not report p values greater than 0.05 as "NS".

Always include a leading zero before the decimal point (e.g., 0.32 not .32).

Do not report tests statistics (such as chi-2, T, F, etc).

REVIEW ARTICLES:

Manuscripts should preferably be a maximum of 10,000 words, excluding tables, figures/diagrams and references.

Reviews may be invited. They generally address recent advances in health policy, health systems and implementation. Systematic reviews are particularly welcomed, but may not be appropriate for every topic. If authors are submitting a review article that is not a systematic review then the paper should explain why a systematic review was not feasible/desirable, and the review methods should be described in a way that is as clear and as replicable as possible.

The title page should contain:

Title - please keep as concise as possible and ensure it reflects the subject matter;

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Each author's affiliation and qualifications;

Keywords and an abbreviated running title;

2-4 Key Messages, detailing concisely the main points made in the paper;

Acknowledgements

A word count of the full article.

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**Commentaries** – Short commentaries on topical issues in health systems are welcomed. Most such commentaries are commissioned by the editors, but the journal will also consider
unsolicited submissions. Commentaries should be of broad interest to readers of Health Policy and Planning, and while they are not research papers, they should be well substantiated. Manuscripts should preferably be a maximum of 1200 words, excluding tables, figures/diagrams and references.

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Each author's affiliation and qualifications;

Keywords and an abbreviated running title;

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Acknowledgements

A word count of the full article.

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In the acknowledgements, all sources of funding for research must be explicitly stated, including grant numbers if appropriate. Other financial and material support, specifying the nature of the support, should be acknowledged as well.

Figures should be designed using a well-known software package for standard personal computers. If a figure has been published earlier, acknowledge the original source and submit written permission from the copyright holder to reproduce the material. Colour figures are
permitted but authors will be required to pay the cost of reproduction.

All **measures** should be reported in SI units, followed (where necessary) by the traditional units in parentheses. There are two exceptions: blood pressure should be expressed in mmHg and haemoglobin in g/dl. For general guidance on the International System of Units, and some useful conversion factors, see 'The SI for the Health Professions' (WHO 1977).

**HOW TO DO...OR NOT TO DO**

This series is meant to explain how to use a particular research or analytical method (e.g. social network analysis, discrete choice experiment etc). The research or analytical methods discussed should be well accepted and clearly defined: this category of paper is not meant to address methodological debates but rather to help disseminate and promote the use of well-accepted methodologies.

Manuscripts should preferably be a maximum of 3000 words excluding tables, figures/diagrams and references.

The sections must be arranged as follows: i) Title page, ii) Abstract, iii) Introduction, iv) Body of the paper, and v) References. Main sections should be coordinated by the author, and inserted between Introduction and Reference sessions. Please contact our office before submitting a manuscript in this category.

The **title page** should contain:

Title - please keep as concise as possible and ensure it reflects the subject matter;

Corresponding author's name, address, telephone/fax numbers and e-mail address;

Each author's affiliation and qualifications;

Keywords and an abbreviated running title;
2-4 Key Messages, detailing concisely the main points made in the paper;

Acknowledgements

A word count of the full article.

Tables and Figures should not be placed within the text, rather provided in separate file/s.

In the acknowledgements, all sources of funding for research must be explicitly stated, including grant numbers if appropriate. Other financial and material support, specifying the nature of the support, should be acknowledged as well.

Figures should be designed using a well-known software package for standard personal computers. If a figure has been published earlier, acknowledge the original source and submit written permission from the copyright holder to reproduce the material. Colour figures are permitted but authors will be required to pay the cost of reproduction.

All measures should be reported in SI units, followed (where necessary) by the traditional units in parentheses. There are two exceptions: blood pressure should be expressed in mmHg and haemoglobin in g/dl. For general guidance on the International System of Units, and some useful conversion factors, see 'The SI for the Health Professions' (WHO 1977).

10 best -is a series of articles that identify and outline the 10 most useful resources from a range of sources to help facilitate a better understanding of a particular issue in global health'

We often commission these articles but we also hear unsolicited suggestions.
This series is meant to address methodological issues in health policy and systems research, where there is currently a lack of clarity about accepted research methods. This series is intended to support the development of the health policy and systems research field, through supporting methodological discussion.

Manuscripts should preferably be a maximum of 3000 words, excluding tables, figures/diagrams and references.

The sections must be arranged as follows: i) Title page, ii) Abstract, iii) Introduction, iv) Body of the paper, and v) References. Main sections should be coordinated by the author, and inserted between Introduction and Reference sessions. Please contact our office before submitting a manuscript in this category.

The title page should contain:

Title - please keep as concise as possible and ensure it reflects the subject matter;

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Keywords and an abbreviated running title;

2-4 Key Messages, detailing concisely the main points made in the paper;

Acknowledgements

A word count of the full article.

In the acknowledgements, all sources of funding for research must be explicitly stated, including grant numbers if appropriate. Other financial and material support, specifying the nature of the support, should be acknowledged as well.

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written permission from the copyright holder to reproduce the material. Colour figures are permitted but authors will be required to pay the cost of reproduction.

All measures should be reported in SI units, followed (where necessary) by the traditional units in parentheses. There are two exceptions: blood pressure should be expressed in mmHg and haemoglobin in g/dl. For general guidance on the International System of Units, and some useful conversion factors, see 'The SI for the Health Professions' (WHO 1977).

RESEARCH IN PRACTICE

Research in practice provides an opportunity for researchers, policy makers and programme managers to reflect on their experiences of translating health policy and systems research into practice.

Manuscripts should preferably be a maximum of 3,000 words.

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Only articles in English are considered for publication

Prepare your manuscript, including tables, using a word processing program and save it as a .doc, .rtf or .ps file. Use a minimum font size of 11, double-spaced and paginated throughout including references and tables, with margins of at least 2.5 cm. The text should be left justified and not hyphenated.

Manuscript file must include text body. Title Page, Figures and Tables should be uploaded separately.
Manuscript Preparation:

Page 1: Title Page - please keep as concise as possible and ensure it reflects the subject matter;

Corresponding author's name, address, telephone/fax numbers and e-mail address;

Each author's affiliation and qualifications;

Keywords and an abbreviated running title;

2-4 Key Messages, detailing concisely the main points made in the paper;

Acknowledgements

A word count of the full article.

Page 2: Abstract

Abstract should be prepared in one paragraph, with a limit of 300 words. No headings are required. It should describe the purpose, materials and methods, results, and conclusion in a single paragraph no longer than 300 words without line feeds.

Page 3: Introduction

The Introduction should state the purpose of the investigation and give a short review of the pertinent literature, and be followed by:

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Results. The Results section should describe the outcome of the study. Data should be presented as concisely as possible, if appropriate in the form of tables or figures, although very large tables should be avoided.

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