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Institute on Health, Politics and Society in Africa

Institut sur santé, politiques et société en Afrique

Private Health Provisioning in Africa

Offre privée de santé en Afrique

Bibliography / Bibliographie

Codice, November/novembre 2007

Introduction

CODESRIA organises from 05 to 30 November 2007 the Institute on Health, Politics and Society in Africa on the theme: *Private Health Provisioning in Africa.*

It is within this framework that CODICE has compiled this bibliography which lists a number of documents on the specific theme of the current session of the institute.

The bibliography is divided into two parts. In the first part are listed documents available at CODICE and in the second one there are links to electronic full text documents available on the web sites of JSTOR http://www.jstor.org and PubMed http://www.ncbi.nlm.nih.gov/sites/entrez?db=PubMed

Besides, searches can also be made upon request on your fields of interests, from the CODICE resources and other information sources.

The staff of CODICE is at your service and wishes you a successful session.

Introduction

Le CODESRIA organise du 5 au 30 Novembre 2007, l'Institut sur Santé, politiques et société en Afrique sur le thème : *l'offre privée de santé en Afrique.*

C'est dans ce cadre que le CODICE a produit cette bibliographie qui signale un nombre important de documents sur le thème spécifique de la présente session de l'institut.

La bibliographie comprend deux parties. Dans la première partie, sont indiqués les documents disponibles au CODICE et dans la deuxième sont signalés des liens aux documents électroniques en texte intégral disponibles sur les sites web de JSTOR http://www.jstor.org et de PubMed http://www.ncbi.nlm.nih.gov/sites/entrez?db=PubMed

En outre, des recherches pourront être faites à la demande sur vos domaines d'intérêt, à partir des ressources du CODICE et d'autres sources d'information.

Le personnel du CODICE est à votre disposition et vous souhaite plein succès à votre session.

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Résumé: La médecine traditionnelle reste une réalité vivante en Afrique. Elle se caractérise par une double dimension proprement thérapeutique et mystique. A ce titre, elle est de plus en plus l'objet d'une revalorisation et d'une réhabilitation permanente de la part des autorités publiques. Ainsi maintes structures étatiques prennent en charge cette entreprise de réhabilitation. Toutefois ce processus doit tendre vers une protection adéquate afin de sauvegarder l'identité propre de la médecine traditionnelle. Celle-ci en effet mérite désormais d'être activement protégée par la loi, tant il est vrai que cet immense héritage médicinal, pharmacologique, psychosomatique et spirituel est toujours vivant au niveau même du quotidien africain

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Résumé: L'objet de cette étude est de mettre en évidence les choix thérapeutiques que font les femmes placées en situation de pluralisme médical quand la santé de leurs enfants est menacée. Cette analyse repose sur les résultats d'enquêtes menées en Côte d'Ivoire et au Togo, tout particulièrement dans le cas d'une maladie facilement identifiable : la diarrhée. Le choix des recours thérapeutiques sont certes conditionnés par le type de structure disponible ; cependant le recours aux pratiques exclusivement traditionnelles est majoritaire lorsque les causes que l'on attribue aux maladies sont surnaturelles.

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Résumé : Cette étude traite des controverses juridiques à propos de la définition du champ de la santé. Critiquant les différentes positions de la fonction sanitaire aussi bien en France qu'en Algérie, l'auteur en arrive à une délimitation positive articulant le domaine du public et celui du privé.

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The Impact of Decentralization on Health Workforce Development in Papua New Guinea
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128. LA MOUSSAYE, Eric De; JACQUEMOT, Pierre

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Les Mutuelles de santé en Afrique : conditions d'un développement
In: Afrique contemporaine, juillet-septembre 2000, No.195, p.230-240

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An Overview of Health Manpower Issues in Relation to Equity in Health Services in Zimbabwe
In: Journal of Social Development in Africa, Vol. 5, No. 1, 1990, p.23-29

/HEALTH SERVICES/ /SOCIAL INEQUALITY/ /HEALTH POLICY/ /MEDICAL CARE/ /SOCIAL PARTICIPATION/ /ZIMBABWE/

Abstract: This paper presents an overview of the positions raised by contributors to the workshop on health manpower issues in relation to equity in and access to health services in Zimbabwe (see Willmore and Hall, 1989). It evaluates the extent to which policy initiatives in 1980, towards equity in health care, have been achieved, and the constraints to realising these policy goals. With "equity" defined as the provision of care in response to need, democratic control over health services is necessary to allow all potential consumers of health care a role in directing services according to their perceived needs. Hence the paper also addresses the question of how far consumers of health care control or participate in the services they use.

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Towards Human - Centred Development: Primary Health Care in Africa
In: Africa Insight, Vol. 21, No. 3, 1991, p.145-151

/PRIMARY HEALTH CARE/ /HEALTH/ /HEALTH POLICY/ /AFRICA/ /TANZANIA/ /ZIMBABWE/ /BOTSWANA/

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African Philosophy, Culture and Traditional Medicine
Athens: Ohio University, 1988.- xvii-154p.
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A Gimpse at the Use of Music in Traditional Medicine among the Bantu: a Case of Healing Among the Bemba Speaking People of Zambia.
In: Muntu : Revue Scientifique et Culturelle du CICIBA, No. 8, 1988, p.117-123

/TRADITIONAL MEDECINE/ /RELIGION/ /MUSIC/ /TRADITION/ /ZAMBIA/

Abstract: Focusing particularly on the Bemba speaking people of Zambia, the article highlights the use and function of music in healing process. The author analyses the traditional religion and infers that spirit possession gives rise to communication between God and man, through the ancestors. And on this occasion, music plays an important role and acts as an essential medicament. Indeed, it intervenes in the rites, diagnosis, the examination of the sick, the treatment of illness and the restoration of health. African rhythm is an exceptional vibratory force and the author strengthens his argument with many original and detailed facts.

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Paris: Karthala, 2002.- 493p.
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Carrboro: IPAS: International Projects Assistance Services, 1991. - 34p.
(Issues in Abortion Care / IPAS, No. 1)

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Une Anthropologie de la proximité : les professionnels de la santé en Algérie.
Paris: L'Harmattan, 1994.- 286p.
(Collection Santé et Sciences Humaines / DESJEUX, Jean-François; DESJEUX, Dominique)

/PERSONNEL DE SANTE/ /SANTE/ /PERSONNEL PARAMEDICAL/ /RELATIONS PROFESSIONNELLES/ /ALGERIE/ - /SANTE DE L'ENFANT/
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152. MONTEILLET, Nicolas
Le pluralisme thérapeutique au Cameroun : crise hospitalière et nouvelles pratiques populaires
Paris: Karthala, 2005. - 262p.

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A Portfolio Model of Patients' Behaviour
In: Eastern Africa Economic Review, Vol. 2, No. 2, December 1986, p.123-127

/PATIENTS/ /BEHAVIOUR/ /MEDICAL CARE/ /HEALTH SERVICES/

Abstract: Use of multiple health facilities in an illness episode is a relatively common phenomenon among patients. This paper demonstrates that if patients are assumed to be risk averse in medical treatment, the visits to multiple providers in an illness period can be explained by the model of porfolio choice. A porfolio choice model of patients'

behaviour is elaborated, using traditional and modern clinics as examples of treatment porfolios on which patients spend their health budgets.

154. MWABU, Germano M.

The Effect of Ownership of Health Care Systems on Distribution and Quality of Health Services
In: Eastern Africa Economic Review, Vol. 2, No. 1, June 1986, p.77-84

/HEALTH FACILITIES/ /HEALTH SERVICES/ /HEALTH PERSONNEL/ /PUBLIC OWNERSHIP/ /PRIVATE OWNERSHIP/ /KENYA/

Abstract: This paper investigates whether form of ownership of health facilities affects the pattern of distribution of health services, their quality and composition. Kenyan data show that public ownership of health facilities is likely to lead to better distribution of health services than private ownership. This result appears to rest more on the country's development strategy than on inherent attributes of public and private ownerships. Quality and mix of health services are also affected by type of ownership of health facilities.

155. MWABU, Germano

Health Development in Africa
Abidjan: African Development Bank, 1998. - 28p. - (Economic Research papers / ADB, NO.38)

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156. MWABU, Germano; UGAZ, Cecilia; WHITE, Gordon, Ed

Social Provision in Low-income Countries: New Patterns and Emerging Trends
Oxford: Oxford University Press, 2001. - x-308p.
(UNU/WIDER Studies in Development Economics)

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157. MWANSA, Lengwe-Katembula

Rural-Urban Health Care Service Imbalances in Zambia: Forces and Outcomes
In: Journal of Social Development in Africa, Vol. 4, No. 1, 1989, p.69-83

/HEALTH POLICY/ /HEALTH FACILITIES/ /HEALTH PERSONNEL/ /RURAL AREAS/ /ZAMBIA/

Abstract: The central argument of this paper is that health care delivery systems, like any other social institution, are shaped by various forces relating to their respective societal context. Essentially, therefore, imbalances can be explained through historical, cultural, social, economic and political forces. In this paper only historical circumstances, prevailing ideology, power and income distribution are considered. These forces vary from country to country in terms of their nature and impact on the health care system. The discussion assumes that rural-urban disparities in the modern health care services in Zambia occur as a logical outcome of a historical process in relation to the forces referred to. A consideration of the introduction of allopathic medicine in Zambia by missionaries, and the impact of the mining industry and the government on the distribution of health care services, is, therefore, of critical importance.

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Women and Access to Health Services in Cameroon
Dakar: CRDI, April 1999. - 29p
(Studies and Work from SPR/WCA Network, NO.3)

/WOMEN/ /HEALTH SERVICES/ /HEALTH FACILITIES/ /REGIONAL DISPARITY/ /CAMEROON/ - /HEALTH CARE/ /ACCESS TO HEALTH SERVICES/
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159. NEUWINGER, H.D.
African Traditional Medicine: a Dictionary of Plant Use and Applications with Supplement: Search System for Diseases
Stuttgart: Medpharm Scientific Publishers, 2000.-x-589p.

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160. NG'WESHEMI Japheth; BOERMA, Thiès; SCHAPINK, Dick; BENNETT, John, ed
HIV Prevention and AIDSCARE in Africa: A district level approach.
Amsterdam: Royal Tropical Institute, 1997. - 339p

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Abstract: This paper discusses the role and importance of voluntary agencies in the promotion of mental health and the rationale for such a role. As the socioeconomic and political problems of societies grow more acute everyday, the potential solutions seem increasingly to indicate the need to make wiser and more effective use of all human resources and potential. Many of the solutions to these problems seem to call for the return of responsibility for making institutions effective to the people and the community to be served, through voluntary work for the common good. This is especially true of the voluntary work undertaken by relatives and citizens in mental health and other institutions. In this period of economic stringency, which seems likely to remain with us for some time, communities, in order to maintain services, have to rely on the contributions of volunteers and voluntary agencies.

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Analyse de l'évolution des statuts et de la structure des dépenses de personnel selon la catégorie dans les secteurs sanitaires

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Résumé : En Algérie, on distingue deux grands groupes de corps distincts de médecins : le corps hospitalo-universitaire et le corps de santé publique. A travers un examen des statuts des praticiens médicaux et des dépenses afférentes à leurs traitements, l'article vise à reconstituer la formation et l'évolution des dépenses de chaque catégorie de personnel pour pouvoir apprécier la tendance et proposer des correctifs.

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L'organisation de la couverture collective des dépenses de santé et modalités de leur financement en Algérie

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Résumé : La gratuité des soins instaurée dans le système sanitaire algérien a posé nombre de problèmes dont celui de la couverture des dépenses et les modalités de financement. Le Service National de Santé et l'Assurance-Maladie obligatoire sont les deux organes qui assurent concomitamment l'organisation du système de santé. Le présent article est une analyse critique de ce système.

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Résumé : La politique de la gratuité des soins instaurée au sein du secteur public algérien est l'objet de cette présente étude. L'auteur y analyse le système sanitaire en général, et ses incidences financières sur le budget de l'Etat. Ce qui lui a permis de dégager des lacunes et de proposer de nouvelles orientations.

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Abstract: This paper summarises Zimbabwe's legacy in both health (or disease) and health services. It then examines the changes in the economic environment which have taken place in Zimbabwe since independence in April 1980, concentrating on those which are relevant to health. It also describes the post independence restructuring of the health sector itself. Access to health care and some aspects of the functioning of the referral system are briefly dealt with. The questions of community participation in health and accountability of health workers, both Central to the Primary Health Care (PHC) approach, are addressed by a brief discussion of the Village Health Worker (VHW) programme. The relevance of this example for the health sector as a whole is briefly examined. Finally, the paper considers some changes which have taken place in health status since independence and attempts to analyse their sources.

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Abstract: Since dying and bereavement are basic to the human condition, all societies have developed ways of providing support for those undergoing these experiences of loss. However, the emergence of the hospice movement marks the beginning of the provision of organisational support beyong that traditionally supplied within the family and friendship network. Zimbabwe presents an interesting situation whereby traditional support systems function side by side with newer voluntary organisations providing services for the dying and bereaved, mainly within the white community but also, increasingly, to those black Zimbabweans in a state of transition between rural and urban life. Both traditional and organisational support systems are analysed with particular emphasis on the "holistic" approach being practised by two voluntary organisations in Zimbabwe. Holistic care manifests several new features, which distinguish it from that provided in more orthodox Western medical settings, and which, actually, converge with traditional African approaches. A brief review of problems being experienced by bereaved and dying people receiving assistance reveals that in the changing social conditions in present day Zimbabwe there is potential for useful cross-cultural fertilisation in approaches to the care of those experiencing loss and some suggestions are made to this end.

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Part II : Electronic Documents / Documents électroniques

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The role of private providers in maternal and child health and family planning services in developing countries
In: Health Policy and Planning, 1996 Jun; 11(2):142-55.
http://heapol.oxfordjournals.org/cgi/reprint/11/2/142

Abstract: This paper uses data from the Demographic and Health Surveys program (DHS) in 11 countries in Asia, Africa, and Latin America to explore the contribution of private health care providers to population coverage with a variety of maternal and child health and family planning services. The choice of countries and services assessed was mainly determined by the availability of data in the different surveys. Private providers contribute significantly to family planning services and treatment of children's infectious diseases in a number of the countries studied. This is as expected from the predictions of economic theory, since these goods are less subject to market failures. For the more 'public goods' type services, such as immunization and ante-natal care, their role is much more circumscribed. Two groups of countries were identified: those with a higher private provision role across many different types of services and those where private provision was limited to only one or two types of the services studied. The analysis identified the lack of consistent or systematic definitions of private providers across countries as well as the absence of data on many key services in most of the DHS surveys. Given the significance of private provision of public health goods in many countries, the authors propose much more systematic efforts to measure these variables in the future. This could be included in future DHS surveys without too much difficulty.
PMID: 10158456 [PubMed - indexed for MEDLINE]

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Alternative Systems of Health Care Provision
In: Economic Policy, Vol. 9, No. 19. (Oct., 1994), p.199-258
Stable URL: http://links.jstor.org/sici?sici=0266-4658%28199410%299%3A19%3C199%3AASOHCP%3E2.0.CO%3B2-I

Abstract: Rising costs of health care provision throughout the world have provoked a vigorous debate about the design of health care systems and the role of government in health care. In countries that have predominantly social provision, there are moves towards privatization and direct attempts to regulate prices. In more market-oriented systems, rising costs seem to be resulting in a greater uninsured problem and this too is provoking demands for reform. Technological change will put constant pressure on health care systems (public or private), generating serious social choice problems. However, this must be seen in the context of a traditional commitment to providing a non-trivial minimum level of health care to all members of society. We discuss evidence from OECD countries from 1960 to 1990, then focus on more recent changes. The central problems of market-oriented systems are cost containment and the fact that significant segments of the population go uninsured. Most OECD countries have therefore chosen solutions where health care

financing is socialized. We present a simple political economy model to describe the conditions under which this will arise. The hallmark of public provision is relative uniformity in access to health care. This creates incentives for individuals to opt out of the public sector and to supplement what they can obtain through the state. In addition, it creates a significant commitment to redistribution through public provision. Rising costs strain the generosity of taxpayers. We expect to see increased reliance on market solutions and moves towards multi-tiered health systems that differentiate health care provisions made for different groups in society.

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The Policy on Public-Private Mix In The Ugandan Health Sector: Catching Up With Reality.
In: Health Policy and Planning, 2001 Dec; 16 Suppl 2:80-7
http://heapol.oxfordjournals.org/cgi/reprint/16/suppl_2/80.pdf

Abstract: An informal public-private mix in the health sector has always existed in Uganda, and policymakers, planners and the public in general have taken this for granted. There is now renewed effort to develop a comprehensive policy on the mix, but the policy process has proved to be tortuous and the mix has been interpreted differently by different stakeholders. While significant differences in opinion on the mix still remain, it is becoming clear that the new policy should enable health institutions, whether in the public or the private sector, to play roles in which they have clear comparative advantage over others.
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Quality and comparison of antenatal care in public and private providers in the United Republic of Tanzania
In: Bulletin of the World Health Organization, 2003; 81(2):116-22. Epub 2003 Mar 25
http://www.scielosp.org/pdf/bwho/v81n2/v81n2a08.pdf

Abstract: OBJECTIVE: To compare the quality of public and private first-tier antenatal care services in Dar es Salaam, United Republic of Tanzania, using defined criteria. METHODS: Structural attributes of quality were assessed through a checklist, and process attributes, including interpersonal and technical aspects, through observation and exit interviews. A total of 16 health care providers, and 166 women in the public and 188 in the private sector, were selected by systematic random sampling for inclusion in the study. Quality was measured against national standards, and an overall score calculated for the different aspects to permit comparison. FINDINGS: The results showed that both public and private providers were reasonably good with regard to the structural and interpersonal aspects of quality of care. However, both were poor when it came to technical aspects of quality. For example, guidelines for dispensing prophylactic drugs against anaemia or malaria were not respected, and diagnostic examinations for the assessment of gestation, anaemia, malaria or urine infection were frequently not performed. In all aspects, private providers were significantly better than public ones. CONCLUSION: Approaches to improving quality of care should emerge progressively as a result of regular quality assessments. Changes should be introduced using an incremental approach addressing few improvements at a time, while ensuring participation in, and ownership of, every aspect of the strategy by health personnel, health planners and managers and also the community.
PMID: 12751419 [PubMed - indexed for MEDLINE

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Clarifying the case on the role and limitations of private health care in Nigeria
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6. **BRUGHA, R.; ZWI, A.**

Improving the quality of private sector delivery of public health services: challenges and strategies
In: Health Policy and Planning, 1998 Jun; 13(2):107-20.
http://heapol.oxfordjournals.org/cgi/reprint/13/2/107

Abstract: Despite significant successes in controlling a number of communicable diseases in low and middle income countries, important challenges remain, one being that a large proportion of patients with conditions of public health

significance, such as tuberculosis, malaria, or sexually transmitted diseases, seek care in the largely unregulated 'for profit' private sector. Private providers (PPs) often offer services which are perceived by users to be more attractive. However, the available evidence suggests that serious deficiencies in technical quality are often present. Evaluations of interventions to promote evidence-based care in high income countries have shown that multi-faceted strategies which increase provider knowledge have had some success in improving service quality. A wider range of factors needs to be considered in low and middle income countries (LMICs), especially factors which contribute to discrepancies between provider knowledge and practice. Studies have shown that PPs, especially, perceive or experience patient and community pressures to provide inappropriate treatments. LMIC governments also lack the capacity to enforce regulatory controls. Context-specific multi-faceted strategies are needed, including the local adaptation and dissemination to providers of relevant evidence, the education of patients and communities to adopt effective treatment-seeking and treatment-taking behaviour, and feasible mechanisms for ensuring and monitoring service quality, which may include a role for self-regulation by provider organizations or provider accreditation. Developing, implementing and evaluating strategies to improve the quality of service provision will depend on the involvement of the key stakeholders, including policy makers and PPs. Focusing on studies from Asia, Africa and Latin America, this paper develops a model for identifying the influences on PPs, mainly private medical practitioners, in their management of conditions of public health significance. Based on this, multi-faceted strategies for improving the quality of treatment provision are suggested. Interventions need to be inexpensive, practical, efficient, effective and sustainable over the medium to long term. Achieving this is a significant challenge.
PMID: 10180399 [PubMed - indexed for MEDLINE]

7. CLARK, P.A.; O'BRIEN, K.

Fighting AIDS in Sub-Saharan Africa: is a public- private partnership a viable paradigm?
In: Medical Science Monitor, 2003 Sep; 9(9):ET28-39
http://www.medscimonit.com/pub/vol_9/no_9/3985.pdf

Abstract: In their most recent study, the United Nations AIDS Program estimates that about 22 million people around the world have died from AIDS, and about 40 million more are currently infected with the HIV virus. About 83% of AIDS deaths and 71% of HIV infections have occurred in war-ravaged, poverty-stricken Sub-Saharan Africa. This pandemic is ripping apart the social and economic fabric of this part of the world. The only remedy for this crisis is both prevention and cure. Only through massive education can early and sustained prevention efforts prevent future infections. And only by giving those infected with HIV effective treatments will people be prevented from dying of AIDS in the future. Without a bold, concerted action, not only will millions die in Africa, but the entire world will suffer. To allow sub-Saharan Africa to become socially and economically devastated will have a major impact on the economies of every country of the world. The African Comprehensive HIV/AIDS Partnership (ACHAP) is one answer to the problem. ACHAP is a joint initiative between the government of Botswana, the Bill and Melinda Gates Foundation and the Merck Company Foundation. This public-private partnership has provided a new sense of optimism for fighting this devastating pandemic. ACHAP offers all interested parties a multifaceted paradigm that addresses not only the need for ARV medications, but also the other social and medical facets of the HIV/AIDS problem facing sub-Saharan Africa. If a coordinated effort can be launched in the other sub-Saharan African nations, using ACHAP as a paradigm, then there is the possibility that the fight against AIDS could be won. CONCLUSIONS: Clinical ethics is of necessity a two-way street, one in which ethical paradigms influence practitioners and researchers whose expertise, in turn, necessarily educates the non-clinical ethicist.
PMID: 12960920 [PubMed - indexed for MEDLINE]

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Public or Private Health Services? A Skeptic's View (in Markets, Nonprofits, and the State: Four Critical Views)
In: Journal of Policy Analysis and Management, Vol. 2, No. 3, spring 1983, p. 386-402
Stable URL: http://links.jstor.org/sici?sici=0276-8739%28198321%292%3A3%3C386%3APOPHSA%3E2.0.CO%3B2-Z

Abstract: For many years economists writing on the delivery of health services dusted off the traditional promarket analyses of textbooks and applied them uncritically to the health care industry. Specialists in health care today are far more cautious. From the medical side there has been an increasing interest in the economic implications of health care organization and medical practice. Good research drawing on the skills of economists and other specialists is rapidly growing. This research offers little support either to those who reason abstractly from a market ideology or to those who are uncritically committed to socialized health care.

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African Health at Home and Abroad
In: Social Science History, Vol. 10, No. 4, the Biological Past of the Black. (Winter 1986), p.369-398
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Pease Porridge in a Pot: "The Social Basis of Health and Healing in Africa"
In: History in Africa, Vol. 20, 1993, p.43-51
Stable URL: http://links.jstor.org/sici?sici=0361-5413%281993%2920%3C43%3APPIAP%22%3E2.0.CO%3B2-7

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The provision of private charitable hospital care in West Africa--a case study
In: Journal of Public Health and Medicine, 1998 Jun; 20(2):125-8.
http://jpubhealth.oxfordjournals.org/cgi/reprint/20/2/125-a.pdf

Abstract: The Hôpital Protestant de Dabou (HPD), a private charitable hospital located in a rural area of the Ivory Coast, has seen its activity decreasing significantly since the beginning of the 1990s. The decrease affected mainly the paediatric and the general medicine specialties. An evaluation suggested that this appeared to have resulted from a combination of determinants including decreasing level of financial support from government and aid agencies, rise in the hospital price list rendering services financially inaccessible to the local population, and episodes of drug shortage. The HPD is facing two options, the first being to evolve towards a self-sufficient organization offering expensive health care to the wealthiest part of the population, thus departing from the original driving principles of affordability and value for money. The second option is to try to stick to these principles by actively seeking greater financial support from government and aid agencies. External donors may find that only with their continued support can the qualities of responsiveness, flexibility and innovation displayed by the HPD and other comparable hospitals be preserved.
PMID: 9675726 [PubMed - indexed for MEDLINE]

12. GRUBAUGH, Stephen G.; SANTERRE, Rexford E.
Comparing the Performance of Health Care Systems: An Alternative Approach
In: Southern Economic Journal, Vol. 60, No. 4. Apr.1994, p.1030-1042
Stable URL: http://links.jstor.org/sici?sici=0038-4038%28199404%2960%3A4%3C1030%3ACTPOHC%3E2.0.CO%3B2-N

13. HARRINGTON, John A.
Between the State and Civil Society: Medical Discipline in Tanzania
In: The Journal of Modern African Studies, Vol. 37, No. 2, Jun 1999, p.207-239
Stable URL: http://links.jstor.org/sici?sici=0022-278X%28199906%2937%3A2%3C207%3ABTSACS%3E2.0.CO%3B2-Y

Abstract: This article seeks to examine the status of the medical profession in Tanzania, in the context of political and economic developments since independence. It demonstrates that doctors have maintained a relatively privileged position within the health care system and in the wider society from the colonial period, through the early years of independence, to the present. This has been achieved by a variety of means. During the 1970s and early 1980s the profession was closely associated with the developmentalist project of the state. Because of economic restructuring since then it has had to adopt the rhetoric and techniques of accountability, to distance itself from the state and position itself in the notional realm of civil society. Recent cases of the Medical Council are used to demonstrate this trend. Renewed legitimation is most significant as a means of maintaining the profession's links with its international counterparts, and with foreign donors who support the health care system in Tanzania.

14. HURSH-CÉSAR, GERALD; BERMAN, PETER ; HANSON, KARA ; RANNAN-ELIYA, RAVI; RITTMANN, JOSEPH

Private and Nongovernment Providers: Partners for Public Health in Africa
Conference Report, November 28 - December 1, 1994, Nairobi, Kenya
http://www.hsph.harvard.edu/ihsg/publications/pdf/No-21.PDF

15. KIRIGIA, J.M.; WAMBEBE, C.

Status of national health research systems in ten countries of the WHO African Region
In: BMC Health Services Research, 2006 Oct 19; 6:135
http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1622748&blobtype=pdf

Abstract: BACKGROUND: The World Health Organization (WHO) Regional Committee for Africa, in 1998, passed a resolution (AFR/RC48/R4) which urged its Member States in the Region to develop national research policies and strategies and to build national health research capacities, particularly through resource allocation, training of senior officials, strengthening of research institutions and establishment of coordination mechanisms. The purpose of this study was to take stock of some aspects of national resources for health research in the countries of the Region; identify current constraints facing national health research systems; and propose the way forward. METHODS: A questionnaire was prepared and sent by pouch to all the 46 Member States in the WHO African Region through the WHO Country Representatives for facilitation and follow up. The health research focal person in each of the countries Ministry of Health (in consultation with other relevant health research bodies in the country) bore the responsibility for completing the questionnaire. The data were entered and analysed in Excel spreadsheet. RESULTS: The key findings were as follows: the response rate was 21.7% (10/46); three countries had a health research policy; one country reported that it had a law relating to health research; two countries had a strategic health research plan; three countries reported that they had a functional national health research system (NHRS); two countries confirmed the existence of a functional national health research management forum (NHRMF); six countries had a functional ethical review committee (ERC); five countries had a scientific review committee (SRC); five countries reported the existence of health institutions with institutional review committees (IRC); two countries had a health research programme; and three countries had a national health research institute (NHRI) and a faculty of health sciences in the national university that conducted health research. Four out of the ten countries reported that they had a budget line for health research in the Ministry of Health budget document. CONCLUSION: Governments of countries of the African Region, with the support of development partners, private sector and civil society, urgently need to improve the research policy environment by developing health research policies, strategic plans, legislations, programmes and rolling plans with the involvement of all stakeholders, e.g., relevant sectors, research organizations, communities, industry and donors. In a nutshell, development of high-performing national health research systems in the countries of the WHO African Region, though optional, is an imperative. It may be the only way of breaking free from the current vicious cycle of ill-health and poverty.
PMID: 17052326 [PubMed - indexed for MEDLINE]

16. KUMARANAYAKE, L.; MUJINJA, P.; HONGORO, C., MPEMBENI, R.

How do countries regulate the health sector? Evidence from Tanzania and Zimbabwe
In: Health Policy and Planning, 2000 Dec; 15(4):357-67.
http://heapol.oxfordjournals.org/cgi/reprint/15/4/357

Abstract: The health sectors in many low- and middle-income countries have been characterized in recent years by extensive private sector activity. This has been complemented by increasing public-private linkages, such as the contracting-out of selected services or facilities, development of new purchasing arrangements, franchising and the introduction of vouchers. Increasingly, however, experience with the private sector has indicated a number of problems with the quality, price and distribution of private health services, and thus led to a growing focus on the role of government in regulation. This paper presents the existing network of regulations governing private activity in the health sectors of Tanzania and Zimbabwe, and their appropriateness in the context of emerging market realities. It draws on a comparative mapping exercise reviewing the complexity of the variables currently being regulated, the level of the health system at which they apply, and the specific instruments being used. Findings indicate that much of the existing regulation occurs through legislation. There is still very much a focus on the 'social' rather than 'economic' aspects of regulation within the health sector. Recent changes have attempted to address aspects of private health provision, but some very key gaps remain. In particular, current regulations in Tanzania and Zimbabwe: (1) focus on individual inputs rather than health system organizations; (2) aim to control entry and quality rather than explicitly quantity, price or distribution; and (3) fail to address the market-level problems of anti-competitive practices and lack

of patient rights. This highlights the need for additional measures to promote consumer protection and address the development of new private markets such as for health insurance or laboratory and other ancillary services.
PMID: 11124238 [PubMed - indexed for MEDLINE]

17. MUULA, A.S.; MASEKO, F.C.

How are health professionals earning their living in Malawi?
In: BMC Health Services Research, 2006 Aug 9; 6:97
http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1555580&blobtype=pdf

Abstract: BACKGROUND: The migration of health professionals from southern Africa to developed nations is negatively affecting the delivery of health care services in the source countries. Oftentimes however, it is the reasons for the out-migration that have been described in the literature. The work and domestic situations of those health professionals continuing to serve in their posts have not been adequately studied. METHODS: The present study utilized a qualitative data collection and analysis method. This was achieved through focus group discussions and in-depth interviews with health professionals and administrators to determine the challenges they face and the coping systems they resort to and the perceptions towards those coping methods. RESULTS: Health professionals identified the following as some of the challenges there faced: inequitable and poor remuneration, overwhelming responsibilities with limited resources, lack of a stimulating work environment, inadequate supervision, poor access to continued professionals training, limited career progression, lack of transparent recruitment and discriminatory remuneration. When asked what kept them still working in Malawi when the pressures to emigrate were there, the following were some of the ways the health professionals mentioned as useful for earning extra income to support their families: working in rural areas where life was perceived to be cheaper, working closer to home village so as to run farms, stealing drugs from health facilities, having more than one job, running small to medium scale businesses. Health professionals would also minimize expenditure by missing meals and walking to work. CONCLUSION: Many health professionals in Malawi experience overly challenging environments. In order to survive some are involved in ethically and legally questionable activities such as receiving "gifts" from patients and pilfering drugs. The efforts by the Malawi government and the international community to retain health workers in Malawi are recognized. There is however need to evaluate of these human resources-retaining measures are having the desired effects.
PMID: 16899130 [PubMed - indexed for MEDLINE]

18. OYEDIRAN, A.B.; DDUMBA, E.M.; OCHOLA, S.A.; LUCAS, A.O.; KOPORC, K.; DOWDLE, W.R.

A public-private partnership for malaria control: lessons from the Malarone Donation Programme.
In: Bulletin of the World Health Organization, 2002; 80(10), p.817-21 Epub 2002 Nov 28
http://www.scielosp.org/pdf/bwho/v80n10/8010a10.pdf

Abstract: In 1996, Glaxo Wellcome offered to donate up to a million treatment courses annually of Malarone, a new antimalarial, with a view to reducing the global burden of malaria. The Malarone Donation Programme (MDP) was established the following year. Eight pilot sites were selected in Kenya and Uganda to develop and evaluate an effective, locally sustainable donation strategy that ensured controlled and appropriate use of Malarone. The pilot programme targeted individuals who had acute uncomplicated Plasmodium falciparum malaria that had not responded to first-line treatments with chloroquine or sulfadoxine-pyrimethamine. Of the 161 079 patients clinically diagnosed at the pilot sites as having malaria, 1101 (0.68%) met all the conditions for participation and received directly observed treatment with Malarone. MDP had a positive effect at the pilot sites by improving the diagnosis and management of malaria. However, the provision of Malarone as a second-line drug at the district hospital level was not an efficient and effective use of resources. The number of deaths among children and adults ineligible for MDP at the pilot sites suggested that high priority should be given to meeting the challenges of malaria treatment at the community level.
PMID: 12471403 [PubMed - indexed for MEDLINE]

19. PALMER, N.; MILLS, A.; WADEE, H.; GILSON, L.; SCHNEIDER, H.

A new face for private providers in developing countries: what implications for public health?
In: Bulletin of the World Health Organization, 2003; 81(4):292-7. Epub 2003 May 16
http://www.scielosp.org/scielo.php?script=sci_arttext&pid=S0042-96862003000400011&lng=en&nrm=iso&tlng=en

Abstract: The use of private health care providers in low- and middle-income countries (LMICs) is widespread and is the subject of considerable debate. We review here a new model of private primary care provision emerging in South

Africa, in which commercial companies provide standardized primary care services at relatively low cost. The structure and operation of one such company is described, and features of service delivery are compared with the most probable alternatives: a private general practitioner or a public sector clinic. In a case study of cost and quality of services, the clinics were popular with service users and run at a cost per visit comparable to public sector primary care clinics. However, their current role in tackling important public health problems was limited. The implications for public health policy of the emergence of this new model of private provider are discussed. It is argued that encouraging the use of such clinics by those who can afford to pay for them might not help to improve care available for the poorest population groups, which are an important priority for the government. Encouraging such providers to compete for government funding could, however, be desirable if the range of services presently offered, and those able to access them, could be broadened. However, the constraints to implementing such a system successfully are notable, and these are acknowledged. Even without such contractual arrangements, these companies provide an important lesson to the public sector that acceptability of services to users and low-cost service delivery are not incompatible objectives.
PMID: 12764496 [PubMed - indexed for MEDLINE]

20. PRATA, N ; MONTAGU, D. ; JEFFERYS, E.

Private sector, human resources and health franchising in Africa
In: Bulletin of the World Health Organization, 2005 Apr; 83(4):274-9. Epub 2005 Apr 25
http://www.scielosp.org/pdf/bwho/v83n4/v83n4a10.pdf

Abstract: In much of the developing world, private health care providers and pharmacies are the most important sources of medicine and medical care and yet these providers are frequently not considered in planning for public health. This paper presents the available evidence, by socioeconomic status, on which strata of society benefit from publicly provided care and which strata use private health care. Using data from The World Bank's Health Nutrition and Population Poverty Thematic Reports on 22 countries in Africa, an assessment was made of the use of public and private health services, by asset quintile groups, for treatment of diarrhoea and acute respiratory infections, proxies for publicly subsidized services. The evidence and theory on using franchise networks to supplement government programmes in the delivery of public health services was assessed. Examples from health franchises in Africa and Asia are provided to illustrate the potential for franchise systems to leverage private providers and so increase delivery-point availability for public-benefit services. We argue that based on the established demand for private medical services in Africa, these providers should be included in future planning on human resources for public health. Having explored the range of systems that have been tested for working with private providers, from contracting to vouchers to behavioural change and provider education, we conclude that franchising has the greatest potential for integration into large-scale programmes in Africa to address critical illnesses of public health importance.
PMID: 15868018 [PubMed - indexed for MEDLINE]

21. SINANOVIC, E.; KUMARANAYAKE, L.

Financing and cost-effectiveness analysis of public-private partnerships: provision of tuberculosis treatment in South Africa.
In: Cost Effectiveness and Resource Allocation, 2006 Jun 6; 4:11
http://www.resource-allocation.com/content/pdf/1478-7547-4-11.pdf

Abstract: BACKGROUND: Public-private partnerships (PPP) could be effective in scaling up services. We estimated cost and cost-effectiveness of different PPP arrangements in the provision of tuberculosis (TB) treatment, and the financing required for the different models from the perspective of the provincial TB programme, provider, and the patient. METHODS: Two different models of TB provider partnerships are evaluated, relative to sole public provision: public-private workplace (PWP) and public-private non-government (PNP). Cost and effectiveness data were collected at six sites providing directly observed treatment (DOT). Effectiveness for a 12-month cohort of new sputum positive patients was measured using cure and treatment success rates. Provider and patient costs were estimated, and analysed according to sources of financing. Cost-effectiveness is estimated from the perspective of the provider, patient and society in terms of the cost per TB case cured and cost per case successfully treated. RESULTS: Cost per case cured was significantly lower in PNP (US $354-446), and comparable between PWP (US $788-979) and public sites (US $700-1000). PPP models could significantly reduce costs to the patient by 64-100%. Relative to pure public sector provision and financing, expansion of PPPs could reduce government financing required per TB patient treated from $609-690 to $130-139 in PNP and $36-46 in PWP. CONCLUSION: There is a strong economic case for expanding PPP in TB treatment and potentially for other types of health services. Where PPPs are tailored to target groups and supported by the public sector, scaling up of effective services could occur at much lower cost than solely relying on public sector models.
PMID: 16756653 [PubMed]

22. SOETERS, R.; HABINEZA, C.; PEERENBOOM, P.B.

Performance-based financing and changing the district health system: experience from Rwanda.
In: Bulletin of the World Health Organization, 2006 Nov; 84(11):884-9
http://www.scielosp.org/pdf/bwho/v84n11/v84n11a13.pdf

Abstract: Evidence from low-income Asian countries shows that performance-based financing (as a specific form of contracting) can improve health service delivery more successfully than traditional input financing mechanisms. We report a field experience from Rwanda demonstrating that performance-based financing is a feasible strategy in sub-Saharan Africa too. Performance-based financing requires at least one new actor, an independent well equipped fundholder organization in the district health system separating the purchasing, service delivery as well as regulatory roles of local health authorities from the technical role of contract negotiation and fund disbursement. In Rwanda, local community groups, through patient surveys, verified the performance of health facilities and monitored consumer satisfaction. A precondition for the success of performance-based financing is that authorities must respect the autonomous management of health facilities competing for public subsidies. These changes are an opportunity to redistribute roles within the health district in a more transparent and efficient fashion.
PMID: 17143462 [PubMed - indexed for MEDLINE]

23. TAWFIK, Y.; NSUNGWA-SABITII, J.; GREER, G.; OWOR, J.; KESANDE, R.; PRYSOR-JONES, S.

Negotiating improved case management of childhood illness with formal and informal private practitioners in Uganda.
In: Tropical Medicine and International Health, 2006 Jun; 11(6):967-73.
http://www.blackwell-synergy.com/doi/pdf/10.1111/j.1365-3156.2006.01622.x

Abstract: OBJECTIVE: In Uganda, formal and informal private practitioners (PPs) provide most case management for childhood illness. This paper describes the impact of negotiation sessions, an intervention to improve the quality of PPs' case management of childhood diarrhoea, acute respiratory infection and malaria in a rural district in Uganda. METHOD: Negotiation sessions targeted PPs working at private clinics and drug shops. The aim was to improve key practices extracted from the national Integrated Management of Childhood Illness Guidelines, and to measure the PPs' performance before and after the intervention. RESULTS: Post-intervention the quality of case management for childhood diarrhoea, acute respiratory infection and malaria was generally better, although certain practices appeared resistant to change. We discovered various types of PPs who were mostly unregistered by the district authorities. CONCLUSIONS: Results suggest the importance of maintaining ongoing monitoring and support to PPs to understand barriers to change and to encourage more practice improvement. Modifications to the intervention are needed to take it to scale and render it more sustainable. Getting local organizations and professional associations more involved could make it easier to establish and maintain contact with PPs. The government needs to simplify registration procedures and reduce associated fees to encourage PPs to register and thus be included in a large-scale intervention. Future interventions need to measure the impact on improving childhood case management at the community/household level.
PMID: 16772020 [PubMed - indexed for MEDLINE]

24. VARENNE, B.; MSELLATI, P.; ZOUNGRANA, C.; FOURNET, F. ; SALEM, G.

Reasons for attending dental-care services in Ouagadougou, Burkina Faso
In: Bulletin of the World Health Organization, Sep 2005; 83(9):650-5. Epub 2005 Sep 30.
http://www.scielosp.org/pdf/bwho/v83n9/v83n9a09.pdf

Abstract: OBJECTIVE: To determine why patients attend dental-care facilities in Ouagadougou, Burkina Faso and to improve understanding of the capacity of oral health-care services in urban West Africa. METHODS: We studied a randomly selected sample of patients attending 15 dental-care facilities in Ouagadougou over a 1-year period in 2004. Data were collected using a simple daily record form. FINDINGS: From a total of 44,975 patients, the final sample was established at 14,591 patients, of whom 55.4% were new patients and 44.6% were "booking patients". Most patients seeking care (71.9%) were aged 15-44 years. Nongovernmental not-for-profit dental services were used by 41.5% of all patients, 36% attended private dental-care services, and 22.5% of patients visited public services. The most common complaint causing the patient to seek dental-care services was caries with pulpal involvement (52.4%), and 60% of all complaints were associated with pain. The patients' dental-care requirements were found to differ significantly according to sex, health insurance coverage and occupation. CONCLUSION: Urban district health authorities should ensure provision of primary health-care services, at the patients' first point of contact, which are directed towards the relief of pain. In addition to the strengthening of outreach emergency care, health centres should also contribute to the

implementation of community-based programmes for the prevention of oral disease and the promotion of oral health. Exchange of experiences from alternative oral health-care systems relevant to developing countries is urgently needed for tackling the growing burden of oral disease.

PMID: 16211155 [PubMed - indexed for MEDLINE]