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PHOTO HANNEKE DE VRIES

PUBLIC PRIVATE PARTNERSHIPS

CURRENT ISSUES

CONTENT

COVER PICTURE

Young women of a fishers community in Kalkbaai, South Africa.

PPPs IN HEALTH

Public-private partnerships are hot. Much is expected from private sector involvement in achieving the sustainable development goals (SDG). 'The greatest political show on earth', that is how *the Guardian* described the 70th UN General Assembly, held in September, at which 17 SDGs were adopted as successor to the MDGs. In the lead-up to this summit, the UN Secretariat launched Partnerships for SDG – an online platform to spur partnership engagement. It contains nearly 1,800 partnerships and initiatives promoting sustainable development. More than ever before, the private sector growth is embraced as a means for development and poverty reduction. Private sector development and PPPs are being portrayed as an alternative for development cooperation.

Dutch Prime Minister Mark Rutte delivered a speech at the summit. He mentioned three lessons the MDG experience had taught us, one of which was '... we must have more private sector involvement in long-term financing, in public-private partnerships, and in projects on the ground. Dutch companies and the Dutch government already have a solid track record'. He cited Heineken and a couple of international initiatives in the domain of agribusiness and insurances.

Also in September, our Minister of Foreign Trade & Development Cooperation, Lilianne Ploumen – you will note that the Development Cooperation part of her mandate comes second to Foreign Trade! – sent a letter to Parliament, outlining Dutch contributions to development and growth. Interestingly enough, efforts towards the promotion of sexual and reproductive health & rights are listed under the heading 'Employment creation'. Strategic partnerships, under the programme 'Samenspraak en Tegenspraak' (Dialogue and Dissent), are considered essential to support civil society organisations in challenging governments on the inclusiveness aspect of their policies. The Minister's action plan contains 20 actions, two of which are about access to medicines, the theme of the previous MT*b* edition.

In October, we learned about Ploumen's decision to allocate another € 10 million to the Health Insurance Fund, which introduced insurance schemes in Nigeria and some other African countries. This came on top of the initial € 100 million that former prime-minister Balkenende made available in 2007 – a demonstration of great faith and a powerful lobby! The programme is implemented by PharmAccess and supported by Achmea, Aegon, and several other Dutch multinationals.

In this edition of MT*b*, we focus on Dutch involvement in PPPs in the context of international health. NVTG organised a session on PPPs at the ECTMIH conference in Basel last September. Three cases were presented, all of which had some kind of Dutch involvement: a female condom programme, the Health Insurance Fund, and an international initiative on drug development for neglected tropical diseases. You will find articles about these partnerships, which elaborate on the respective roles of public and private parties, their comparative advantages, and the challenges they face in working together. While there is an abundance of examples of governments and industry working together, or failing to do so, the evidence of what works and what doesn't is rather anecdotal. Yet, people hold strong opinions about PPPs. Policy makers seem to embrace them, impressed as they are by lobbyists. Some scientists challenge them with empirical evidence . Practitioners may do likewise by sharing their experience with PPPs. What counts in the end is not whether we work together nicely, but whether we are successful in working collectively towards a legitimate public goal.

LEON BIJLMAKERS, EDITOR THIS EDITION

PUBLIC-PRIVATE PARTNERSHIPS FOR HEALTH ARE NOT A PANACEA

Public-private partnerships (PPPs) in the context of global health attract a lot of interest and resources. Governments around the world, especially in Europe and the United States, have increasingly engaged with the private sector in developing and financing health infrastructure and technologies and in delivering health services through PPPs. While public support for development cooperation in the Netherlands has decreased quite substantially in the past decade, the interest in cooperation between public and private parties to tackle poverty and other global problems seems to have grown – or at least it has not faded. What is it that PPPs in health try to achieve? What characterises a sound PPP? What are the benefits and the critical conditions for success and what are the controversies? And is there any evidence that warrants the high expectations that are often placed upon such partnerships? How does one assess their performance in the first place? A special session organised by NVTG at the European Congress on Tropical Medicine and International Health in Basel, in September 2015, addressed these questions.

'THE EVIDENCE (OF WHAT WORKS AND WHAT DOESN'T) IS RATHER ANECDOTAL'

DIMENSIONS

PPPs are diverse in nature. We find them not only in health but also in urban development projects and the housing, water supply, and transport sectors. Many government led initiatives, new or old, emphasise the support they receive from commercial, sometimes multinational, firms or from international not-for-profit NGOs. Private associations and firms tend to strengthen their corporate social responsibility profile, for instance by improving the working conditions of their employees or by engaging in development initiatives related to their core business, in their own countries or abroad. Some of them engage in charity. At the global level, transnational initiatives such as the Global Fund for AIDS, Tuberculosis and Malaria, and the Global Alliance for Vaccines Initiative are forms of public-private initiatives in which several agencies of the United Nations play a prominent role [1]. The Netherlands Ministry of Foreign Affairs supports various international PPPs in health, agribusiness or other sectors [2]. In its relationship with development organisations, the Ministry prefers to present itself no longer as a donor, but as a partner, or at least as a promoter of strategic partnerships aimed at socio-economic development [3]. At the same time, it has not gone unnoticed that since 2012 we no longer have a Minister (or State Secretary) of Development Cooperation but a Minister of Foreign Trade and Development Cooperation. This demonstrates the present government's intention to strengthen the link between trade and development, and between public policy and private commercial interests. Examples can be found in the area of food, nutrition and agribusiness (e.g. the Ghana School Feeding programme, with involvement of the World Food Programme and Unilever), market chain development (e.g. the Dutch Sustainable Trade Initiative, which is active in the cocoa, cotton, soya, timber, tea and tourism sectors), medical technology (e.g. Philips Medical Systems supplying radiology and imaging equipment to district-level hospitals in Africa, supported through ORET, a facility funded by the Dutch Ministry of Foreign Affairs that promotes Development-Related Export Transactions), information communication technology (e.g. mobile phone technology in Africa), microfinance and microcredit (Queen Maxima), and health insurance (see the article about PharmAccess elsewhere in this edition of MT*b*). Some of these PPPs have been evaluated and they all invest a lot in promotion and public relations.

ARE PPPs A HEALTHY OPTION?

A recent systematic review with this exciting title, published in Social Science and Medicine, identified more than 1400 publications about PPPs from a wide range of disciplines over a 20-year period [5]. One of its sobering conclusions was that there is little conceptualisation and in-depth empirical investigation into how PPPs actually work. One of the many definitions of a PPP is the following: 'An arrangement – formal or informal – between two or more entities, of which one public and one private party, that enables them to work cooperatively towards shared or compatible objectives, and in which there is some degree of shared authority and responsibility, joint investment of resources, shared risk taking and mutual benefit'. However, it is good to realise that sometimes the very purpose of PPPs is to break through the strict boundaries between government led strategies and free market forces. This can be tricky, especially when the PPP involves the delivery of public goods, such as health services, education or drinking water. Some of the key dimensions of PPPs, identified in the systematic review include: shared objectives, joint investments, bundling, sharing of risks, sharing of benefits, inter-organisation relationships, contractual governance, power and information sharing. The typical strength of a PPP that is often mentioned lies in the distinct roles of the private and public parties involved. Private companies bring in certain technical knowledge and skills and they are generally considered good at innovation, with a certain dose of entrepreneurship and managerial efficiency. Public parties are considered necessary for creating the right enabling environment, promoting social justice and ensuring public accountability. The latter implies that engaging in PPPs in countries that have a poor track record on governance may be tricky. It is further important to note that PPPs in the context of global health usually involve more than just one national government. For instance, in PPPs supported by the Netherlands Ministry of Foreign Affairs and (co-) implemented in Africa by private firms, it would be an omission not to engage with the national governments of those countries where the PPP products and services are actually delivered.

CRITICAL SUCCESS FACTORS

Based on surveys among practitioners who participated in cross-sector partnerships (not necessarily PPPs), the Partnerships Resource Centre of the Erasmus University in Rotterdam identified a set of critical success factors of partnerships [6]. These include: (1) clarity of roles and responsibilities and some ground rules for working together (2) a common understanding of mutual benefits (3) a clear vision of objectives (4) sound communication, shared planning and decision making and (5) leadership. One could argue that these also apply to international PPPs for health, and they are not to be taken for granted. Think only of corporate cultures in the private sector, which are often quite different from those in (semi-) government institutions. This means that smooth cooperation is not automatic. The Ghana School Feeding Programme, for example, which was set-up as a pilot in 2005, faced a lot of difficulties and has

'PPPs AS AN ALTERNATIVE FOR DEVELOPMENT COOPERATION?'

drawn strong criticism, partly because of an apparent gap between the aspirations and approach of its Dutch architects and the socio-cultural values held by local programme implementers and beneficiaries.

CRITIQUES, CONTROVERSIES

Several organisations and advocates have come out strongly against excessive faith in PPPs. Oxfam and the People's Health Movement, for example, have criticised the World Bank's privatisation policy and certain PPPs that attracted huge sums of taxpayer money. In a report that carries the ominous title 'Why public-private partnerships don't work', David Hall, a scholar in the UK, explores the importance of public investment and examines private sector motives, capabilities, influence and performance [7]. Arguing that experience over the past 30 years has shown that privatisation is fundamentally flawed and trying to explain the resurgence of this phenomenon in the form of PPPs, he argues that PPPs '... are used to conceal public borrowing ...' and that they are '... fundamentally incompatible with protecting the environment and ensuring universal access to quality public services'. Basically the controversies centre around questions such as the following. Who benefits from PPPs? Who carries the risk? Are local stakeholders (read: beneficiaries) sufficiently represented in how these PPPs are designed and governed? How do they affect public sector capacity, and the people's trust in the public sector? In short, do PPPs have a role to play in achieving sustainable development goals?

EVIDENCE SO FAR

The evidence that PPPs are actually instrumental in achieving better health or development in general has been diverse so far. The scrutiny by researchers comes from various disciplines, but it's striking that accountancy, finance and public administration predominate. This is understandable, as financial value and risk transfer are at the heart of PPPs. But there appears to be insufficient attention from strategic management fields such as human resources, management information systems, procurement & supply chain management, and governance. WHO has recognised these as health system building blocks, i.e. essential sub-systems that make up a country's health system [a]. It seems logical that the evaluation of a PPP that aims at introducing a new medical technology or a health insurance scheme would include an assessment of, for example, the local human resource implications, the information requirements, and the maintenance arrangements around the newly introduced technology/scheme. But that is usually not the case. Evaluations are usually not that comprehensive, as they tend to focus on just a few indicators, for instance the number of patients diagnosed or treated, or the part of the population that has enrolled in the new insurance scheme.

EMERGING RESEARCH THEMES

The systematic review by Roehrich and his colleagues 5 identifies three emerging research themes: PPP outcomes, PPP policies (with a focus on macro-level analysis) and the practice of PPPs (focusing on meso and micro levels). Bringing together these three key themes, the authors propose a multidimensional framework (*see Figure 1*) that integrates the manifold research streams and provides a basis for advancing both research and practice. This framework is useful, both for those wishing to do research on the functionality of particular PPPs and those who are already involved in policy making around PPPs or in the concrete management or implementation of programmes that have a PPP arrangement.

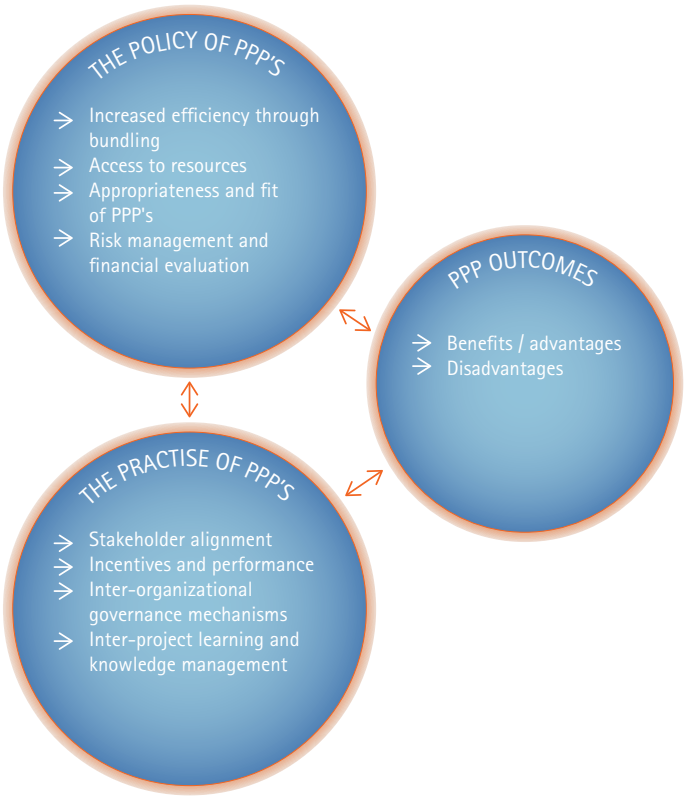

Figure 1: Multidimensional framework for public-private partnerships
Adapted from Roehrig et al. (2014)

While PPPs can be very complex because of the variety of stakeholders involved, the multi-level ambitions, and the range of interests, which may or may not always be compatible, one could argue that the criteria by which the performance of a particular PPP would ultimately need to be evaluated are in fact quite simple and straightforward. In the context of global health, two ways of evaluating PPP performance could be considered. Firstly, the three dimensions of universal health coverage [9] would apply: (1) Which services or products are being delivered? (2) Who is covered? (3) At what cost? *(see Figure 2.)* The overall question is: What does the PPP contribute in respect of these three dimensions? In order to obtain a robust answer to this question through sound research, it is probably necessary to also include, or at least consider, the following question: What would have been the situation in the absence of the PPP?

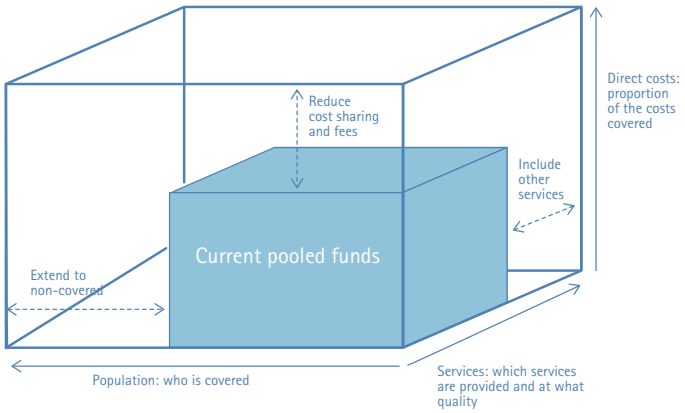

Figure 2: Three dimensions of universal health coverage
Source: www.who.int/health_financing/strategy/en/

Secondly, the OECD/DAC criteria for evaluating aid effectiveness could be applied: relevance, effectiveness, efficiency, impact and sustainability [10]. In addition, because of the complexity and the international dimension of PPPs, it would be appropriate to include some additional criteria such as transparency, accountability, legitimacy and environmental impact. Admittedly, this makes the PPP evaluation less simple and straightforward, as it calls for a mixed methods methodology.

CONCLUSION

PPPs in health are diverse, which makes it challenging to evaluate their performance. There is a large diversity in the extent to which they are successful – or claimed to be successful – even though the empirical evidence is scanty. Some of the critical success factors for PPPs have been reported on and appear to be universal. There is much less consensus about the precise criteria to be used, but the good news is that several sets of criteria already exist. It would be appropriate to invest more in research and apply these criteria when evaluating a particular PPP. We need to generate evidence and really learn from it, instead of simply assuming it works just because vested interests want it to work.

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The Drugs for Neglected Diseases Initiative: a public-private partnership for drug development

Back in 1999, a team of international experts was brought together as the DND Working Group of Médecins Sans Frontières (MSF) to study the crisis in research and development (R&D) for neglected diseases. Of the total of 1,393 approved products developed between 1975 and 1999, a mere 1.1% were for neglected diseases despite their accounting for a global disease burden of 12%, a so-called *"fatal imbalance"*[1]. Although progress has been made, over the following decade still only 4% of all approved new products (reformulations, combinations and vaccines) and 1% of all approved new chemical entities were indicated for neglected diseases; with little change in their global health burden (estimated at 11%)[2], the fatal imbalance persists.

FOCUS ON KINETOPLASTIDA

Product development partnerships were initiated 15 years ago and include the Drugs for Neglected Diseases *initiative* (DND*i*), created in 2003 as a collaborative, patients' needs-driven, non-profit drug R&D organization. DND*i* established an innovative model to develop products that may not otherwise have been developed, fill gaps in translational research, and build and strengthen R&D capacity in countries where neglected tropical diseases (NTDs) are endemic. The organization has had a strong focus on developing treatments for kinetoplastid diseases – sleeping sickness, leishmaniasis and Chagas disease - with further projects addressing filarial worm infections (causing onchocerciasis and lymphatic filariasis), the development of an affordable, taste-masked HIV treatment adapted for the very young, and two antimalarials.

The innovative R&D model works through partnerships forged with the international research community in the public and private sector, who are involved at all stages of the development process. In early drug discovery stage, compounds originating from academia and pharmaceutical or biotechnology companies are screened for parasitological activity at standard "reference centres" before undergoing preclinical development, often by contract research organizations. Clinical trials are carried out in partnership with international and local disease experts. Clinical research platforms build and strengthen local capacity in endemic countries by bringing non-governmental organizations, academia, regulatory authorities and national control programmes together. Such platforms now exist in sub-Saharan and eastern Africa for sleeping sickness and leishmaniasis respectively, and in Latin America for Chagas disease. Platform members are involved from the outset, contributing to the development of target product profiles in line with patients' needs. Local personnel are trained to conduct patient trials in line with international standards, and improvements to infrastructure are usually necessary. For example, treatment and diagnostic facilities have been built or renovated and equipped for sleeping sickness and leishmaniasis patients. The platforms are also able to facilitate registration and accelerate implementation of new treatments, working with

A global network of partnerships to leverage resources

national disease control programmes to ensure uptake of treatments in-country and advocating for policy change.

SIX SUCCESSES, WITH MORE TO FOLLOW

By adapting and improving on existing treatments, six treatments have been successfully developed by DND*i* and partners since 2003: ASAQ and ASMQ for malaria (fixed dose combinations of Artesunate + Amodiaquine and Artesunate + Mefloquine, respectively), NECT for sleeping sickness (Nifurtimox-Eflornithine Combination Therapy), SSG&PM for visceral leishmaniasis (VL), a set of treatments for VL in Asia, and a paediatric dosage form of benznidazole for Chagas disease. In addition, the results of longer term research are now also bearing fruit, with a number of entirely new chemical entities from early drug discovery efforts now populating the research portfolio. Two such compounds currently undergoing clinical development are fexinidazole and SCYX-7158, through collaboration with Sanofi and Anacor respectively, for sleeping sickness.

The development of the two fixed dose combinations (FDC) for the treatment of malaria were the first projects DND*i* undertook. They were designed to be affordable, patient-adapted antimalarial treatments, able to resist the demands of a tropical environment, and to be easy to administer, particularly to children. An innovative, stable formulation of the ASAQ FDC was developed with early development partners before Sanofi, the industrial development partner, signed an agreement to develop the combination as a non-patented product at a target price of less than one US dollar per treatment in 2005. The product has since been recognized by the WHO prequalification programme, an assurance of high quality which is used as a guide by international procurement agencies that bulk-purchase medicines for distribution in resource-limited countries. An innovative Risk Management Plan to monitor safety in the field was developed with Sanofi and submitted as the first of its kind to the World Health Organization, comprising a series of trials to gather data on the efficacy and safety of ASAQ FDC in patients in a variety of geographical settings. Studies have been undertaken with MSF, Epicentre, Medicines for Malaria Venture (MMV) and others. The treatment is currently registered for use in 30 African countries, as well as in India, Ecuador and Colombia, and it is the second most widely used treatment in Africa, with over 400 million treatments distributed to date. Both antimalarial projects, ASAQ and ASMQ, were formally handed over in May 2015 to the Access and Product Management Team of MMV, in order to continue efforts to help maximize patient access.

RISK SHARING

Having a strong pharmaceutical partner is key to success. Projects are managed by joint development committees, with DND*i* in charge of the clinical development through its regional clinical platforms, and the industrial partner responsible for manufacturing, registration and distribution. Such partnerships are mutually beneficial: DND*i* gains access to expertise in drug development, manufacturing and registration, access to compound libraries for screening, and in-kind expertise along the development chain, whilst pharmaceutical companies are able to fulfil their social corporate responsibility commitments. More than this however, with this new business model, companies are now working in non-traditional areas enabling them to expand their scientific know-how – which may be applied in other more commercially viable areas of research – and to establish links with new partners. The risks associated with the development of a new product are shared and access to new markets gained. This may, for example, result in the USA Food and Drug Administration's Priority Review Voucher being granted in a scheme designed to incentivize the development of treatments and other products for NTDs or rare paediatric diseases, entitling the bearer to a priority review for any other product.

DIVERSIFIED FUNDING AND MULTILATERAL PARTNERS

Sustainable funding of neglected disease research is vital. DND*i* receives approximately half of its funding from the public institutional sector – such as governmental or international development aid agencies – and half from private donors or foundations. The Dutch Ministry of Foreign Affairs awarded two grants, between 2006 and 2014, and negotiations for a five-year grant are currently being finalised. DND*i* tries to maintain its financial independence by pooling resources from diverse funders, limiting donations to a maximum of 25% from any one donor, and minimizing earmarked donations. Approximately €380 million has been raised to date.

As a virtual research organization, DND*i* has approximately 150 staff members, half of whom are based in endemic countries, and a further 600 people working on DND*i* projects. A global network of over 130 partnerships has been developed, mostly in endemic countries, involving academia, pharmaceutical and biotechnology companies, international and non-governmental organizations, health ministries, contract research organisations and others (see figure), spanning the entire drug development process and united around a shared vision. But partners are not service providers, and this multilateral approach to achieving a common goal takes time and requires mutual understanding and above all trust: face-to-face meetings are encouraged and lead to an increased awareness of a partner's working culture and its restraints. It is also important to define operating rules and be clear about the decision making process from the outset in order to manage expectations. Clearly there is strength in working together – as the oft-quoted African proverb states, "If you want to go fast go alone. If you want to go far, go together".

FUTURE OUTLOOK

In October 2015, DND*i* launched a new business plan, aiming to develop 16-18 treatments (including the existing six) by its 20th anniversary in 2023[3]. By incorporating a more dynamic portfolio approach, the organization will be able to maintain its primary focus on the most neglected diseases, with the added possibility of extending the scope of diseases in response to future unmet or urgent needs.

Together with other public health experts, DND*i* is advocating for a global biomedical R&D fund and mechanism, as current proposals to tackle R&D gaps are too fragmented and fail to adequately address affordability and patient access to treatments[4]. There is a need to delink the cost of R&D from product price and to integrate global health R&D monitoring, coordination and financing.

The recent award of the Nobel Prize for Physiology or Medicine, which was shared by William C. Campbell and Satoshi Omura for their discoveries concerning a novel therapy against infections caused by roundworm parasites and Youyou Tu for her discovery of a novel therapy against malaria, is a welcome recognition of valuable research conducted on neglected diseases. Meanwhile, new and improved treatments are still needed to alleviate the suffering of all neglected patients in the future.

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For further information: http://www.dndi.org/about-us/overview-dndi.html

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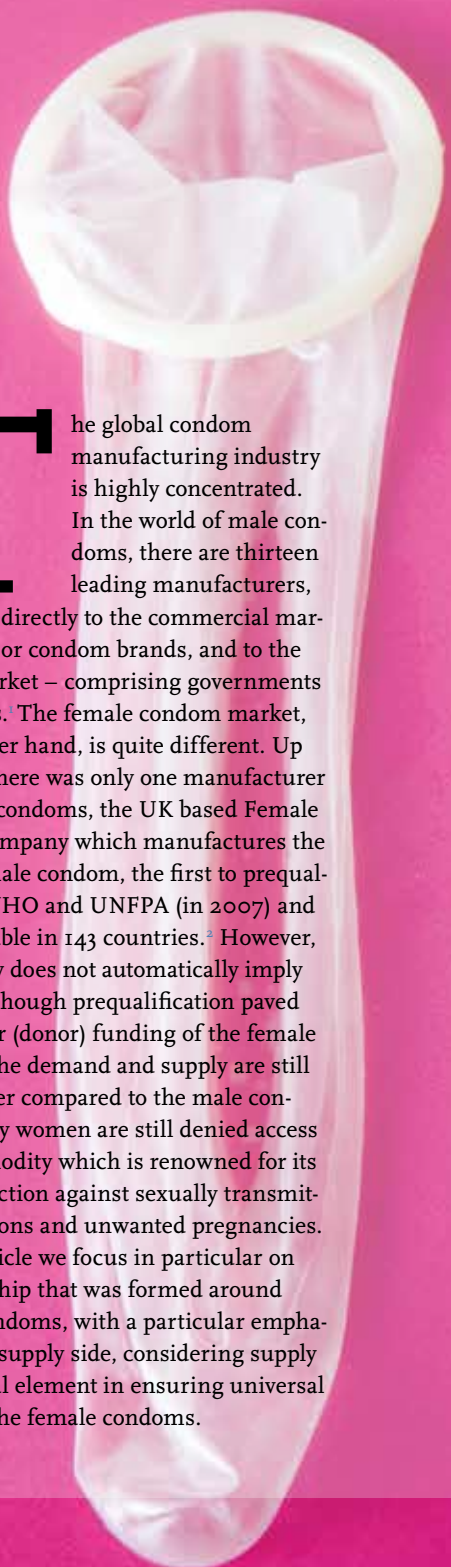
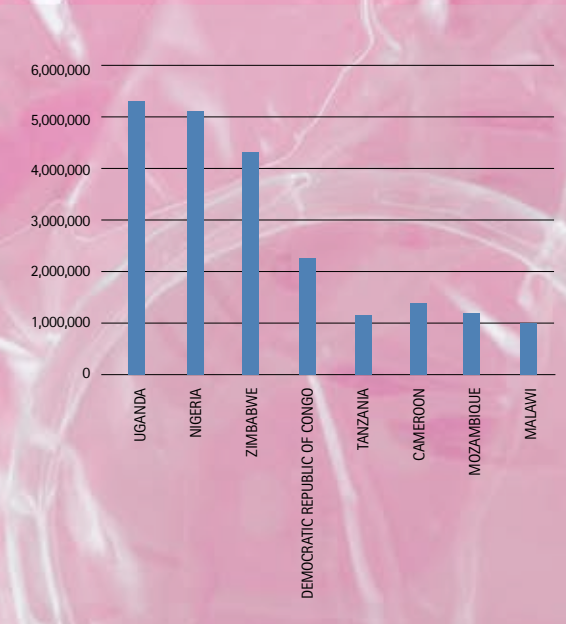
Female condoms on the global market: an insight into the dynamics of a public-private partnership



The global condom manufacturing industry is highly concentrated. In the world of male condoms, there are thirteen leading manufacturers, supplying directly to the commercial market, to major condom brands, and to the tender market – comprising governments and NGOs. The female condom market, on the other hand, is quite different. Up to 2008, there was only one manufacturer of female condoms, the UK based Female Health Company which manufactures the FC2® female condom, the first to prequalify with WHO and UNFPA (in 2007) and now available in 143 countries.[2] However, availability does not automatically imply access. Although prequalification paved the way for (donor) funding of the female condom, the demand and supply are still much lower compared to the male condom. Many women are still denied access to a commodity which is renowned for its dual protection against sexually transmitted infections and unwanted pregnancies. In this article we focus in particular on a partnership that was formed around female condoms, with a particular emphasis on the supply side, considering supply as a crucial element in ensuring universal access to the female condoms.

Figure 1 Volumes (in million pieces) of FC shipped to FC2020 countries in 2013



Source: Family Planning Market Report (2015), Clinton Health Access Initiative

PARTNERING FOR FEMALE CONDOMS

Universal Access to Female Condoms (UAFC) is an initiative of four Dutch parties. The programme ran from 2008 to 2015 and was set up to stimulate the demand for and the supply of female condoms. What brought this partnership together was the strong conviction of the parties involved that more impulses were needed to firmly put female condoms on the donor community agenda to make them more widely available. As Peters et al. argue in the article 'The international denial of a strong potential', universal access is not primarily hampered by obstacles on the user side, but it is reluctance on the side of policy makers that has largely positioned the female condom in the market.[3] The partnership therefore was formed with parties focusing on different aspects of making female condoms more widely available. The Dutch Ministry of Foreign Affairs proved to be a strategic ally in promoting female condoms among the donor community at international and national levels. Building on its experience in grant management, Oxfam Novib undertook a variety of activities to stimulate demand through its field offices. Rutgers brought to the partnership its expertise with Sexual Reproductive Health and Rights (SRHR), including advocacy at national and international levels. i+solutions, an independent not-for-profit organization that is specialized in pharmaceutical supply chain management for low and middle income countries, worked with various partner countries to secure availability of female condoms. i+solutions also took care of the manufacturing and regulatory component of the programme, including procurement, quality assurance, technical assistance for manufacturers in regulatory issues, technical assistance in supply chain management, gathering market intelligence, and informing manufacturers about the WHO/UNFPA prequalification process.

LINKING SUPPLY WITH INCREASING DEMAND

The UAFC programme aimed to increase the variety of quality-assured and affordable female condoms on the market. This objective was founded on the premise that an increase in demand and variety of female condoms would arouse greater competition in the market, leading to a lower price and better affordability. Besides focusing on manufacturers and research institutions, the UAFC consortium also worked closely with in-country advocacy organizations and social marketing organizations, who in turn worked with local public and private distribution outlets and ministries of health. Three countries were selected for implementation, all for different reasons. In Nigeria, Oxfam Novib partners requested being selected because of the public sector failure with the implementation of previous female condom programmes. i+solutions worked with a social marketing organization in Cameroon, following a promising approach in demand creation – the hair-dresser saloon distribution model. In Mozambique, UAFC collaborated in the context of an already existing donor funded female condom programme.

As shown in Table 1 below, according to the Reproductive Health Interchange (RHI) overview, there was an overall increase in procurement volumes between 2011 and 2014, though global (donor) procurement fluctuates.[4] The stark decrease in 2014 is explained by the fact that a large amount was purchased in 2013 by the Brazilian Ministry of Health. It is normally the case that, after a country makes such a big purchase, no procurement will take place in the following 2 years.

Table 1 Female condom procurement volumes

2014	27,211,000
2013	49,722,000
2012	27,081,030
2011	21,879,000

These are conservative estimates, since not all procurement can be monitored by the RHI, as for example direct purchases from private parties or governments are not always registered. UNFPA is the biggest procurer (more than 13 million female condoms in 2014), supplying female condoms through their programmes with governments, other agencies and civil society organisations. UNFPA has been procuring contraceptives for more than 30 years and, as of today, remains the largest public sector procurer. Other actors include the USAID / Deliver Project (procured 11,049,000 in 2014) – which supplies commodities through various field projects on HIV/AIDS and the prevention of unwanted pregnancies. The Global Fund procures female condoms as part of their HIV/AIDS prevention strategies. IPPF also procures female condoms for use in their SRHR programmes – albeit in small quantities (48,000 in 2014). Though it would be unfair to compare the supply of female and male condoms, the statistics are staggering. In 2014, for every 37 male condoms, UNFPA procured 1 female condom (MC: 489 million and 13 million female

condoms); in the case of USAID, the male-female procurement ratio is 83 to 1 (MC: 909 million and 11 million female condoms).[5]

A recent global market analysis shows the volumes of female condoms that are shipped to 69 countries that are enrolled in the Family Planning Initiative (FP2020). The countries with the highest volumes are shown in Figure 1 on page 10.[6]

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STIMULATING CHANGE

Gradually the interest in manufacturing female condoms has increased. In terms of volume, the Female Health Company still dominates the market. Since 2008 however, more private companies have shown interest in manufacturing female condoms, such as Cupid Ltd – which produces both male and female latex condoms, with a yearly capacity of 400 million male and 15-20 million female condoms. Others have followed suit, with some seven companies now manufacturing female condoms. The role of the partnership within the UAFC programme in stimulating these developments is hard to quantify. Nevertheless, in the context of UAFC, i+solutions provided technical assistance to manufacturers on regulatory issues and on FC registration requirements in different countries, built their capacities in good manufacturing practices, and launched a web-based market intelligence portal (through the FCMi portal).[7] UAFC has (co-) financed testing labs, is developing a manual for parallel programming, and has invested in a number of functionality studies.[8] Considering the slow entry of female condoms into the global market, an increased interest from manufacturers can be considered promising.

LESSONS LEARNED

Public health issues are better addressed through a holistic approach involving public-private partnerships. The UAFC initiative has stimulated the demand for and supply of female condoms. The partners in the consortium have different roles, each focusing on a different aspect of the female condom promotion, production and marketing process. A recent end-of-term evaluation demonstrated the benefits of this synergy and also how persistent bottlenecks in availability and use of female condoms can be tackled. Involving men in female condom promotion and use, a strategic change that was taken in the course of the programme, has paid off, as Koster et al have demonstrated in the male acceptance studies conducted in the context of UAFC.[9] The studies clearly show the benefits of involving men in SRHR issues, in particular in using female condoms for family planning or STI prevention. The technical expertise offered to manufacturers, local NGOs and social marketing organisations, and to some ministries of health, has enhanced the credibility of the consortium globally and at the country level. The neutrality of UAFC – not being attached to one particular manufacturer – has proven its use in bringing the product to the attention of new players in the field. The end-of-term evaluation also revealed some weaknesses, such as the need for early involvement of local implementing partners, governments and the private sector, thereby stimulating ownership and ensuring the sustainability of female condom uptake strategies. Also, besides strengthening national health systems, adequate focus should be given towards engaging all market players, aligning priorities, and leveraging each party's individual expertise to reach the common goal of a healthy sustainable market. The UAFC programme may provide further insights into the potential of such partnerships. The model of engaging with the private sector and coupling the demand and supply of a particular public health commodity may be expanded to other commodities in the field of sexual and reproductive health, and replicated in other countries.

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Making health markets work for the poor in Africa

How public–private partnerships can drive systemic change in healthcare

Public goods that may be taken for granted in high-income countries suffer from ineffective and inequitable distribution in many low and middle income countries (LMICs), for example electricity supply, road networks, public transport, education, or indeed healthcare. In contrast, the distribution of *private* goods such as soft drinks (Coca Cola!), cars, or cell-phone services does not appear to encounter major problems making them literally available everywhere.

This paradox can be better understood when we distinguish public and private sector roles. The creation and maintenance of public goods that are universally accessible is a complex and costly task. It requires institutions to function effectively, but also a government that is capable and competent to regulate, implement and administer such public functions. Clearly, in many developing countries, the government (for reasons that vary from one country to the other) is not able or hasn't demonstrated enough will to provide these functions in the interest of the general public.

In such circumstances, vital public functions may be left to the private sector and market forces. Unfortunately, these markets are often plagued by market failures preventing them from flourishing, and benefiting only part of the population, for instance those who are better off. This also applies to healthcare in most African countries. So the question we must ask is: How can we make African health markets work for the poor?

DOWNWARD SPIRAL IN HEALTHCARE

Although African governments do provide health services, their capacity is often inadequate resulting in limited access to services – both geographically and financially. As a result, healthcare is de facto privatized and provided by numerous small healthcare facilities run by a doctor, a nurse, a midwife, or, in the case of larger facilities, by churches or other NGOs. In contrast with the Western world, where private clinics are used primarily by the rich, private healthcare facilities in LMICs, despite being small in size, often serve 50% of the population or even more in rural areas.

These small-scale markets do not always function properly. For markets to work well, reliable institutions are needed, since people need to be able to trust that their money and efforts are well invested. Where, for example, licensing regulations are non-existent or not properly enforced, the quality of medical services or medicines is neither clear nor guaranteed, and this affects patient safety. Investors, entrepreneurs and banks will then be reluctant to invest in quality improvement and upgrades, so patients continue to receive a low quality of care and generally have little faith in the system.

As a result, people's willingness to pre-pay for health services through mechanisms like health insurance remains low. Without pre-payment mechanisms, even poor patients are left to fend for themselves and have no choice but to pay out-of-pocket for healthcare at the point of service. Thus they often become trapped in a downward spiral of high unexpected costs, paired with lost income when they fall ill. An added problem is that the lack of a pre-payment mechanism that provides financial protection also means that most people seek medical care too late. In sum, a badly functioning government means that people are trapped in badly functioning healthcare markets and stuck in a vicious cycle of high risk, low trust, low quality and low investments.

STRENGTHENING THE PRIVATE HEALTH SECTOR

The PharmAccess Group focuses on making health care markets work for the poor by reducing risks for all involved and building trust throughout the health system. On the supply side, our approach focuses on enabling quality improvement. PharmAccess established the first accredited quality rating system for resource-restricted settings (SafeCare), which creates transparency for patients and healthcare workers as well as investors. Using this system, local banks can now better evaluate the risk involved in lending in this sector. Through the Medical Credit Fund, which is another PharmAccess innovation, they are now providing loans to clinics. In combination with business training and technical assistance, this empowers healthcare providers to structurally improve the range and quality of their services. This in turn stimulates demand for healthcare from local patients. PharmAccess further strengthens this demand by decreasing financial barriers through health insurance and other forms of risk pooling. The vicious cycle becomes a virtuous cycle leading to better healthcare that is more affordable for a larger number of people.

This approach drives our results in many places in Africa, including Kwara, a small rural state in Nigeria. Kwara has remained largely off the radar of international donors. Over 60% of its population is poor, and access to care, let alone quality care, is extremely limited. Against this backdrop, the Kwara State government, local insurer Hygeia Community Health Care, the Health Insurance Fund, and PharmAccess formed a public-private partnership that United

Nations Secretary-General Ban Ki-moon has described as 'ground-breaking and innovative'.

THE KWARA STATE HEALTH INSURANCE PROGRAM

In 2007, the Kwara State health insurance programme was launched. It covers primary healthcare, maternal and child healthcare, and treatment for chronic diseases, malaria, tuberculosis and HIV/AIDS and related opportunistic infections. Over 110,000 people are currently enrolled and obtain health services at public or privately owned health centres and hospitals. Aishatu Atahiru, a small local seller of groundnuts and popcorn: *'Before the programme, there never used to be any staff and hardly ever any drugs in the facility. This is the reason why there were many drug hawkers and medicine stores in the community. All that is now history, we now have staff at the facility and good drugs.'*

The Kwara programme addresses challenges on both the demand and the supply side of the health system. Due to the renovation of both public and private health facilities as well as the setting and raising of standards of care via SafeCare, patients gain faith that their money will be well spent. When quality improves, cross-subsidization and risk equalization in efficient state risk-pooling mechanisms can be introduced through insurance. Via subsidies of the premium, low-income groups gain access to insurance and healthcare.

The programme was set up using development aid funding from the Dutch Ministry of Foreign Affairs, and from the outset it has been driven by committed support from the local insurance company, healthcare providers, politicians and religious leaders. In 2014, the Kwara State government, which currently pays about 70% of the health insurance premium subsidy, committed to increasing their funding of the program to 7 billion Naira (USD 35 million). Over the next five years, local authorities will improve the quality of clinics and extend the program across the state, eventually giving 600,000 rural low-income Nigerians access to quality healthcare.

Investments have been made in administrative infrastructure to ensure transparency, accountability, efficient business practices, and quality control in the health system. To stimulate investments in the private sector, PharmAccess supported Hygeia by encouraging Dutch multinationals Shell and Unilever to insure their Nigerian staff through Hygeia's corporate programme. The Investment Fund for Health in Africa, a private equity fund set up by PharmAccess, invested in Hygeia to support its expansion. Increasing health insurance coverage is an essential step to improving access to care in Africa, as it has been in the West.

IMPACT RESEARCH

Bio-medical and socio-economic research is being carried out by the University of Ilorin Teaching Hospital, the Amsterdam Institute of Global Health and Development (AIGHD) and the Amsterdam Institute of International Development (AIID) to monitor the impact of the program and stimulate effective implementation. Studies are being conducted into the cost-effectiveness of maternal healthcare and the prevention of cardiovascular diseases, as well as household financial diaries so as to understand how financial constraints affect people's ability to enrol in health insurance or renew their membership. The research partnership has resulted in significant research capacity building. More than 50 publications and peer-reviewed papers have been published in internationally renowned journals.

Impact evaluations have shown that the programme is making important contributions towards achieving the Millennium Development Goals of reducing child mortality, improving maternal health, and eradicating extreme poverty. There has been a 52% decline in out-of-pocket payments (including the premium), a 30% increase in hospital delivery, and a 580% increase in under-5 hospital visits. Utilization of higher quality healthcare providers has doubled and there has been a 90% increase overall in service utilization. Patients with hypertension have experienced a significant decrease in blood pressure, leading to a recommendation in one of the studies that health insurance programmes should be included in strategies to combat cardiovascular disease in sub-Saharan Africa. Also, new World Bank data show that, since the start of the programme, health statistics in Kwara State have improved drastically and Kwara is now the second best performing state in Nigeria in maternal and child care. *'We have developed our infrastructure, our building, our machinery and even our staff. All my staff are better equipped now, intellectually, to handle the challenges that medical services demand,'* says Dr. Jacob Kayode Agbede of Ogo Oluwa Hospital, Kwara.

BLUEPRINT TO REACH UNIVERSAL HEALTH COVERAGE

In March 2015, a National Council of Health memo emphasized the need for Nigerian states to adopt and implement state-supported health insurance schemes. It recognized the Kwara State health insurance programme as a model to achieve universal health coverage in Nigeria. As evidenced in Kwara, in situations where government health related institutions aren't functioning properly, public-private partnerships can be a catalyst in driving systemic change and making health markets work for the poor.

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PKDL

SETTING

This case is set in a hospital run by Médecins sans Frontières, amidst an IDP (internally displaced people) camp in Bentiu, South Sudan. The camp is situated within the war zone and is inhabited by 130,000 people, some of whom have been on the run for months. The MSF hospital is their only source of medical help, providing basic facilities such as simple laboratory tests, ultrasound, and wards for a total of 100 inpatients. Among the Sudanese population, there is a high prevalence of malnutrition and tuberculosis. Visceral leishmaniasis is common among IDP from specific counties. Currently, there is an outbreak of malaria and hepatitis E. HIV prevalence is low, although the exact percentage among IDP is unknown.

Figure 1: Dense dry rash, consisting of papules affecting the entire face. For privacy purposes, the upper part of the face has been removed from the picture. Here, the same rash and a bilateral conjunctivitis was seen.

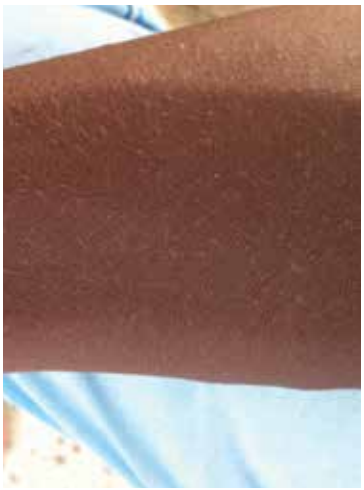

Figure 2: Macules affecting the upper extremity (and chest, not shown in this picture).

CASE

A 22-year old male patient presented at the outpatient clinic with a rash affecting the whole body. It was most prominent in the face, where the rash had started a few months earlier. It was not painful, itchy, or ulcerating, nor did it demonstrate purulent exudate. Apart from the rash, the patient was well. There was no fever. The patient had completed treatment for visceral leishmaniasis 8 months previously (sodium stibogluconate and paromomycin) and currently was not using any traditional medicine. His HIV status was unknown.

On physical examination, a papular rash was seen affecting the entire face, including the lips (Figure 1). Furthermore, there was bilateral conjunctivitis. On the chest and arms, small macules were found with less density than the facial rash (Figure 2). There was no lymphadenopathy or hepatosplenomegaly.

SPECIALIST ADVICE

The dermatologists were consulted for advice on the differential diagnosis as well as the treatment of this particular case. They suggested post-kala-azar dermal leishmaniasis (PKDL) as the most probable diagnosis and advised treatment with AmBisome or sodium stibogluconate, depending on local availability. As a differential diagnosis, the dermatologists proposed lepromatous leprosy or lichen nitidus.

TREATMENT

The patient was started on AmBisome. After 20 days, the rash had disappeared and the skin was near normal, much to the satisfaction of the patient.

BACKGROUND

Visceral leishmaniasis (VL), in the Sudan known as kala-azar, presents with fever, weight loss and hepatosplenomegaly. It is caused by the parasite

Leishmania, which is transmitted by the female sandfly. Post-kala-azar dermal leishmaniasis (PKDL) is a dermatological complication of VL, although it occasionally occurs without a previous history of VL.

EPIDEMIOLOGY AND PATHOPHYSIOLOGY

PKDL occurs in East Africa and the Indian subcontinent, with marked differences in presentation1. In Sudan, it occurs in up to 50% of cases with VL. The disease-free interval between the successful treatment of VL and developing PKDL is 2 weeks up to 6 months. In India, PKDL is less common, affecting 5-10% of VL cases and presenting 2 to 3 years after VL.

PKDL is predominantly associated with VL caused by Leishmania donovani, although it may occur sporadically in Leishmania infantum[2,3]. The disease is thought to be immunologically mediated, showing a mixed Th2 (as found in VL) and Th1 (as found after treatment of VL) immune response[1,3].

Potential risk factors are young age (5-17 years), inadequate treatment of VL (short duration, low dose or mono therapy), comorbidity (including HIV), malnutrition, and exposure to UV light.[3] The severity of PKDL is determined by age and disease-free interval, with more severe disease occurring among young children after a shorter interval[1].

CLINICAL MANIFESTATIONS AND DIAGNOSIS

PKDL is characterized by a skin rash without fever or other symptoms of systemic disease[3]. A combination of symmetrical papules, macules and nodules may be found. The lesions typically start in the face, may spread to the trunk and upper extremities, and may ultimately become generalized. In more severe cases, subsequent crusting, ulceration, and involvement of lips and palate may occur. In India, there may be an erythematous rash in the butterfly area of the face.

Other post-kala-azar manifestations include mucosal leishmaniasis, laryngitis, colitis, uveitis, conjunctivitis and blepharitis. In some patients, PKDL occurs during (treatment of) VL (para-kala-azar dermal leishmaniasis)[1].

PKDL can be diagnosed by identifying the parasites in slit-skin smears or biopsies[2,3]. Serological tests are of less clinical value, as they are likely to remain positive due to persisting antibodies after VL infection.

The differential diagnosis of PKDL is extensive and includes leprosy, pityriasis versicolor/alba, vitiligo, scabies, measles, acne vulgaris, lupus vulgaris, miliaria rubra, secondary syphilis and nutritional deficiencies[3,4].

THERAPY

PKDL regresses spontaneously within a year in the majority (85%) of cases in Sudan. Therefore, patients are only treated in the case of severe disease, lesions lasting longer than 12 months, anterior uveitis or feeding difficulties (oral lesions in young children)[1]. In India, however, all patients are treated. It is thought that PKDL patients may act as reservoirs for leishmanial parasites and can therefore be a source of transmission; however the evidence for this is not conclusive.

Different treatment strategies have been proposed[5]. First choice of treatment is AmBisome (liposomal amphotericin B, 2.5 mg/kg/day intravenously for 20 days), as it is associated with a high cure rate, short duration of therapy, and negligible side effects. Second choice is sodium stibogluconate (SSG, 20 mg/kg/day for 40 days), which has several toxicities and requires a prolonged hospital stay and painful injections. It may be combined with paromomycin. Because of the incomplete immunological response, immunochemotherapy has been studied with promising results. In Asia, miltefosine (150 mg/day for 60 days or 100 mg/day for 90 days) is the standard treatment; this has not been studied in Africa. Azoles, such as itraconazole or ketoconazole, were not found to be effective.

Post-kala-azar ophthalmological complications are often missed and may cause blindness in the case of uveitis. Steroid containing eye drops should be given in addition to antileishmanial therapy.

OUTCOME

The most important outcome of successful treatment is the disappearance of parasites from the skin. However, clinical response is the most important goal for the patient and is easier to monitor. Lesions disappear after 120 to 200 days (nodules/papules and macules, respectively), those around the mouth remaining longest1. In some cases, scars or depigmentation may remain. As in VL, patients will develop immunity for leishmaniasis after treatment, although rarely relapses of PKDL or VL may occur[1].

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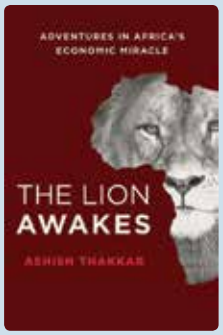

We do not need aid We want partnerships

The lion awakes: adventures in Africa's economic miracle
BY **ASHISH J. THAKKAR**
ST. MARTIN'S PRESS, NEW YORK, AUGUST 2015, 240 PAGES, €23.99

'WE WANT TO DO BUSINESS WITH YOU, AND WE BELIEVE YOU WILL BENEFIT FROM THESE BUSINESS RELATIONSHIPS AS MUCH AS WE WILL'

With these words Ashish Thakkar introduces his recently published book The Lion Awakes. The author is a successful African entrepreneur whose conglomerate 'Mara Group' is active in 22 African countries. In this book he tells his story, together with many other stories of Africans like him - full of ambition, ideas and skills - aiming to show a different Africa, not the stereotype of a hopeless continent full of starving children, war and corruption, but the Africa full of opportunities, economic growth and development. After the success of the Asian tiger, the time has come for the African lion.

OUR HISTORY IS NOT OUR FUTURE

In the first part, Thakkar describes that lion, starting with his own story. His parents, of Indian-Ugandan background, were expelled from Uganda during the Idi Amin era. They fled to England but kept hoping to be able to return home one day. Ashish Thakkar is 14 years old when his family actually moves back to Africa. They start a business in Rwanda, where they witness the horror of the genocide in 1994. Despite this horrible history, the motto of the family, and of the whole book, is: "Our history is not our future". Starting all over again for the second time in Kampala, Ashish sells his first computer when he is 15 years old and then decides to go into business. He leaves school and at the age of 16 establishes his own company in Dubai, from where he imports computer parts into Uganda. It is during that time in Dubai that, to his own surprise, he meets guys like him - young, ambitious and looking for business. That was not the image of Africa he got during his childhood in England.

ONE-SIDED STORY

Based on this anecdote, Thakkar fights the stereotype of a hopeless and dependent Africa, often based on (celebrity-driven) fundraising campaigns and one-sided news about war, hunger and disease. No matter how true this might be for parts of Africa, it is not true for the whole of it ('Africa is a continent, not a country'). And no matter how good its intentions were, the aid model 'fed corrupt rule in Africa and absolved rulers of their responsibility'. To quote the Nigerian author Chimamanda Nguzi Adichie, 'The single story creates stereotypes, and the problem with stereotypes is not that they are untrue, but that they are incomplete. They make one story become the only story.'

WHEN THE WEST SNEEZES, AFRICA CATCHES A COLD?

As an example of Africa's growing economic development, Thakkar mentions the impact of the global economic recession, or rather the lack of impact on Africa. Where in the past the African continent often paid the bill for political and economical changes in the rest of the world (like after the Cold War), African economies appeared surprisingly stable after 2008. In fact, many young and talented Africans who moved to the West in the past decades have returned back home, because there are now more chances for them in Africa than in Europe.

Coming back to his experience in 1994 in Rwanda, Thakkar describes the exceptional development of that country ever since. Instead of staying a victim of the past, the country transformed itself into a modern business hub, despite everything. In 2008, Rwanda was still ranked number 150 in the 'Ease of Doing Business' report of the World Bank, but it jumped to number 32 in no more than five years. That proves once again that "Our history is not our future".

CHINESE EXPLOITATION?

Thakkar also discusses the role of China on the African continent. Where westerners often cite this as a negative example of exploitation which would only serve Chinese interests, Thakkar is more nuanced. 'The West brings aid and charity to Africa, but I also notice that aid workers all want big homes with swimming pools and gardens. (...) The Chinese do not live like this. Yes, they are here for the money, but they come from poverty. And you know what? When they leave, they leave behind a road or a factory. What do aid groups leave behind?' The fact that China gets the chance to exploit Africa is Africa's own fault, argues the author. It underlines the need for strong leadership, able to negotiate business deals that are also profitable for Africa.

CONCLUSION

Not aid, but trade. That is in short the argument of The Lion Awakes. Even though this book contains a lot of anecdotes without providing much (statistical) evidence, the anecdotes are actually original, hopeful and inspiring. Without denying the existence of huge problems like poverty in large parts of Africa, Thakkar tells the other side of the story in a passionate and personal way. His writing is informal and the structure of the book is at times chaotic. The many examples and details -often about his own success story - affect the readability of the story. But the story works. It is inspiring and contagious, and forms a welcome addition to all the negative news about the continent. In short, it's recommended reading for foreigners working in Africa.

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On a personal note ... about Public Private Partnerships

Interview with William Allen

Muona, Malawi, November 1st, 2015. Exactly 27 years ago, Mr William Allan, Principal Hospital Administrator at Trinity Hospital, signed up for the task. Through Skype and a telephone call, he told me that partnership is of great significance for the health sector in Malawi. William has a clear view and message on partnership in low-resource societies.

William, what is your background?
I have worked at Trinity Hospital since November 1988. One and a half years later, my wife joined me as a nurse-midwife. We have three children. I was born at the same Trinity Hospital in 1965, and our home is just about 300 metres away. After my secondary school education, the Congregation of the Sisters of Divine Providence invited me to work in the hospital's administration department. They trained me on the job and later supported me for my post-graduate and Master's degree in Health Management, which I did in 1996-97 at the University of Birmingham in England.

How would you define Public Private Partnership for us who don't know?
Public private partnership is an arrangement where the private or public sector or both fill gaps in projects that would otherwise be implemented by a single party. In our case, it is about the participation of private and public entities in the delivery of services that we, as a church related health facility, provide.

What kind of partners does Trinity Hospital have, in a nutshell?
Our hospital is a member of the Christian Health Association of Malawi (CHAM), an umbrella organisation that supports the interests of all church related health facilities in Malawi. CHAM is an important partner of the Ministry of Health. It has 19 member hospitals, along with an even larger number of church-owned health centres. Together they provide about 40% of all health services in Malawi. Trinity Hospital works in partnership with the Nsanje District Health Office and a number of NGOs, some of which have their headquarters outside Malawi.

What is the role of Trinity Hospital?

Our hospital is situated in the Lower Shire Valley, in Nsanje district, the southernmost district of Malawi. It is a 200-bed mission hospital, founded in 1960. It serves approximately 150,000 people. Most families earn their living through subsistence farming along the river banks. We are committed to providing free health services to patients with HIV/AIDS, STI, TB or malaria, and immunisations to children under five years of age. We also have four health centres (Masenjere, Makhanga, Sankhulani and Thekerani) situated within our catchment area, and we run outreach clinics. We refer complicated cases to Queen Elizabeth Central Hospital in Blantyre for specialised care. We do this at no cost to the patient concerned. We also receive patients from Mozambique.

Are there any foreign partners connected to Trinity Hospital?
Many, for example Trinity Hospital Malawi Foundation in the Netherlands. This foundation has co-funded our annual Primary Health Care budget since 1992. Passion for people is another foreign partner: they provide medical equipment and funds for infrastructure development, such as a Nutrition Rehabilitation Unit. They are also funding the 'Family Friendly' maternity services. Other foreign partners include: Action Medeor, a German organisation, which sends us drugs; the Dr. Harrie van den Brekel Foundation in the Netherlands, which organises donations by Dutch hospitals of medical supplies and second-hand medical equipment; and lastly the Congregation of the Sisters of Divine Providence in Germany, which donates money to help us take care of very poor families who cannot afford even the low fees that we charge.

How important is the support from foreign partners for your hospital?
Their support is crucial as it covers part of the cost that we incur for running the hospital. But we are facing challenges. The rapid process of secularisation that has taken place in the Netherlands and elsewhere in Europe has affected us in the past two, three decades. Churches have seen a decrease in the number of their followers and they have lost much of their influence and financial capital. This has affected their ability to provide

personnel and financial assistance to hospitals they used to support in low-income countries. At Trinity hospital, we are struggling to maintain our standards of care. Our hospital is situated in a remote area, which brings extra costs when we need to evacuate patients to Blantyre or get our vaccines in Nsanje. The people we serve are mostly very poor. On top of that, we have difficulty attracting staff because of the remoteness of our hospital.

27 years: What made you stay?
During all these years, I have dedicated my energy to the hospital and our community. The opportunities for professional growth and various trainings that I was able to attend motivated me to stay on, despite the harsh conditions. Our climate in Shire Valley is very hot, our area is infested with mosquitos, we have a poor road network and Blantyre, our nearest city, is far. I realise that I have had some great opportunities in life; once I was in a similar position as many patients that we treat.

Health funding in general is precarious in low-resource settings. Do partnerships alleviate this burden?
Financial support from the Sisters of Divine Providence is dwindling, which has forced our hospital management team to increase the fees we charge for some of our services. It is hard to keep treatment and admission fees low and to ensure access for the poorest people of our society. Still, among those who come to our hospital nobody is refused treatment, even if they cannot afford to pay.

But we know that the fees that we charge prevent certain people from coming to the hospital. This has led to our hospital being underutilised, even though we still play an indispensable role in the provision of health care in our catchment area.

Do you see any challenges related to partnerships?
Our hospital is situated in a remote area, with a harsh climate and poor infrastructure. It is a continuous struggle to recruit staff and retain them. In the past, the hospital was able to provide our staff with decent housing at an affordable price and to give them some financial incentives to compensate for the hardship. But house rents have increased, and currently we are not in a position to provide financial compensation for extra duties. Actually, hospitals that are owned by the Government pay their workers night duty allowances, which we cannot afford. This situation causes a great deal of dissatisfaction among our employees, and it is a continuous source of unease and stress for us as hospital managers.

Any advice for young professionals who wish to go and work abroad?
Partnership is one of the survival mechanisms for many health care providers in low-income countries. Government funding in itself is not enough. It is good to try to avoid working in isolation, no matter where you are. Working in partnership and trusting your partners goes a long way in ensuring that underserved communities get access to essential care.

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NVTG

Membership of the **Netherlands Society for Tropical Medicine and International Health** (NVTG) runs from January 1st to December 31st and may commence at any time. Membership will be renewed automatically unless cancelled in writing before December 1st. Membership includes MT and International Health Alerts. An optional subscription to TM&IH carries an additional cost.

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