Preliminary Research Report

Private Sector Innovation Programme for Health (PSP4H)

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Cardno
Shaping the Future

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Summary of PSP4H Programme Research

Although PSP4H is primarily an action research programme aimed at producing empirical evidence that will inform future health programme design, sound analysis constructs the foundation for specific market interventions. To underpin our action research, PSP4H has conducted pertinent primary and secondary research. The programme began by synthesizing existing data, knowledge and experience of for-profit health markets used by the poor in Kenya. The synthesis was presented in two reports, one exploring the demand side of the market and one exploring the supply side. More literature synthesis was done on demand side health care financing, comparing different approaches adopted in various markets in sub-Saharan Africa and drawing lessons for our health financing interventions at PSP4H. Three primary research studies have been conducted, one exploring various aspects of the private health sector and the poor, including finding an operational definition of the poor, their health-seeking behaviour and the opportunities and challenges of health care in the private sector. The second primary research study sought to understand the pharmaceutical supply chain in Kenya, with a view to inform the programme on possible interventions in the area. The third primary research study was on the subject of sustainability in health programmes, in which PSP4H sought to understand the progression of donor-funded programmes in the health sector in Kenya over time, and the sustainability of both activities and institutions after the end of donor-funded subsidies and projects. This report is a summary of the key findings and programme recommendations for each of the studies.

Table of Contents

Summary of PSP4H Programme Research **iii**

1 The Kenyan Poor and their Use of the Private Health Sector **5**

2 What Do We Know About the Kenyan Private Health Sector? A Synthesis of the Current Literature **6**

3 Comparing Kenya's Health Markets with Neighbouring Markets: A Focus on Healthcare Financing **8**

4 A Formative Survey of the Private Health Sector in Kenya in the Context of the Working Poor **10**

5 A Study on Sustainability Outcomes of Donor-funded Programmes **12**

6 Overview of Experiences in the Pharmaceutical Supply Chain: Implications for the poor in Kenya **14**

1 The Kenyan Poor and their Use of the Private Health Sector

Key Findings

- **Who are the Poor?** The number of poor in Kenya is overwhelming. In 2009, 45.2% live below the poverty line (estimated at Ksh 1,562 and Ksh 2,913 per adult equivalent per month for rural and urban households respectively). Half of Kenya's rural population lives in poverty while one third of urban residents live below the poverty line.
- **There are extreme income inequalities in Kenya.** The average median income in the richest county – Nairobi– is more than five times greater than the poorest county – Wajir. Income disparity is highly varied between urban and rural areas, as well as within urban and rural areas. There are pockets of extreme poverty in urban settings that are comparable to those found in rural areas.
- **There are a number of ways to measure poverty**: it is multidimensional and complex in nature, making its definition difficult. Poverty measurement approaches include: 1. Monetary/Income and Consumption Expenditure Assessment; 2. Subjective Measures of Poverty; 3. Food Security Assessment; 4. Progress Out of Poverty Index (PPI). These approaches have various weaknesses.
- While poverty is common in both rural and urban Kenya, b**eing poor in urban areas is not the same as being poor in rural areas.** Kenyans living in urban areas have almost ten times more income to expend than their counterparts in rural areas. They also have greater access to social services, such as education, health, water and sanitation. However, this comes at a price: the cost of living is much higher and the urban poor do not have access to resources commonly available in rural areas, such as food and, at times, better housing. Also, individuals without education living in urban areas are twice as likely to be unemployed as compared to their rural counterparts.
- **Health seeking behaviour among the poor is influenced** by: 1. Geographical factors – distance to health facility; 2. Socio cultural factors – local beliefs of illness etiology; 3. Socio demographic factors – age, level of education, employment status; 4. Economic factors – cost of obtaining health care; 5. Organizational factors – provider attitude.

Key Recommendations

- Given the limitations of the existing poverty approaches, the PSP4H team proposes three options: 1) a hybrid approach that includes additional indicators, 2) a private health sector approach to segmenting the market, and 3) poverty risk profile. Based on the findings in the literature, this programme adopted a definition of "the working poor" who mainly fall in the bracket of monthly consumption expenditure of between Ksh 1,562 to 2,200 and Ksh 2,913 to 4,000 for rural and urban respectively. This group is calculated to have a disposable income of about Ksh 300 per day, to be distributed between competing interests at the household level. These include food, shelter, healthcare, among others. This income group is viewed to be able to pay for health care in the private sector. This target group is found in the second and third household income quintiles and makes up upward of 24 million people in Kenya.
- The literature also demonstrates the characteristics the poor look for in a private provider that will inform the PSP4H market interventions. To be responsive to the working poor's needs and preferences, market interventions will need to: 1. Include mechanisms that remove economic barriers (e.g. insurance, medical saving plan, vouchers, contracting); 2. Be geographically accessible and located in the communities where the working poor work and live; 3. Compete on quality issues, ensuring adequate supply of affordable drugs, offering appropriate diagnostics, attending clients quickly and providing well trained staff; 4. Take into account cultural beliefs as well as social customs on who makes household decisions on health; and 5. Change private providers' attitudes to respect the poor.

2 What Do We Know About the Kenyan Private Health Sector? A Synthesis of the Current Literature

The objective of this study was to identify the market interventions that have the greatest likelihood for success in reaching the working poor, through exploring three basic questions:

- What areas of the health system can potentially make the greatest impact on the health outcomes of the working poor? (E.g. health system areas such as drug supply, diagnostics, personnel, etc.)
- What are the constraints in the market and operating environment preventing the private health sector from realizing these opportunities? (E.g. regulations, unfair competition, consumer inability to pay, etc.)
- How will the project interact and partner with the private and public health sectors to unlock this market potential? (E.g. interventions to generate demand; broker agreements to minimize/share market risks; etc.)

Key Findings

- Structure of the Private Health Sector
  - > The Kenyan private health sector is comprised of a diverse range of actors and is one of the largest and most dynamic in Sub-Sahara Africa. The Ministry of Health now recognizes a pluralistic health system and defines the private health sector to include “all players outside of the public or governmental sector”.
  - > The private health sector comprises of the informal (unlicensed) providers, formal providers, private health facilities, pharmaceutical and health products and equipment operators, and financiers of health.
  - > The most common informal providers (IPs) in Kenya include drug sellers; followed by village doctors/traditional healers; followed by Traditional Birth Attendants (TBAs), of which there are a significant number. IPs generally practice poor preventive medicine, rely on massage and herbal medicines, and dispense products or services in discrete single dose units (e.g., drug sellers). TBAs. Kenyans living in rural areas are more likely to obtain their health care from one of these types of IPs than their urban counterparts.
  - > The formal private health sector can be divided between (i) the not-for-profit FBO and NGO sectors and (ii) the for-profit, commercial sector.
  - > Other key actors in the health system that influence the private health sector in Kenya include the public health sector and international development partners.
- **More than 65% of the total health expenditure in Kenya is in the private sector.** There are several donors that are providing substantial levels of funding to the health sector. As can be seen in the National Health Account data from 2001-2010, donor contributions have increase dramatically in the last decade – from 16% to 35% of total health expenditures.
- **The large number of and sheer magnitude of donor funding flowing to the public sector potentially crowds-out opportunities to work with the private-for-profit sector**. They support many of the markets of interest to the commercial sector such as child health, FP/RH, HIV/AIDS and TB, malaria, and maternal health. For-profit providers will be reluctant to enter into these health markets if they have to compete with free public or highly subsidized FBO/NGO services.
- **The number of health professionals working in Kenya has increased significantly,** by almost twenty percent, from 2006-2009. Despite this remarkable increase, the ratio of health professionals to the total population remains quite low when compared to that of other low-income countries.

- This review also showed some health markets segments that would be attractive to investors in the health sector. These include pharmaceutical and medical supplies, demand side health financing, and maternal and child health.

Recommendations

This report demonstrates that the private sector is already in several health markets important to the poor, such as FP/RH, HIV/AIDS, maternal and child health. The private sector owns and manages a significant portion (more than 50%) of the health infrastructure in Kenya. Almost three-quarters of doctors and almost two-thirds of nurses and clinical officers work in the private sector. Many of these facilities and health professional work in or near the communities where the poor reside. Based on results of this review, PSP4H recommends the following focus areas as having potential for private providers to reach the poor with services:

- **Laboratory and diagnostics market:** This can be leveraged through placement, service outsourcing, referral of specialized services, transport of specimen, management contracts, and pooled procurement.
- **Pharmaceutical supply chain:** There is growing experience worldwide in leveraging private sector capacity to increase access to quality drugs among the poor. The most common model is developing country governments contracting-out different aspects of supply chain management in order to free up human and financial resources. A second model is franchising pharmacies and drug sellers as a strategy to expand access and assure quality. A third model is leveraging consumer packaged goods (CPG) companies to improve distribution of health products in remote areas.
- **Demand side financing:** Potential areas of intervention include voucher schemes, pro-poor health insurance schemes and government health insurance.
- **Maternal and child health:** Interventions in this area would reach the poor through approaches that enhance skilled delivery at the community level, at facility level; and also availability of delivery kits at community and facility levels.
- **Non-Communicable diseases:** According to the World Health Organization (WHO), 80% of deaths from NCDs now occur in low- and middle-income countries, up from 40% in 1990. By 2030, NCDs will be the leading cause of death and disability in every region of the world. Despite the growing incidence of NCDs, few donors in Kenya work in this health area. The strong consumer demand for and provider interest in expanding services to include treatment of NCDs, combined with the absence of donor funds to crowd out the market, NCDs present a strong potential for a markets approach to providing health services to the poor.

3 Comparing Kenya's Health Markets with Neighbouring Markets: A Focus on Healthcare Financing

With the aim of contributing to our understanding of the global private health financing sector, with a particular focus on low-cost private health financing approaches for poor populations in developing countries, PSP4H explored the literature on the following private health financing schemes:

- Risk-rated private health insurance
- Employer-based health insurance
- Enterprise financing schemes
- Community-based health insurance (including health micro insurance)

Key Findings

- **Risk-rated private health insurance:** In sub-Saharan Africa, whilst risk-based private health insurance schemes may offer relatively comprehensive financial protection for the individual insured, when taken as a whole, risk-based PHI schemes do not constitute a large share of overall health expenditure. For example, in South Africa, private insurance schemes accounted for an estimated 81% of private health expenditure and 42% of total health expenditure in 2011 while covering only 16% of the population.
- There are a few examples of **employer-based health insurance schemes** in a few developing countries. In Yemen, they represent the most prevalent source of third-party coverage of health services. We also found an innovative way of delivering employer-based health insurance by DomestiCare in South Africa which caters for domestic workers.
- Some companies have **enterprise financing schemes** as part of their corporate social responsibilities, and/or as extensions of work injury compensation schemes. AngloGold Ashanti, a mining company, is a good illustration of this. It provides free healthcare for its employees and their dependants, and is subsidized for the local community, at the Obuasi Edwin Cade Memorial Hospital.
- **Community-based health insurance** (CBHI) exists in many low- and middle-income countries, especially in Africa and Asia. In terms of population coverage, these schemes exist within localised communities, most often in rural areas: members make small payments to the scheme, often annually and after harvest time, and the scheme covers the fees charged by local health services. Scheme participation, which is linked to cost-recovery, varies considerably across schemes and also within schemes across different sites. This study finds that CBHI schemes are often unable to raise significant resources because of the limited income of the community, and the pool is often small, making it difficult to serve a broad risk-spreading and financial protection function. The schemes' size and resource levels make them vulnerable to failure. They are also placed at risk by the limited management skills available in the community, and they have limited impact on the delivery of health care, because few negotiate with providers on quality or price. At the same time, CBHI has reduced household's out-of-pocket expenditures on health.
- **Micro-insurance for health** is a particular form of CBHI where micro health insurance is included in microfinance schemes. It has shown promise in providing some financial risk protection for poor families in developing economies. However, they have rarely been able to represent a perfectly balanced portfolio, between risk and return, either because their client volume is too small (either due to enrolment demand or capacity), or because the relatively large risks they cover among low-income populations represents a disproportionate impact on the portfolio as a whole. The case of Microcare Uganda is instructive in looking at the successes and failures of micro-insurance schemes for health.

Recommendations

Assessing the examples of voluntary private health insurance schemes overall, we find that even from the experiences in high-income countries, it is difficult to draw generic, empirically based, policy lessons. Nevertheless, for all the types of private health financing schemes discussed, the following recommendations could be useful in increasing their scope, effectiveness and impact:

- Mandating core benefits is important if the various forms of private health insurance are intended to be a primary source of coverage for large segments of the population.
- If coverage restrictions exclude care for common high-cost conditions in developing countries, like AIDS and cancer, then the financial protection provided will be insufficient.
- It is important to strike a balance between providing effective financial protection and assuring affordable premiums.
- Policy-makers need to remember that methods used to calculate premiums have an important effect on equity and affordability.
- There is scope for donors and other non-state actors to promote and ensure that countries are openly vigilant regarding the potential for fraud, abuse and corruption.

4 A Formative Survey of the Private Health Sector in Kenya in the Context of the Working Poor

The programme sought to generate evidence for interventions that address opportunities for accessing health care through the private sector. A formative study to understand the health seeking behaviour and preferences of the poor, in late 2013 PSP4H commissioned this primary research study which was designed to answer, among others, the following key questions:

- What are the barriers and opportunities for the private health sector to providing health services to the poor?
- What are the health seeking behaviours of health care consumers within the PSP4H programme's target population?

Key Findings:

- In this study we used a qualitative measurement tool to select the working poor (skilled or unskilled causal workers and labourers). The tool was developed based on the existing approaches to defining poverty such as the Poverty Index, Household Assets Assessment, Monetary/Income and Consumption Expenditure Assessment, Progress out of Poverty, among others. The criteria used 12 domain areas for scoring on a scale of 1-3, with the 1 being the poorest and 3 indicating the wealthiest. The scoring indicators covered housing, house space, rental status, source of water, fuel and cooking security, garbage collection, sanitation, daily household income, average number of meals per day, access to health services and type of work.
- There was a general pattern for each illness episode: seeking health care sequentially progresses from self-medication, herbal/traditional care, public health facility to private health facility. In severe cases, the pattern skips the public facility direct to the private facility. The costs to the poor include payment for services and commodities at each stage. At the end of the illness episode, they pay more than they would have if they went straight to a public or private health facility. This premium is termed the "poverty penalty".
- Most of the working poor who participated in the study mentioned that the services available to them were generally inaccessible in terms price, quality and physical location. While there are some focus areas such as HIV/AIDS, malaria, child health and maternal health which are relatively accessible, there are some areas that are grossly underserved. These are: non-Communicable diseases such as cancer, diabetes and heart disease; dentistry; gerontological services (age-related illnesses); respiratory infections; and mental health. The main reason for these underserved areas is the lack of skilled professionals at the facility level found in poor communities. Also, because of the specialization in these services, the price tends to be too high for the working poor to afford.
- Reasons why the poor prefer the private sector: These include perceived quality of services, confidentiality, convenience (longer working hours), easy access to the facility, positive provider attitude and behaviours, availability of specialised services, shorter waiting times, and availability of staff, particularly doctors
- The focus group discussions with private providers revealed their primary challenges in delivering services to the working poor. These include Enabling Environment - policies and regulations present several barriers, impacting private providers' ability to serve the poor; Business Climate - many private providers consider the Kenyan health market attractive for growth and investment, and the MOH is increasingly receptive to working with the private health sector; Market Competition - private providers stated that competition is a big challenge and comes from multiple sources including informal providers,

government and donor programs; Lack of Information - there are persistent problems of poor communication and information sharing.

Recommendations can be summarized in the matrix below:

Intervention objective	Interventions geared towards policy makers	Interventions geared towards providers	Enabling consumers and their representatives
Increase coverage of products and services with a public health benefit which are affordable for the poor	**Strategy 1** Lower policy, regulatory and fiscal barriers Remove barriers to private sector entry to market Liberalize scopes of practice for key health cadre in private sector such as pharm tech and clinical officers	**Strategy 2** Recruit and network pharmacies into retail networks Recruit and network community nurse midwives **Strategy 3** Recruit PSPs into an accredited network for specific health Services, such a maternal health, with a public health benefit **Strategy 4** Contract with PSPs to deliver essential health care or diagnostic services	**Strategy 5** Market private sector services among priority target groups **Strategy 6** Introduce demand-side financing to remove economic barriers for priority target groups
Limit harmful practices and improve technical quality of care among PSPs	**Strategy 7** Enact and enforce quality standards Strengthen and enforce provider / facility licensing Better integrate private sector in quality supervision	**Strategy 8** Provide training supports and incentives to PSPs to conform to good practice norms	**Strategy 9** Enact consumer protection law and raise awareness of consumer rights **Strategy 10** Increase consumer's knowledge through community education campaigns
Make PSP services more affordable	**Strategy 11** Publish PSP prices Encourage price minimums for priority services Use insurance and contracting to influence prices	**Strategy 12** Organize PSPs into group practices, insurance schemes and contracting	**Strategy 13** Publish information to users on maximum permitted prices

5 A Study on Sustainability Outcomes of Donor-funded Programmes

The purpose of this study was to undertake primary research to assist the PSP4H team to assess the sustainability outcomes of prior donor-funded health care programmes in Kenya, particularly those offering grants and subsidies to partners in the public sector, not-for-profit sector, and commercial sector. The study period allowed a closer look at ten programmes and has discussed a range of issues including social franchising, social marketing, branding, category promotion, and capacity building. It looked at the range of programmes from different perspectives including that of the small private for-profit entrepreneur. The study explored a range of issues including the influence of government fiscal and sector policies on existing strategies for engaging the private sector. It looked at the influence of donor priorities and issues of aid effectiveness on the sustainability of individual programmes and of progress in more general terms on achieving more sustainable private sector services for the working poor.

Key Findings

- **Defining Sustainability:** For the purposes of this study sustainability was defined as achieving agreed outcomes in private sector provision through donor support, both in terms of quality, accessibility and affordability of services, and maintaining these once that funding ends. It included a consideration of effective use of all available resources and recognised that some on-going subsidy for the poorest quintile will need to be maintained.
- **Developing the private health sector:** Interviews held with different key informants showed that views on the role of the private sector in health provision and the interface with public sector provision vary considerably. Some informants adhering to the need to push for universal access to free health services for all through the public sector and others advocating a variety of solutions that look at different models of financing health care, including involvement of the private for-profit sector, while providing a safety net for the poorest that cannot afford to pay for services, through some form of risk-pooling mechanism.
- **The evolving social franchising model:** Social franchising is an approach to organizing private providers into networks that deliver specific health services under a common brand, with a promise of quality assurance. Several donor-funded social franchising programmes are taking place in Kenya. The interest in social franchising with private for profit and not-for-profit provided an interesting area to explore the positive and negative effects of programme design, donor interest and issues of ownership and harmonisation on sustainability outcomes.
- **Subsidy and social marketing of selected products and services:** An advocate of the M4P approach called for a different approach that does not involve any subsidized commodities, but rather focuses on creating demand in the population so that clients increasingly make informed choices and seek services either in the public or private sector. The challenge of providers being used to receiving free or highly subsidized commodities was seen as a problem and unsustainable.
- **Capacity building and sustainability:** Nearly all respondents stated that one of the most important inputs from donor-programmes for sustainability was capacity building. This has taken many forms over the years. It has included pre-service and on the job training. Private providers reported that management and business skills training together with regular supervision and mentoring were areas that increased their understanding of how to run a business effectively and were particularly useful.

Recommendations

The study does not vindicate or recommend any donor funded programme but is utilizing this information to learn best practices in implementation. These are the key recommendations, based on the findings:

- Donor programmes should build government ownership and private sector engagement into design in more comprehensive and robust ways. This should include ensuring local authority voice in donor funded programme decision-making and implementation.
- New donor programmes need to learn the lessons of the last two decades of working with bilateral programmes. New designs should look at supporting market development as much as possible, using and facilitating existing manufacturers, service providers and local resources.
- Design of new programmes needs to harness the experience of successful SMEs much more and active engagement of owners should be a key component of future design of programmes whether aiming at service delivery, introduction of new technologies or developing financing packages for the poor.
- Donors should look at continuing to support carefully designed demand creation components in their programme as this is often an area that small private sector providers generally do not have the skills to develop and cannot afford to support.
- More emphasis should be given to developing sustainability planning at design stage and more attention given to its implementation during programme reviews.
- More analysis should be undertaken to understand the decision-making around private sector investment in healthcare and how the private sector judge risk and opportunity.

6 Overview of Experiences in the Pharmaceutical Supply Chain: Implications for the poor in Kenya

The study sought to describe and analyse the commercial supply chain for pharmaceuticals in Kenya and identify potential areas of interventions to improve the supply of quality and affordable medicines to the poor. A mixed methods approach was used, including reviewing literature, and primary data collection in four counties (Nairobi, Machakos, Kilifi and Nyamira) between March and May 2014. Primary data were collected using in-depth interviews, focus group discussions and a survey of commercial retail pharmacies.

Key Findings

- **Changing landscape of the supply chain creating new opportunities:** Kenya has public, private non-profit, and commercial supply chains, but with a high degree of interlinking. The recent devolution of procurement functions to county governments has seen the Kenya Medical Supplies Authority (KEMSA - the public procurement agent) and Mission for Essential Drugs and Supplies (MEDS, the non-profit procurement agency) reposition to better serve counties directly and meet the medicine needs of commercial facilities, thereby expanding their markets. However, the inability of the highly fragmented commercial supply chain to attract larger discounts via bulk purchasing, and enjoy economies of scale in distribution, has put the sector at a disadvantage when compared to the other two supply chains.
- **Pharmaceuticals market competitive but poorly structured, and cannot guarantee quality:** The commercial supply chain has a highly fragmented pyramidal structure, with a few manufacturers at the top and a large but undefined number of retailers at the base. The distribution of suppliers is skewed in favour of urban locations, creating a crowded environment there, and a large underserved market in rural locations.
- **The market has high concentration of retailers**, with few distributors/wholesalers controlling the bulk of the market share. Informal retailers are numerous, mainly located in rural areas, and buy stocks mainly through vertical arrangements with (usually) larger pharmacies. Under these arrangements, larger pharmacies serve as ‘mini-wholesalers’ despite not having the requisite wholesale licenses.
- **The market is highly distorted,** with blurred boundaries between wholesalers and retailers. This has been linked with perverse behaviours, for instance, retailers acquiring medicines of questionable quality through parallel importation, and others pilfering medicines from the public sector.
- **Kenya has low numbers of pharmaceutical personnel** mostly concentrated in major towns, a factor that is linked to the large informal retail sector. While a large proportion of staff in the informal sector receives training in a health or pharmacy-related field, they do not qualify for licensure under current laws.
- **Urban and rural retailers face different competition environments**, with the former competing along price and quality dimensions while the latter compete majorly on price. This has compromised the services offered to rural dwellers. The outcome of the highly distorted and fragmented commercial distribution chain is a market characterized by many low quality retailers. Inadequacies have been reported in the content of the products, technical quality of the services, and equity.

Recommendations

#	Intervention area	Possible interventions/policy responses
1	Strengthen the role of local industry in promoting equitable access	Partner with local firms to increase production and distribution of low-cost high demand commodities through the commercial chain Explore strategies for commodity and price differentiation with the aim of designing specific products that can reach the poorer groups
2	Increase capacity of the labour force working in the pharmaceutical supply chain	Encourage public sector capacity building initiatives to be directed to the private sector as well through public-private dialogue Map and describe roles played by informal providers to inform initiatives for filling demand gaps or deciding how to go forward with this group Explore possibility of introducing 'telepharmacy' as a way of utilizing health-qualified (but un-licensable) personnel running pharmacies in rural areas
3	Promote public-private dialogue and exchange of ideas on best practice	Encourage knowledge transfer between public and private sector. Best practices can be shared across the three supply chains, for instance, KEMSA's ERP and LMIS systems have won awards; the private sector is known to have efficient distribution systems. Knowledge transfer can be achieved through sponsored workshops and working via the Kenya Healthcare Federation network
4	Reduce fragmentation in the commercial distribution chain	Encourage distributors to share infrastructure through facilitated discussions. This may also entail promoting the sharing of information on who has what medicines, should they be required urgently, and what the purchasing plans are for retailers operating in one market area/region. Encourage commercial suppliers to share distribution infrastructure in order to compete effectively in the changing policy landscape Explore supporting pooled procurement and distribution across the country. KPA are working on a bulk procurement model which could be built upon
5	Generate reliable (and updatable) information on the range and distribution of medicine retailers	Encourage the mapping and sharing of information on the pharmaceutical outlets across the country. Support initiatives to have a Master Pharmacy List showing the distribution of private retailers. This can be linked to other information such as licensure, inspections reports and quality improvement/accreditation achievements.
6	Promote access to finance	Promote interventions to legitimize commercial retailers to make them attractive to financing institutions. These include strengthened inventory management and financial record-keeping, which will also improve quality, as reliable information on performance can be fed back to the government. Study the lessons from supply-side financing initiatives from similar initiatives targeting private health facility (e.g. PharmAccess' Medical Credit Fund (MCF) targeting social franchise clinics and IFC's supply side financing mechanisms under the Health in Africa Initiative)

7	Client signalling and consumer awareness activities	Engage the professional bodies in developing the PSK Green Cross and KPA Blue cross. Learn lessons from past failure (e.g. inadequate marketing and failure to link with continuous professional development initiatives, etc.). Devise other innovative ways of educating consumers on the importance of price reducing strategies such as generic prescribing