Public–Private Partnerships for Family Planning

Case Studies on Local Participation

Keywords: Family planning, public-private partnership, private sector engagement

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Summary

The value of local participation is presented in five case studies on public–private partnerships for family planning: Marie Stopes Papua New Guinea, Sehat Sahulat Card in Pakistan, Sayana Press implementation in Senegal, Wazazi Nipendeni in Tanzania, and accredited drug dispensing outlets in Tanzania. The publication begins by discussing partnership mechanisms and the types of partners. The authors consider the experience of PPP unit representatives that worked on health issues, including family planning. The primer closes with a discussion about ongoing challenges and opportunities for these partnerships.

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Public–Private Partnerships for Family Planning: Case Studies on Local Participation

Governments have historically used public-private partnerships (PPPs) to engage the private sector to mitigate financial risks, pool resources, and expand infrastructure and public services. There are many differing descriptions of what constitutes a PPP (Barnes 2011; Llumpo et al. 2015; National Council for Public-Private Partnerships 2016; World Bank 2016), but common ground can be found within the following definition.

Public–private partnerships defined

A **public-private partnership** is a formal arrangement between a government agency and a private entity through which the investments, risks, and rewards are shared in delivering a service or asset for the benefit of the general public.

PPPs are commonplace in the sectors of energy, telecommunications, transportation, and water and sanitation due to the ability of the private sector to efficiently organize and manage large projects. The private sector offers technology, materials, expertise, capital, flexibility, and management strategies that can support public sector objectives. Over the past 15 years, the World Bank Group has tripled its lending, investments, and guarantees for PPPs across sectors, from $900 million in 2002 to $2.8 billion in 2016 (World Bank 2016). Increasingly, PPPs are looked to as a way to expand the reach, impact, and efficiency of global health programs.

Jessica Scranton

Objective and audience

Intended for ministries of health and finance, and private organizations, this primer highlights diverse case studies of PPPs for family planning that demonstrate local engagement and have the potential to be replicated in resource-constrained settings. Through these examples, the primer discusses each PPP's relevance to family planning; its achievements and challenges; and the contributions of each partner. Ultimately, these examples may encourage public and private actors to think more broadly and inclusively about how PPPs can advance family planning. The primer may also stimulate discussion among the international community about inclusive approaches to PPP development.

Family planning partnerships

Despite growing interest in PPPs for health, there has been a relatively narrow scope of PPP development. Common examples of PPPs for health include the development of physical infrastructure, such as hospitals and health centers, through specific contract mechanisms,[1] and the delivery of health services through service level agreements. Low-resource settings present a unique challenge to the development of PPPs for health because laws and regulations governing PPPs are typically less established and government actors often lack capacity to effectively and transparently negotiate partnerships. Although there are positive developments in the formulation of new PPP laws in several countries, many of the resulting PPPs are heavily skewed toward large, capital-intensive infrastructure projects and do not provide clear frameworks for service delivery PPPs. Recognizing the importance of PPPs in low-resource contexts, the World Bank encourages ministries of health in Africa to harness the potential of the private sector to help achieve their public health goals (World Bank Group 2013). To increase support for PPPs in health and other sectors, coordinating bodies such as PPP units have been established within national ministries in several countries, including Malawi (2011), Kenya (2013), and Uganda (2015) (World Bank Group 2016).

In family planning, developing PPPs is challenging. Vertical programming structures and the sometimes politically contentious nature of this health area have restricted the scope of these types of PPPs almost exclusively to contracting out mechanisms such as service level agreements[2] (Tayag, White, and Mijares 2014; Strengthening Health Outcomes through the Private Sector Project 2012; Corby, Nunn, and Welch 2012; Pakistan Initiative for Mothers and Newborns 2006). Contracting out

[1] Design-build-operate-transfer contracts are a type of public-private partnership for health care facilities. Depending on the needs of the public sector and the specific PPP arrangements, the private sector can design, build, finance, operate, or maintain the facility and then own, lease, or transfer it back to the public sector. Learn more at ww.ncppp.org/ppp-basics/types-of-partnerships.

[2] Contracting out is an arrangement in which the government enters into a partnership with a private provider for the delivery of goods and/or services to the government or to a designated third party on behalf of the government. Provision or production takes place outside public facilities (Corby, Nunn, and Welch 2012).

A public–private partnership is a formal arrangement between a government agency and a private entity through which the investments, risks, and rewards are shared in delivering a service or asset for the benefit of the general public.

constitutes an important component of a strategy to increase human resources for health and access to family planning services. Still, there may be untapped potential for additional PPPs to close gaps in demand, affordability, access, and quality in family planning through other PPP models.

This primer begins by discussing partnership mechanisms and the types of entities that engage in PPPs. Five family planning-focused PPPs with local participation are highlighted in the areas of service delivery and workforce, financing, medical products and technology, health information and communication, and leadership and governance. Next, the authors share local perceptions of PPPs for family planning based on interviews with representatives from ministries of health. The primer closes with a discussion about ongoing challenges and opportunities for these partnerships.

The partners

Much is written on the contractual mechanism between partners, but there is little consideration of the partners themselves. The text box on page 4 broadly outlines the types of partnership arrangements between public and private entities. Public actors are often thought of as the national, regional, or community government entities in the country in which the PPP takes place. However, publicly funded international development and aid agencies such as the World Bank, the United States Agency for International Development (USAID), and the United Kingdom's Department for International Development often take on a public sector role as a surrogate for public funding in resource-constrained settings. This is typically done with the assent of host governments, which rely on external donors to bridge gaps in the public health system.

Elements of public–private partnerships

Types of PPPs

- Collaboration formalized through contracts
- Cooperation through non–contractual agreements and memorandums of understanding
- Communication and sharing of information

Public sector

- National ministries (health, finance)
- Regional, district, or other state actors
- Parastatal organizations
- Publicly–funded bilateral aid agencies (USAID, DFID, Sida)
- Publicly–funded multilateral aid agencies (UNFPA, WHO, World Bank)

Private sector

- For–profit companies
- Nonprofits, including faith–based organizations
- Implementing partners (NGOs funded by donors for specific objectives)
- Private foundations

Similarly, private actors include corporations, faith-based organizations, and other nonprofits, as well as private donors and implementing partners (nongovernmental organizations financed by public or private donors for specific objectives). In many ways, private donors, such as the Bill & Melinda Gates Foundation and the Aga Khan Foundation, act like global public financing mechanisms, blurring the line between public and private actors. While partnerships involving public aid agencies or private donors have yielded important accomplishments for family planning on a global scale, it may be difficult for host country actors to replicate these PPP models. It is worth considering these questions:

1. Is the participation of the host country government more passive in settings with active public and private aid agencies?
2. Does the participation of the host country government have implications for the sustainability of PPPs?
3. What balance should the international community strike in building the capacity of the local public sector versus engaging in PPPs directly?

The answers to these questions are not apparent given the current state of evidence, but they present important areas of future research to better understand the intended and unintended long-term consequences of PPPs.

International aid agencies and private donors have historically played a vital role in enabling PPPs for family planning and have amplified their global visibility and impact. Prominent examples of these PPPs include the USAID Bayer Schering Pharma Contraceptive Security Initiative for oral contraceptives, the Ouagadougou Partnership, the Sino-implant (II) initiative, and the global partnership for the pricing and introduction of Sayana Press. However, as emphasis in development shifts toward country-led sustainability and accountability, local ownership may offer a more sustainable way to align the private sector with national health policies and priorities. New platforms such as the Global Financing Facility further incentivize local participation by supporting country-led efforts to improve the health of women, children, and adolescents. National governments are asked to engage with the private sector to achieve universal health coverage and family planning objectives, but they may have limited experience navigating PPPs. This primer offers examples of PPPs for family planning with active participation and substantive contribution of host country public sectors.

Country delegations discuss family planning successes and challenges at the 4th annual Ouagadougou Partnership meeting in Cotonou, Benin.

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Methods

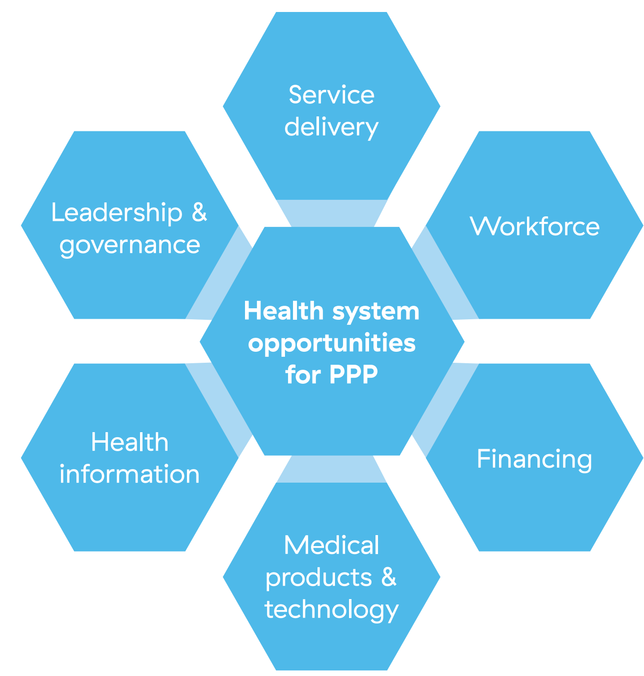


Figure 1. Health system building blocks

WPRO 2016

In identifying and selecting examples of PPPs for family planning to include in the review, the authors considered a broad spectrum of PPP mechanisms. These ranged from simple resource sharing and memorandums of understanding to more complex contracting. To date, most PPPs for family planning are service contracts for service delivery. One objective of this primer was to highlight a variety of functions beyond service delivery, which may inspire innovation and encourage novel partnerships. The authors used the WHO health system building blocks framework (Figure 1) as an organizing principle to stimulate new thinking on how PPPs could address various health system functions (WPRO 2016). Using this framework, the authors identified examples of PPPs for family planning in service delivery, workforce, financing, medical products and technologies, health information, and leadership and governance.

While there are many examples of strong PPPs for family planning at the global level, driven by aid agencies and private donors, this primer highlights PPPs for family planning that are relevant to host country ministries of health and finance in low-resource settings. Therefore, only PPPs with active participation of local governments or ministries of health are included.

A two-pronged approach was used to identify PPPs for family planning and understand their contexts:

1. **A comprehensive literature review** of PPPs in family planning, health, and other sectors, such as energy, water, and infrastructure, to identify documented innovations, achievements, and challenges. Secondary sources included peer-reviewed articles, project reports, policy documents, and technical briefs.
2. **Key informant interviews** with representatives of public and private entities in four sub-Saharan African countries (Kenya, Malawi, Tanzania, and Uganda). Stakeholders included PPP practitioners and members of newly established PPP units housed within the ministries of health and policy.

Five case studies are presented on the following pages. While focusing on different aspects of the health system, all examples show local participation. They are a subset of PPPs for family planning.

Dr Léhié Bi Lucien, mayor of Bouaflé, Côte d'Ivoire (left), was a pioneering force behind a model public–private dialogue forum in his district. Dr. Alphonse Kouakou, chief of party of the USAID Private Sector Health Project in Cote d'Ivoire (right), meets with Dr. Bi to discuss and share lessons learned from the partnership.

Case Studies

Jessica Scranton

Service delivery and workforce

Marie Stopes Papua New Guinea

Publicly financed delivery of family planning services and products through private providers

This example offers a model of a PPP for family planning in the context of service delivery and workforce; there is an abundance of examples in this area (SHOPS 2015; SHOPS 2012; Corby, Nunn, and Welch 2012). In both developed and developing countries, contracting out under a PPP is used to extend the geographic reach and improve the quality of resource-constrained public health services through partnership with a network of private providers. Contracting out appeals to aid agencies and governments as an efficient way to increase access to targeted, high-quality family planning services for underserved populations.

This is especially valid in settings where public health facilities are at capacity or do not provide certain services (see the following text box). Further, if there are cultural or political sensitivities associated with the provision of family planning services, contracting out may offer an appealing solution.

The rationale and mechanisms for contracting out family planning services are well established. Still, examples are needed of how family planning service providers can effectively integrate partnerships with both government and aid agency partners, resulting in a diversified funding stream and increased host country government capacity for partnership. Marie Stopes International (MSI) is a private, nonprofit organization known globally for its provision of quality family planning services. The international NGO engages in a wide range of PPPs for family planning, including service level agreements,

Reasons for contracting out family planning services

Access — Increased availability, use, and coverage of family planning services

Quality — Improved provider capacity, adherence to clinical protocols for patient care, and health outcomes

Efficiency — Maximized health objectives at least cost; use of existing provider capacity (buy versus build)

Sensitivity — Outsourced family planning and reproductive health services that may be controversial or culturally sensitive

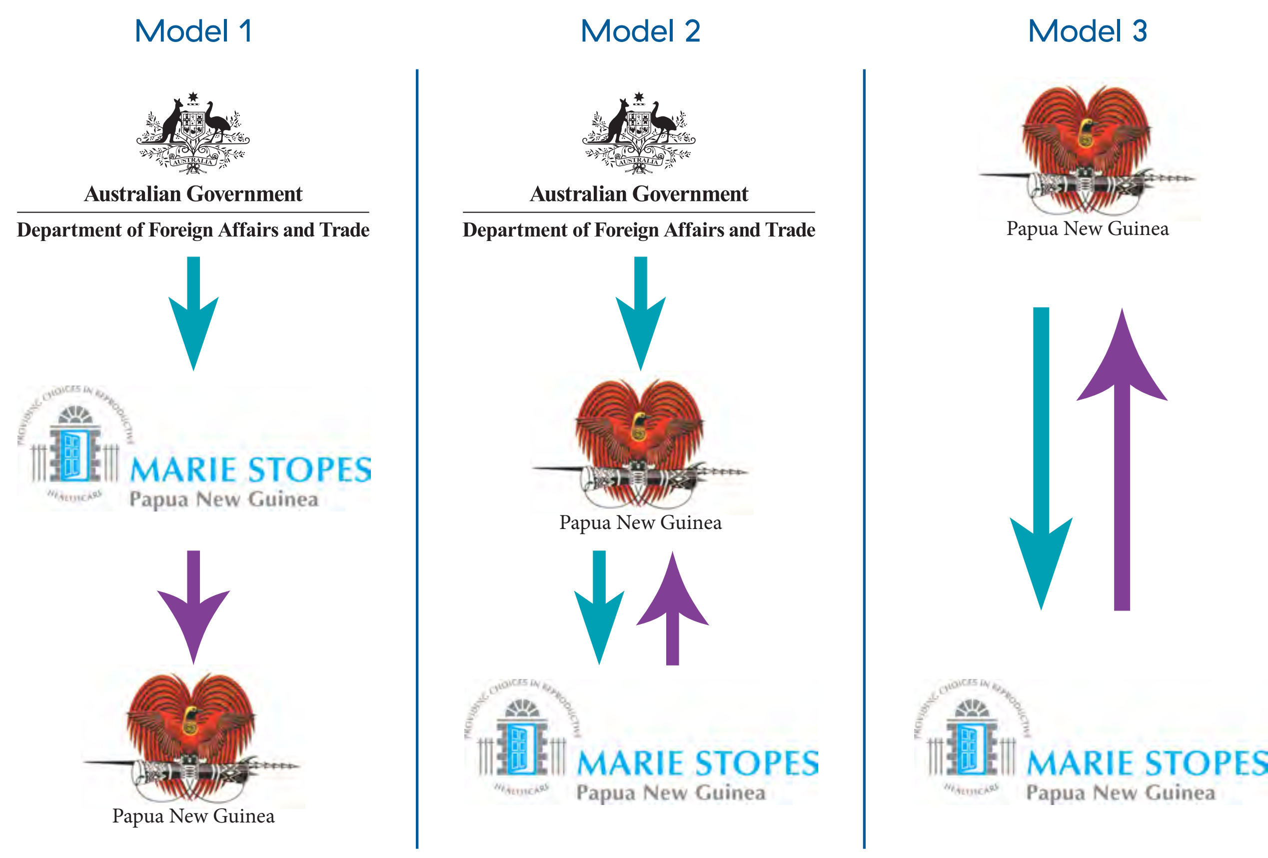
social franchising of public facilities, and other procurement arrangements for technical assistance and mobile outreach. The financing mechanism of these service delivery arrangements varies, with MSI being exclusively donor-funded in some settings, and in others contracting directly with government. In Papua New Guinea, there was an evolution of partnerships between Marie Stopes Papua New Guinea (MSPNG), the Australian Department of Foreign Affairs and Trade (DFAT), and the government of Papua New Guinea that resulted in the government's participation and autonomy as well as a blended funding portfolio for MSPNG.

Originally funded directly by DFAT to provide family planning and sexual and reproductive health services to the Papuan public (Figure 2, Model 1), MSPNG worked steadily since its inception in 2006 to build its relationship with the government. As part of its approach, MSPNG ensured that its policies and practices were aligned with national strategies to prevent maternal death and unplanned pregnancy (MSI 2015). While MSPNG was able to demonstrate the value of its services to the government, at first the government lacked the experience and capacity to contract directly with MSPNG. To build this capacity, DFAT intervened in 2011–2014 to facilitate several pilot flow-through models (Figure 2, Model 2). In these flow-through models, DFAT financed the provincial governments, which in turn managed contract implementation and payment procedures with MSPNG. These models also afforded the opportunity to develop national contracting policies and procedures. In 2014, MSPNG established its first direct contract with the Papua New Guinea Department of National Planning and Monitoring for approximately $2 million to provide family planning services to 20,000 clients and build public sector capacity to deliver services (Figure 2, Model 3) (MSI 2015).

Penny Williams, deputy secretary, Australia Department of Foreign Affairs and Trade (left), at a Marie Stopes Clinic in Goroka, Papua New Guinea.

Australia Department of Foreign Affairs and Trade website — dfat.gov.au

Figure 2. Service delivery contract models for family planning in Papua New Guinea



Model 3 was developed because of the Department of National Planning and Monitoring's disinclination to rely on external donors to fund its National Strategy for Responsible Development (MSI 2015). Similarly, MSPNG was interested in developing new revenue streams with the government, and DFAT had an interest in building public sector capacity. The contract between the Department of National Planning and Monitoring and MSPNG represented 40 percent of MSPNG's annual income and substantially increased its scope in Papua New Guinea. However, MSPNG noted challenges with its direct contract with the government, including uncertainty about timing and funding of annual renewals. Ultimately, MSPNG noted that having a mixed revenue stream (from both DFAT and the government) had been a stabilizing force, and funding streams should complement rather than replace each other. Model 2 provides a useful training or transition model that can be used in many settings. Yet, the coexistence of Models 1 and 3 may provide the most feasible paradigm for comprehensive service delivery in light of inconsistencies of local government PPP execution and diminished funding or changes in funding priorities among aid agencies.

This case study illustrates three models for contracting with the private sector to achieve national family planning service delivery and workforce objectives. In 2014, through partnerships with DFAT and the government, MSPNG provided

more than 40,000 family planning services and averted more than 47,000 unintended pregnancies (MSPNG 2014). This indicates that there may be opportunities for further host country government engagement in service delivery PPPs for family planning in settings with active international aid agencies that are willing to help develop the transparency, capacity, and readiness of the local public sector.

Mike Reys

Financing

Sehat Sahulat Card, Pakistan

Publicly funded vouchers to increase demand for and access to family planning services and products through private providers

A voucher program is a well-established financing mechanism used to stimulate demand among disadvantaged populations who face financial barriers to accessing family planning services. For voucher programs implemented under PPPs, the public sector or its implementing partner distributes vouchers for family planning services and products at minimal or no cost to clients. The public sector issues contracts with pre-qualified private health providers to accept the vouchers based on a negotiated rate. This example of a PPP for family planning allows the public sector to increase purchasing power in low-income populations, generating demand for family planning services, and to increase access to private providers. In low-resource settings where government capacity to offer health services is limited, bilateral and multilateral aid agencies often finance the voucher programs and private sector voucher program implementers. Most notably, MSI has implemented more than 24 family planning and sexual and reproductive health voucher programs in 11 countries in Asia and Africa, largely funded by USAID and other aid agencies (Eva, Quinn, and Ngo 2015). The MSI voucher programs have been successful in reducing cost as a barrier to care, increasing demand for and uptake of family planning services, and improving service quality (Eva, Quinn, and Ngo 2015).

While MSI family planning voucher programs have been extremely successful, they do not offer examples of substantial investment by host country governments. A 2015 systematic review identified 31 family planning voucher programs in low- and middle-income countries, of which only four were PPPs that included financing by the host country government (Bellows et al. 2015). Of these four PPPs, only one (in Pakistan) was entirely financed by the host country government, and three (in Colombia, Dominican Republic, and Uganda) were co-funded by international aid agencies (see the following table).

Family planning voucher programs with host country financing

Program	Sehat Sahulat Card[1]	Profamilia	Red Segura[2]	Healthy Baby/Healthy Life[3,4]
Country	Pakistan	Colombia	Dominican Republic	Uganda
Source of financing	District governments of Kasur and Rawalpindi	State government, USAID	Ministry of Health, KfW, USAID	Government of Uganda, KfW, World Bank
Years active	2009 to present	1966 to present	2013 to present	2006 to present
Voucher management agency	Zahanat Foundation	International Planned Parenthood Federation	–	MSI
Service providers	Private	Private	Private	Private
Beneficiaries	Underprivileged pregnant women, children under 5 years old	Youth (ages 10–19), men and women	Young adults (ages 13—24), men, women, adults in bottom-, lower-, middle-income brackets	Poor men and women
Services covered	Antenatal care, delivery, postnatal care, family planning, counseling	Contraception, gynecological exams, pregnancy and STI testing, cervical and breast cancer screenings	Gynecological exams, family planning, and STI services	Family planning and STI services, antenatal care, delivery, postnatal care
Number of providers	100	66	5	130
Published evaluations	No	No	No	yes

KfW = Originally *Kreditanstalt für Wiederaufbau,* or Reconstruction Credit Institute, STI = sexually transmitted infection
[1] Learn more at www.healthmarketinnovations.org/program/sehat-sahulat-card-ssc.
[2] Learn more at www.healthmarketinnovations.org/program/red-segura-dominican-republic.
[3] Learn more at www.shopsplusproject.org/node/11183.
[4] Learn more at www.shopsplusproject.org/node/15470.

The Sehat Sahulat Card voucher program in Pakistan is a district government PPP for family planning. District governments of Kasur and Rawalpindi financed the program to facilitate access to a package of quality reproductive, maternal, newborn, and child health services, including family planning counseling, delivered through private providers (Center for Health Market Innovations 2016a). The program targets expectant mothers from disadvantaged backgrounds in peri-urban and rural areas through the Rawalpindi, Shakrial, Gangal, and Kasur Union Councils. Eligibility is based on a poverty index score.

Eligible recipients receive a voucher card, financed by public funds, which allows them to "purchase" a pre-specified set of reproductive, maternal, newborn, and child health services from approved private health providers.

Private providers in the voucher program agreed to public sector reimbursement rates and to monitoring through a third-party voucher management agency. In return for providing services, private providers could benefit from additional clients and revenue. In a PPP for family planning voucher model, the public and private sectors contribute and gain marginally for the overall benefit of the underserved public (Figure 3).

Figure 3. Contributions and gains of public and private partners for Sehat Sahulat Card program

Public sector contributions
- Voucher financing

Pakistan Ministry of Health

Private sector gains
- New client business
- Redeemed voucher revenue

Sehat Sahulat Card Program

UK Department for International Development

Public sector gains
- Extension of health service coverage through private sector
- Increase in population able to afford family planning services

Private sector contributions
- Human resources
- Acceptance of voucher reimbursement rates
- Data reporting

As a testament to the popularity and success of the program, in 2016 the Sehat Sahulat cards were adapted and launched in additional districts of Chitral, Mardan, Kohat, and Malakand and the second phase of the Sehat Sahulat Card program was launched throughout the province of Khyber Pakhtunkhwa (Govt Jobs in Pakistan 2016; Radio Pakistan 2016). This PPP for family planning is envisioned as step toward universal health coverage and is expected to cover more than 1.8 million families at a cost of 5.3 billion rupees (Radio Pakistan 2016).

Sehat Sahulat card recipients use a publicly funded voucher card (shown here) to access a pre-specified set of health services from approved private health providers.

Khyber Pakhtunkhwa Health Department

Worth noting is that the Sehat Sahulat Card program finances family planning services within a larger bundle of health services. The difference between the Sehat Sahulat Card program and the MSI voucher programs may highlight a key distinction between national government programs and those of international aid agencies. The former must address all health needs of citizens, while the latter often channel money through vertical programming priorities such as family planning, HIV, or malaria. Further, when aid agencies finance family planning initiatives, there may be less incentive for local governments to prioritize PPPs for this health area.

Challenges for family planning voucher programs such as Sehat Sahulat Card can include the coordination and accreditation of a diffuse network of private providers, the logistics of voucher distribution and eligibility verification, fraud during voucher redemption and processing, and providing recurring services (such as contraceptive injections) with one-time vouchers. Additionally, voucher programs can be expensive to set up, and the cost of administration can sometimes exceed the perceived benefits of targeting high-need populations (Eva, Quinn, and Ngo 2015).

Nevertheless, voucher programs for family planning that include public and private actors have demonstrated their ability to subsidize beneficiaries and engage the private sector to reduce financial barriers to contraceptive services, increase contraceptive uptake, and expand client choice by expanding private provider options for disadvantaged clients (Bellows et al. 2015; Eva, Quinn, and Ngo 2015). Voucher programs also provide valuable lessons for demand-side health care financing reforms—such as risk pooling—and build capacity of local private actors to manage voucher and other health care financing programs. The voucher model of a PPP for family planning is one that is replicable, scalable, and effective. It is worth further consideration by governments looking to partner with the private sector to expand access to and reduce cost as a barrier of family planning services.

Medical products and technology

Sayana Press implementation science, Senegal

Joint public and private research on implementation of family planning technology (Sayana Press) to increase operational and cost efficiencies of service delivery

Sayana Press is a three-month progestin-only injectable contraceptive that uses the Uniject disposable injection system. The pricing and procurement of Sayana Press was the product of a well-known global PPP for family planning. This global partnership between Pfizer Inc. and a consortium of private donors and public aid agencies resulted in making the novel contraceptive delivery method available to qualified purchasers in the world's 69 poorest countries at $1 per dose (Pfizer News 2015). The achievements of this global PPP were significant, highlighting a successful global pricing and procurement model for family planning. It has also led to research-related PPPs as governments consider how to effectively and safely deliver Sayana Press to citizens.

PATH, funded by the Bill & Melinda Gates Foundation, partnered with the Senegalese Ministry of Health (*Ministère de la Santé et de l'Action Sociale*, or MSAS) to conduct two research studies on the feasibility and cost-effectiveness of the subcutaneous self-injection delivery of Sayana Press in Senegal. The following text box presents the research objectives associated with the administration of Sayana Press.

Family planning research objectives for Sayana Press public–private partnership

- Assess feasibility of self-injection as demonstrated by competence and timeliness of injector.
- Identify operational considerations such as approaches to health worker and client training, reminder systems, and waste management.
- Determine characteristics of women for whom self-injection is acceptable or not acceptable.
- Assess the relative costs of self-injection versus provider-administered intramuscular DMPA.
- Determine whether women who self-inject continue to use injectables longer than women who receive DMPA.

Source: PATH (2016a)

Research conducted in Senegal and Uganda indicates that provider and patient acceptability of and preference for Sayana Press is high (Burke et al. 2014a; Burke et al. 2014b). Further, the introduction of Sayana Press into the contraceptive method mix may lessen logistical challenges related to supply, storage, and waste management (Cover et al. 2014). Sayana Press was rolled out in 2014 in Senegal and is approved for administration by providers at health facilities (PATH 2016b). The Uniject system has been approved for self-injection by the stringent United Kingdom Medicines and Healthcare Products Regulatory Agency, and WHO supports this delivery channel as a means to increase access and uptake. Considering these endorsements, there is interest in exploring self-injection as a delivery channel in Senegal (PATH 2016a).

To determine the safety and efficacy of allowing women to self-inject, PATH partnered with MSAS to research the operational feasibility, effectiveness, and cost-effectiveness of self-injection as compared with health professional-administered intramuscular DMPA injections in public health facilities in a subset of districts (PATH 2016a). Co-investigators at PATH and MSAS share the responsibility and benefits of conducting this ongoing research.

In this partnership, MSAS contributed its existing infrastructure (public facilities and human resources) and scientific expertise, and facilitated the recruitment of public sector clients by allowing the work to take place in public facilities (Figure 4). It also co-developed the study design and procured the product through UNFPA, a public aid agency that paid for the product. On the private side, the Bill & Melinda Gates Foundation financed the research, and PATH co-developed the study design and directed the overall research agenda.

Figure 4. Contributions and gains of public and private partners for Sayana Press

Public sector contributions

- Technical research expertise
- Human resources
- Access to public sector facilities and clients

Private sector gains

- Reputational capital
- Data on self–injection
- Potential to distribute Sayana Press through new channels

Senegal Ministry of Health

Sayana Press

PATH

BILL & MELINDA GATES foundation

Public sector gains

- Data on self–injection
- Technical support
- Research financing
- Potential to distribute Sayana Press through new channels

Private sector contributions

- Technical research expertise
- Human resources
- Financing for research

A community health worker gives the Sayana Press injection at her own home.

© 2016 Laura Wando, WellShare International Uganda, 2016, Courtesy of Photoshare

This implementation science PPP demonstrates how a ministry of health can partner with the private sector to generate evidence that may lead to operational efficiencies, cost savings, and increased reach and effectiveness of public and private family planning services. The Senegal ministry of health and implementing partners will gain insight into channels of contraceptive administration that may reduce the current human resource burden on its infrastructure and reduce unintended pregnancies among citizens. Governments in developing countries might consider partnering with private organizations, with or without funding from donors, to explore efficiencies and technologies for family planning through research PPPs.

While this PPP for family planning relied on donor and aid agency financing, there might be other opportunities for operational or implementation research partnerships in which the private sector would benefit more directly. Private sector partners such as pharmaceutical companies or distributors might be motivated to participate in a PPP for family planning. If they can demonstrate the safety, efficacy, or feasibility of a product, they could reap substantial financial earnings for the company and offer new benefits to the public.

Health information

Wazazi Nipendeni, Tanzania

Partnership to promote family planning knowledge and positive maternal health behaviors through mobile communication

The Wazazi Nipendeni ("parents love me" in Swahili) behavior change communication campaign was developed through a PPP in Tanzania to promote healthy pregnancy and early childhood care behaviors, including postpartum family planning. Wazazi Nipendeni involves more than 30 partners and is led by the Tanzanian Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) Reproductive and Child Health Section. The organizations worked in coordination with the National Malaria Control Program, the National AIDS Control Program, the Health Promotion and Education Section, and the Mobile Health (mHealth) Tanzania Public-Private Partnership (Nyoni, Orkis, and Ainslie 2016).

To establish a mobile communication channel, the mHealth Tanzania PPP program—working under the leadership of the ministry of health and with financial support from several US government agencies—brought together multiple public and private implementing partners, including all major mobile network operators. Airtel was the first to support the Wazazi Nipendeni campaign with free text messages. Tigo, Zantel, and the Vodacom Foundation have since joined so that men and women can receive free informational messages and reminders of doctor visits through text messages.

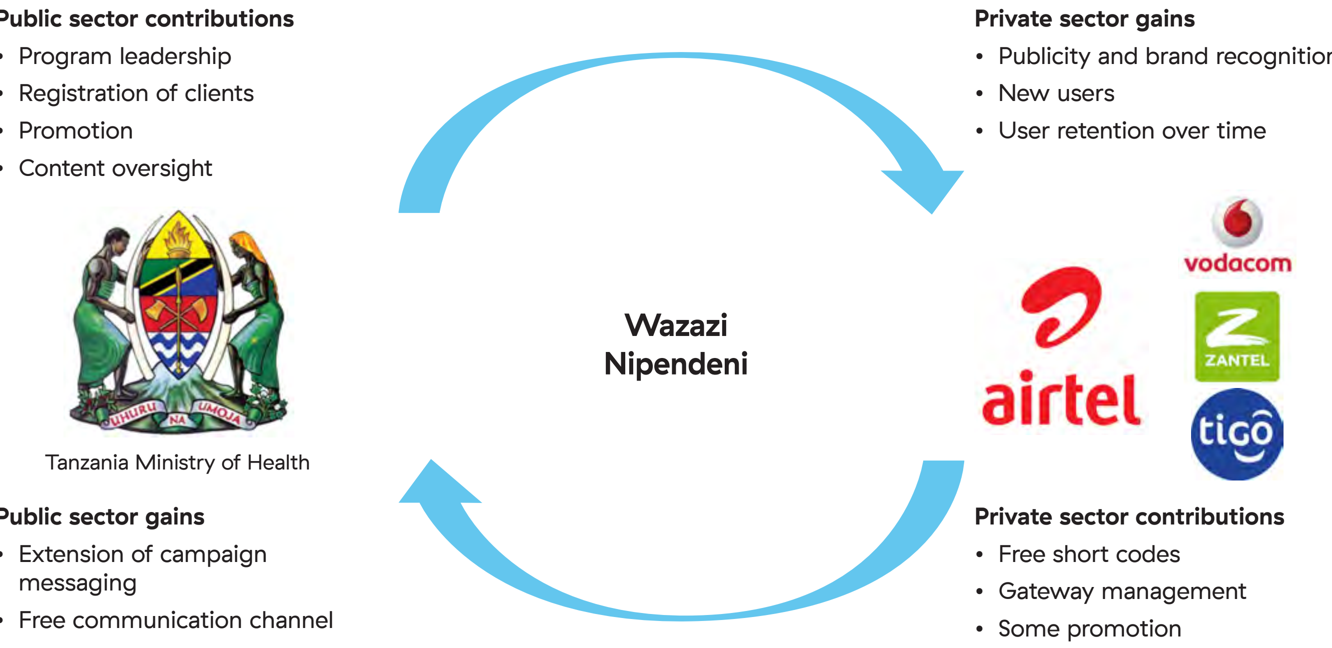
Beneficiaries enroll by texting the keyword "*mtoto*" (child) to the free short code. In 2016, Airtel added an Unstructured Supplementary Service Data application on the Government of Tanzania's e-Gov short code to provide instant interaction with the service platform. It also enabled thousands of health care professionals and community health care workers to easily register participants for free safe motherhood messages, including postpartum family planning, and appointment reminders.

Airtel and other major mobile operators provided free text messages and some promotion for the program, while the ministry of health provided direction and oversight. USAID, the President's Malaria Initiative, the US President's Emergency Plan for AIDS Relief, and the Centers for Disease Control and Prevention contributed financial support (Figure 5) (Nyoni, Orkis, and Ainslie 2016). Wazazi Nipendeni is one activity of the mHealth Tanzania PPP that is managed by Cardno, which provides several services including management of funds, monitoring and evaluation, private partner identification, and partnership expansion (Cardno 2015). Several other implementing partners contribute to the content and coordination of the activity.

A banner from the Wazazi Nipendeni campaign. More than 1.3 million people registered for the text message service.

Johns Hopkins Center for Communication Programs

Figure 5. Contributions and gains of public and private partners for Wazazi Nipendeni



As of March 2016, more than 1.3 million people had registered for the service, and more than 86 million safe motherhood text messages had been sent to users, including basic family planning messages and cross-promotional messages for the complementary Mobile for Reproductive Health service (Nyoni, Orkis, and Ainslie 2016). The service offers text messages on family planning in Tanzania and Kenya. While these numbers reflect popularity among users, only 329 people reported receiving family planning services based on the messages (Nyoni, Orkis, and Ainslie 2016). The difference between the number of registered users and the number of users who accessed family planning services may indicate a disconnect between the ability to reach people with information and their ability to act on that information. At the outset of any PPP for family planning information, a clear path from knowledge to action should be delineated.

The Mobile for Reproductive Health service offers text messages on family planning in Tanzania and Kenya.

This example demonstrates how ministries of health can partner with mobile network operators to promote key health and family planning content and encourage healthy behaviors at a national scale. In general, mobile operators are motivated by arrangements that differentiate their services and brands from their competitors and can help build market share. Free messages and airtime are becoming more difficult to negotiate because of the number of requests received by mobile operators.

A clear path from knowledge to action should be delineated at the outset of any PPP that aims to promote family planning information.

Reduced prices for bulk messages are common but paying for ongoing, often intensive engagement with beneficiaries at a national scale is prohibitively expensive. As in the cases of Wazazi Nipendeni and the mHealth Tanzania PPP, ministries of health may be more successful in PPP negotiations with telecom companies if they are part of a consortium that has financial backing and they can demonstrate that their proposed program has wide appeal. Family planning, which can be a culturally taboo or sensitive topic, may need to be bundled with less controversial topics such as safe motherhood and child health.

Leadership and governance

Accredited drug dispensing outlets, Tanzania

Partnership to improve the quality, capacity, and branding of private sector drug shops as outlets for family planning products

In Tanzania, as in many settings, health facilities and full-service pharmacies are disproportionately located in urban areas, meaning that the three-quarters of Tanzanians who live in rural areas often access medicine and services at private drug shops as their first point of care (Tanzania Ministry of Health and Social Welfare 2009). Drug shops offer a wide variety of services but are particularly important for family planning because the shops can offer improved accessibility and shorter wait times, as well as improved patient experience of respect and privacy (Akol et al. 2014). Indeed, the provision of family planning products and services through drug shops is considered a high impact practice (High Impact Practices in Family Planning 2013).[3] In contrast, when drug shops are unregulated, there are greater challenges with medicine quality, inadequate storage for medicines, untrained staff, inadequate regulatory enforcement and supervision, illegal prescribing of medication, prescribing of expired medication, and limited choice in products (Rutta et al. 2015).

[3] USAID defines high impact practices for family planning as service delivery or systems interventions that, when scaled up and institutionalized, will maximize investments in a comprehensive family planning strategy. Learn more at www.fphighimpactpractices.org.

To leverage the popularity of privately run drug shops among rural populations, the Tanzanian Food and Drug Administration established a private provider accreditation program in 2003 for community-based drug shops based on the Ministry of Health's provider standards (Center for Health Market Innovations 2016b). As part of the accreditation process, the accredited drug dispensing outlets (ADDOs) program provided training in business skills, recordkeeping, and customer service (Figure 6). Equally important, public inspectors monitored and evaluated drug shops and their products and supported local regulatory capacity.

In return for participation in the accreditation program, drug shops could use accredited drug dispensing outlet branding, which customers recognize as denoting quality drug outlets. These accredited shops are called *duka la dawa muhimu*. While non-accredited drug shops only offer oral contraceptives and condoms, accredited shops are being considered as locations that can administer injectable contraceptives. This allowance could provide another funding stream, attract new clients, and incentivize participation for private drug dispensers. Further, this partnership can increase choice, improve access to more effective methods, and relieve workload pressure at health facilities (Advancing Partners and Communities 2014).

Although this PPP for accreditation was initially established with donor funding from USAID and the Bill & Melinda Gates Foundation, the government of Tanzania has expanded the ADDO model for the entire country. In some regions (Rukwa and Mtwara), the local government has included budgetary allocations to finance the partnership for accreditation themselves. The ADDO PPP offers a successful model of national accreditation of private providers for pharmaceutical delivery and quality assurance that can improve the quality and safety of family planning products and services in drug shops.

Figure 6. Contributions and gains of public and private partners for accredited drug dispensing outlets

Public–private partnership units

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Public–private partnership units

The USAID-funded Strengthening Health Outcomes through the Private Sector project supported the establishment of PPP units within the ministries of health in Kenya, Malawi, Tanzania, and Uganda. The project recognized that ministry of health leadership plays a critical role in achieving national family planning objectives. Ministry engagement with the private sector has been underdeveloped due to environmental, cultural, legal, and regulatory challenges. This engagement between the US government-funded project and the ministries indicates an interest among donors in developing the capacity of local governments to build partnerships directly with private actors. PPP units are intended to act as the screening and coordinating arm for partnership with the private sector based on public health needs and priorities.

As part of the approach to this primer, PPP units were queried on their experience with PPPs for family planning. Though these PPP units have led to several PPPs for health, when asked about examples of PPPs for family planning, members of the PPP units did not perceive this health area as ideal for PPPs because of its limited scope. The PPP policy and legal frameworks that are the basis for the formation of the PPP units and that guide their mandates are heavily skewed toward large infrastructural PPPs. This is partly due to the heavy involvement of the World Bank, IFC, the African Development Bank, and local finance ministries in articulating and developing the national PPP framework and institutions. Hence, most of the PPP unit staff in ministries of health are also focused on large infrastructure PPPs such as hospital construction and wide-scale medical technology upgrades. In addition, PPP unit staff opine that it is not economically viable to develop a PPP focused on a "single curative or preventative service". The job of engaging the private sector in family planning and other priority health services is largely left to the specific service delivery departments in the ministry of health that are frequently busy with donor- and publicly funded vertical programs. They may not think of PPPs as a policy option to expand services. One PPP unit member from Kenya described ideal PPPs as large, complex infrastructure and hospital management contracts.

Family planning and other services are not perceived as suitable for PPPs. PPPs are viewed as [ideal for] large complex infrastructure or equipment supply and maintenance projects.

—Dr. Samuel Were, PPP unit head, Kenya Ministry of Health

Kenya Ministry of Health staff hold a meeting in 2012.

Jessica Scranton

To create clarity on how to engage in novel, financially smaller, non-infrastructural PPPs, the Kenya Treasury PPP Unit developed PPP regulations, which were enacted in December 2014. These regulations allow the cabinet secretary to approve innovative and cost-effective PPPs not specifically defined in the PPP Act, set thresholds for approval, and recognize county governments as contracting authorities. "Service PPPs" that do not involve large external funds nor breach a set financing threshold are delegated for management at the subnational level. The PPP unit would manage larger contractual PPPs frequently involving external funding and international transaction advisory services. The general trend of decentralization of health care provision to regional entities (districts and counties) may also contribute to the diminished role of the central ministry of health and its departments in PPPs for family planning. Both public and private actors acknowledge that, when ministries are involved with a PPP, they often play a minor coordinating or oversight role. This paradigm is especially true when larger donors are active in that setting and may be due to financial, technical, and human resource capacity constraints of the ministry. Where legal frameworks are in place, devolved systems of government may present an opportunity for marketing smaller PPP for family planning models.

Of the nine PPPs developed by the PPP unit in Tanzania, seven were service level agreements or contracts and three involved family planning directly (service level agreements for maternal, newborn, and child health and family planning; mhealth; and procurement and distribution of health commodities). Challenges noted by the PPP unit in Tanzania included a need for technical assistance, a lack of evaluation of PPPs, and difficulties working with certain faith-based organizations that had restrictions on some family planning products and activities. PPP unit representatives in Uganda echoed several of these challenges. Ultimately, PPP units had minimal experience envisioning, developing, or managing PPPs for family planning; this could be an area for future capacity building.

Challenges for PPP units include the need for technical assistance, lack of evaluation of PPPs, and limitations on working with certain faith-based organizations for family planning.

—Dr. Mariam Ongara, PPP unit head, Tanzania Ministry of Health and Social Welfare

Stephanie Jones

Discussion

To reach the Family Planning 2020 goal of enabling 120 million more women and girls to use contraceptives by 2020, governments of developing countries must leverage private sector strengths and resources. And they must do so in ways that expand the reach, quality, and impact of family planning programs in a world of declining donor funding. This primer identifies PPPs for family planning service delivery with strong host country government participation. However, in areas such as financing, health information, medical products and technology, and leadership and governance, the examples of PPPs for family planning were less apparent, and those that were found were largely driven by donor or aid agency support and priorities.

There are several reasons why family planning PPPs are less common than PPPs in other health areas. One reason is that "single service" PPPs are not considered economically viable in health care. Therefore, many PPPs tend to be based on a defined package of essential or primary care services (which may or may not include family planning). For example, the development of infrastructure is one of the most common PPPs in health, yet it is non-existent for family planning due to the multi-purpose nature of most infrastructure projects. Indeed, family planning programs typically do not require significant infrastructure to succeed and have been exceptionally successful through community-based workers and mobile distribution. Single-service health care interventions are the legacy of vertical donor-funded programs, which, on their own and in the absence of donor funding, may not have sufficient market (demand, ability, and willingness to pay) to be financially self-sustaining. Most governments, in line with public health and primary care principles, are instead concerned with underserved populations' access to a package of priority primary care services rather than targeting one area of health care such as family planning. Additionally, in low-resource settings, acute care spending is often prioritized by governments over preventive care spending because benefits are more tangible and immediate.

Another reason for the lack of family planning-focused PPPs that involve the governments of host countries may be that aid agencies and private donors often assume the role of local governments by providing substantial funding for family planning. A result may be an unintentional displacement of local public and private partners. When the bulk of family planning commodities and services are donor-funded, the public sector may not prioritize this health area when allocating financial resources and habitually leaves it out of national programming. WHO global health expenditure data for 2014 indicated that donor-sourced health expenditures were a substantial component of total health expenditures in 23 of 24 countries that USAID identified in its ending preventable child and maternal deaths (EPCMD) strategy (USAID 2016).

Country delegations discuss family planning successes and challenges at the 4th annual Ouagadougou Partnership meeting in Cotonou, Benin.

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On the private sector side, one reason for the lack of PPPs in family planning service delivery may be the crowding-out effect of free family planning commodities and services from the public sector. Some private providers will not invest in family planning when there is a chance that clients can access family planning through the public sector. The sometimes culturally sensitive nature of family planning may further dissuade investment by corporations and other private entities.

As a result of intensive donor involvement and distrust resulting from limited and inconsistent communication between private actors and local government agents, private partners have little engagement with the government outside of regulatory matters. Instead, their partnerships in family planning tend to be with well-funded international aid agencies and implementing partners that provide financial support, training, and subsidized commodities for family planning. Few partnerships demonstrate an equal investment in risks and outcomes.

Mobile network operators, also known as wireless service providers, are the gatekeepers to telecommunication and are one promising private actor for family planning-focused PPPs across the health system. Mobile network operators can facilitate regulation, financing, payment, digital financial inclusion, service delivery, research, surveillance, and communication partnerships with their vast physical and human infrastructure. The operators have partnered with the public sector to provide mobile money and transactional services for health insurance, client-facing behavior change communication campaigns, clinical monitoring and reminder services, surveys for monitoring and evaluation, and supportive supervision tools. In many cases, mobile network operators have supported family planning messaging, in programs such as Wazazi Nipendeni in Tanzania and Mobile for Reproductive Health in Kenya. One challenge in working with the operators may be a reluctance to promote family planning in settings in which it is perceived as a controversial topic, due to the potential risk to reputation and market share. Otherwise, mobile network operators are receptive to contract-based PPPs and often have innovation labs that can help design and build interventions for health.

Conclusion

In general, PPPs for family planning do not yet have the scientific evidence base to be listed as a family planning high impact practice. This is in part because PPPs are not one practice but several practices with varying contractual and financing models. To better understand the potential scope and impact of these partnerships, clearer definitions, deeper interrogation of the roles of key parties (the government, donors, and the private sector), additional examples, and further research are needed. Effective monitoring and evaluation are needed to fully understand the effects of PPPs and assess whether partnerships can endure beyond the life of donor-funded projects.

Expectations of who should engage in PPPs must evolve with changing governance models and structures. Host country governments, not just international aid agencies, must be recognized as key partners in PPPs. Like central ministries of health, most local governments have a legal mandate and a budget to make decisions, plan for and deliver health care services, and are recognized as contracting authorities under PPP laws. In addition, proximity to local consumers makes local governments more directly accountable for service delivery performance. This pressure might make them more amenable to potentially simpler, less costly, and more effective service PPPs. Such PPPs are often below the threshold that requires central government approval and hence may be less bureaucratic and easier to implement. New strategies are therefore needed to engage with these subnational authorities—counties, zones, regions, or districts.

PPPs that focus on contracting out family planning services should not only focus on value for money but also value for health.

The capacity of the ministry of health and subnational entities to partner with the private sector is a necessary factor for successful health PPPs. If the objective is more public sector participation in PPPs, donors must develop host country government capacity, support PPP units, and make room for these types of PPPs rather than provide all commodities, financing, and service directly or through their implementing partners. The PPPs in Papua New Guinea demonstrate how an international aid agency worked with the government and the private sector to increase capacity to contract out family planning services. Such partnerships should not only focus on value for money but also value for health. This requires going beyond improving the efficiency and effectiveness of the health system to address prevailing health inequities and delivering on overall public health goals.

Finally, the traditional use of value for money as the main measure of PPP effectiveness (primarily in infrastructure PPPs) is inadequate to measure the impact of service PPPs. Other, more comprehensive measures such as patient satisfaction and outcomes, organizational and clinical performance, and human resource productivity should be developed (PwC Health Research Institute 2010). PPPs in family planning might also have wider appeal if they adopted an integrated approach that includes other priority health services (such as maternal, newborn, child, and adolescent health; malaria; tuberculosis; HIV; and non-communicable diseases) in the benefit package. A “bundle” of services may be more economically attractive to private investors and more aligned to national health priorities. The PPPs should also look beyond actual family planning service delivery to other health systems strengthening interventions such as supply chain management,[4] human resources for health, information technology, and health care financing.

Thinking beyond traditional models, development practitioners can cultivate creative solutions in which public and private partners share in the risks and rewards of family planning partnerships. This will require significant stakeholder engagement to clarify roles, develop trust, and achieve a shared understanding of investment in overall goals.

[4] Learn more at www.intrahealth.org/projects/expanding-the-informed-push-model-for-family-planning-in-senegal.

Appendix A. Partnerships at a glance

Service Delivery and Workforce: Marie Stopes (Papua New Guinea)

- Contracting out family planning services can extend the reach and improve the quality of resource-constrained public health services through partnership with private providers.
- Marie Stopes Papua New Guinea developed multiple contracting relationships with the government of Papua New Guinea and the Australian Department of Foreign Affairs and Trade. It did so to achieve national family planning objectives while expanding public services to citizens and complementing donor-funded programs.

Financing: Sahat Sahulat Card (Pakistan)

- Vouchers have effectively been used as a demand-side financing mechanism to address the financial barrier to accessing family planning services and products among vulnerable populations.
- Vouchers can be specific to family planning, as in the case of many MSI programs, or integrated with other services to make the voucher more appealing to private for-profit providers, as was the case with the Sehat Sahulat Card program.

Medical Products and Technology: Sayana Press (Senegal)

- PPPs between pharmaceutical companies, private donors, and public aid agencies can facilitate breakthrough innovations in the form of new products and delivery channels.
- The research conducted by PATH, the Bill & Melinda Gates Foundation, and MSAS in Senegal demonstrates how governments can partner with the private sector to conduct operational and implementation science research to improve the delivery of Sayana Press.

Health Information: Wazazi Nipendeni (Tanzania)

- Wazazi Nipendeni demonstrated how ministries of health can leverage the information and communication technology infrastructure through PPPs with mobile network operators to promote key family planning content and encourage healthy behaviors at a national scale.
- Ministries of health may be able to build PPPs for family planning with mobile operators if they can demonstrate that the proposed program has wide appeal and may attract and retain potential clients.

Leadership and Governance: Accredited Drug Dispensing Outlets (Tanzania)

- The ADDO network in Tanzania is an example of how the public sector can work to provide accreditation for private providers to enhance the quality of products and services.
- Bringing pharmaceutical and clinical outlets together in a network can enhance regulation by increasing accountability and establishing practice and reporting standards.

Appendix B. Interviewees

Kenya

Samuel Were, PPP Unit Head, Ministry of Health

Kanyenya Gakombe, Secretary, Kenya Association of Private Hospitals

Jonah Maina, Family Planning Unit Head, Ministry of Health, Division of Reproductive Health

Malawi

Fannie Kachale, Director, Reproductive Health Unit, Ministry of Health

Gilbert Mwandira, President, National Association of Private Paramedicals of Malawi

Tanzania

Mariam Ongara, PPP Unit Head, Ministry of Health and Social Welfare

Samuel Ogillo, Chief Executive Officer, Association of Private Health Facilities in Tanzania

Uganda

Blandinah Nakiganda, Assistant Commissioner of Reproductive Health, Ministry of Health

Patrick Kerchan, Head of Programs, Uganda Protestant Medical Bureau

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