



EXPANDING ACCESS TO VOLUNTARY FAMILY PLANNING SERVICES IN MIXED HEALTH SYSTEMS

Lessons from linking private health care networks to domestic financing

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Acknowledgements

Purpose

Many low- and middle-income countries (LMICs) have committed to ambitious family planning (FP) goals, including expanding access to and choice of high-quality FP services and products. These initiatives are often underpinned by service delivery in both the public *and* private health care sectors. This report provides insights on engaging the private sector within national stewardship and financing systems for FP. These insights draw upon private sector engagement efforts by Results for Development (R4D) and Population Services International (PSI) under the USAID-funded Support for International Family Planning and Health Organizations 2: Sustainable Networks (SIFPO2) initiative. Insights are of relevance to global and national funders, as well as stewards and managers of FP programs.

SIFPO2

The PSI-led [SIFPO2](#) (2014-2020) project is a USAID-funded program designed to strengthen voluntary FP programs in lower- and middle-income countries (LMICs), with a focus on strengthening private sector delivery, including through social franchise networks. As well as scaling up and improving access to voluntary FP products and services within a number of LMIC contexts, PSI and R4D explored the “health” of FP markets to facilitate sustained use. This work focused on better integration of the private sector into national health systems in areas such as health financing, quality assurance, monitoring and reporting, and innovation in cost recovery enterprises.

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List of acronyms

CIP	Costed implementation plan for family planning
FP2020	Family Planning 2020
FP/RH	Family planning & reproductive health
GFF	Global Financing Facility for Women, Children and Adolescents
HMIS	Health management information system
KCCA	Kampala Capital City Authority
LARC	Long-acting reversible contraception
LMICs	Low- and middle-income countries
MaNe	Maternal and Newborn Health Kampala Slum project
MOH	Ministry of Health
MOU	Memorandum of understanding
NGO	Nongovernmental organization
NHIF	National Health Insurance Fund, Tanzania
mCPR	Modern Contraceptive Prevalence Rate
PACE	Program for Accessible Health Communication and Education
PHC	Primary health care
PHI	Private Health Insurer/Insurance
PPE	Public-private engagement
PPHF	Public Private Health Forum
PPMV	Private patented medicine vendor
PPP	Public-private partnership
SFH	Society for Family Health Nigeria
SIFPO2	Support for International Family Planning and Health Organizations 2: Sustainable Networks
UHC	Universal health coverage
USAID	United States Agency for International Development

Introduction

Governments in many low- and middle-income countries (LMICs) and their funding and technical partners have embarked on ambitious agendas to increase access to modern methods of contraception and reach millions of new voluntary family planning (FP) users. Family Planning 2020 (FP2020), the Global Financing Facility for Women, Children and Adolescents (GFF), and the Ouagadougou Partnership are prominent examples of such global and regional initiatives.¹ At the same time, the global movement toward universal health coverage (UHC) and strengthened primary health care (PHC) provides further opportunities for integration of voluntary FP and reproductive health (FP/RH) into these initiatives as countries consider how to expand access to promotive and preventive care.² To meet these commitments, many countries have developed FP-costed implementation plans (CIPs) under FP2020, and/or investment cases under the GFF. These CIPs and investment cases focus on priority reproductive, maternal, newborn, child, and adolescent health interventions—including FP. Additionally, countries working toward UHC and transitioning from donor funding for key priority health services and commodities³ are considering how to integrate FP/RH and other preventive services into essential benefit packages. Overall, this body of work has the potential to expand and strengthen financing, service delivery, and governance of FP/RH in LMICs.

“Mixed health systems have centrally planned government health services that operate side-by-side with private markets for similar or complementary products and services, which often existed long before the creation of national health ministries and have grown organically.”

- From *Public stewardship of private providers in mixed health systems* by Gina Lagomarsino, Stefan Nachuk, and Sapna Singh Kundra, 2009

The private sector plays an important role in the delivery of FP/RH services in LMICs. Its contribution can be significant, but does vary by region and country, as well as within countries. Private providers may range from drug shops to hospitals, comprising both for-profit and charitable facilities located in urban and rural areas. These providers often serve as the first point-of-care for many services. Despite their contribution to health service provision, small-scale providers, such as maternity homes and health clinics, are typically excluded from government purchasing systems and stewardship. More intentional inclusion of small-scale providers within health systems would allow public sector planners and purchasers to more effectively leverage the private sector for

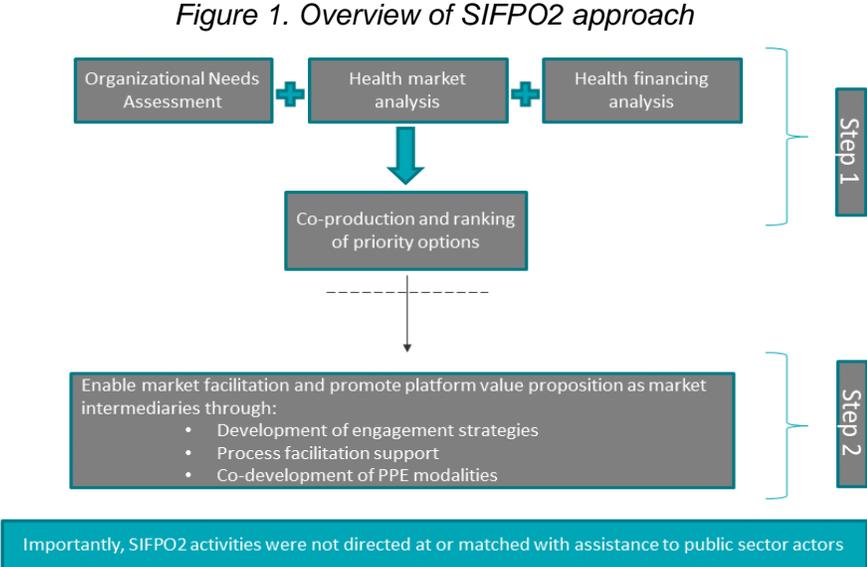
FP/RH. This would require advancing notions about public-private partnerships (PPP) from passive modalities of resource exchange to more active institutional and operational arrangements that acknowledge and facilitate mixed health systems (see text box).⁴

But mechanisms for public-private engagement (PPE) in many LMICs are often lacking or inadequate. Where they do exist, they may be centralized, limiting their usefulness at decentralized levels where service delivery is often organized and managed. Systemic issues and functional gaps in the delivery of quality health care may undermine strategic engagement between the public and private sectors. These challenges may be of a political, legal/regulatory, organizational, and economic nature⁵ and may be entrenched through institutional norms and political economy, making them difficult to change.

Under the SIFPO2 project, Results for Development (R4D) and Population Services International (PSI) partnered with PSI-affiliated country teams in Cambodia, Nigeria, Tanzania, and Uganda to explore how private providers of FP/RH services can be better integrated into public sector financing and

stewardship functions in order to expand access to voluntary FP services and products. The approach began with targeted in-person support to the country teams, and then ongoing remote support as needed. The work succeeded in several areas: developing a clear stepwise process for understanding complex health financing concepts; transferring capacity in landscaping health financing modalities to country-level private FP/RH networks; supporting facilitation and engagement with public sector counterparts; articulating diverse options for private actor contributions to health goals beyond service delivery; and translating those options into a realistic and coherent health financing roadmap to follow, within the context of a mixed health system.

Figure 1 shows the key elements involved in this process.



Before working in person with the country teams, R4D carried out desk research, conducted interviews with key public and private sector stakeholders, and triangulated the information gleaned from the research and interviews to develop a preliminary landscape analysis. Upon meeting in country with the PSI teams, R4D first oriented country staff to general health financing concepts and language, so that the preliminary analysis had greater resonance. Then, through a series of dedicated sessions with key senior staff, R4D and the country teams developed a set of health financing and/or PPE options. As a final step, the country teams prioritized one option to pursue. Of the 19 total options that were developed across the four countries in this activity, the teams in Uganda, Nigeria, and Cambodia saw their top choices come to fruition. Table 1 below shows the top options that were prioritized by each of the teams.

Table 1: Highest-priority PPE options developed with PSI country teams

Tanzania (2015)	Uganda (2015)	Nigeria (2016)	Cambodia (2017)
Work with government contracts : Contract with Council Health Management Teams/Regional HMTs through Service Level Agreements to provide priority FP/RH and PHC services	Develop a maternal health public private partnership with the Kampala Capital City Authority (KCCA)	Franchising-in PHC: Add a new tier of full and/or partial public sector franchisees via public private partnerships	Help develop and implement routine accreditation protocols for private facilities by the public sector

Through these activities and subsequent discussions with the four country teams, SIFPO2 learned that private sector-led engagement—while successful in generating PPP opportunities—is not by itself enough to develop well-functioning mixed health systems at scale. **Instead, our findings suggest that actions and assistance by the public sector must complement private sector-led engagement efforts.** In this report, the SIFPO2 team describes insights from our in-country work to support financing and stewardship models for FP/RH PPE within “mixed health systems.” This report highlights the challenges for expanding access to FP through the private sector in contexts where government capacity and functions for private sector engagement are still emerging and evolving.

Findings and insights from SIFPO2 are organized in six sections:

- Section 1: The rationale for PPE in the provision of voluntary FP/RH services;
- Section 2: An overview of the R4D-PSI approach and frameworks applied under SIFPO2;
- Section 3: How the R4D and country teams worked together to develop options for better private sector-led engagement with the public sector;
- Section 4: The SIFPO2 team’s experiences using this approach, and examples of the enablers and barriers encountered in progressing toward a well-functioning mixed health system;
- Section 5: Summary of recommendations and reflections for public sector counterparts; and
- Section 6: Conclusion

1. Why engage the private sector for expanded provision of voluntary FP/RH services

Private sector providers are a prominent source of preventive and curative primary care services, including FP/RH, in LMICs. These providers typically consist of a heterogeneous mix of for-profit and (often faith-based or charitable) not-for-profit, as well as medical- and non-medical facilities. Examples include large or medium-sized hospitals; community-level clinics run by doctors, nurses, and midwives; larger pharmacies and smaller drug shops; traditional birth attendants and providers of traditional medicine; and other formal or informal institutions and individuals.^{6,7} Often, providers engage in dual practice and provide concurrent services in both public and private health facilities.⁸ In some LMICs—particularly those with large populations such as India, Nigeria, and Pakistan—private providers may account for a majority of facility-based care seeking at the outpatient, PHC level.^{9,10} This section outlines how well-functioning public-private engagement can support the provision of voluntary FP/RH services—especially by small-scale providers—and the achievement of national FP/RH goals.

1.1 Why public-private engagement can help public stakeholders better steward FP/RH delivery and meet national commitments



A PSI Tanzania-supported provider

Leveraging supply-side strengths can expand access and choice under key FP initiatives

Global and regional initiatives (such as FP2020, Ouagadougou Partnership, and the GFF), have spurred LMIC governments to make ambitious FP commitments. Many of these commitments have taken a “public sector first” approach to investment and interventions, which may help secure domestic financing for high-impact preventive care interventions such as FP.¹¹ But it does not systematically incorporate the provision of private sector services in strategies to expand access and

choice in voluntary FP service provision. For instance, small-scale providers that typically offer most FP/RH services in the private health sector are not formally included in public sector planning and implementation encapsulated in FP2020 CIPs and GFF investment cases. However, the widespread presence of the private sector—especially in rural and underserved communities—provides an opportunity for public sector actors to leverage established private sector facilities and infrastructure to enhance access, especially where public facilities may be non-functional.¹² Instead, governments may support private facilities to participate in priority service delivery programs, such as FP/RH, or engage them to provide a broader package of PHC services. The evidence suggests that the private health care sector may bring “greater service capacity, more managerial expertise, higher quality of services and technology and innovation, as well as investment and funding” to priority government initiatives.¹³

Engaging private providers can help to improve FP user access at preferred service delivery locations

Health-seeking behavior in many LMICs demonstrates reliance on the private sector for FP/RH services and products.¹⁴ Data from countries clearly shows private sector providers—such as drug shops, pharmacies, and community-level clinics—are often a major or primary source of short-acting methods of FP (i.e., pills, injectables, and male condoms)¹⁵ and a first point-of-care for a range of PHC conditions. In particular, evidence from the 69 FP2020 focus countries shows that 106 million women relied on the private sector for provision of a modern FP method in 2016.¹⁶ If the private sector maintains its market share, another 32 million women could be added to this number by the end of 2020—accounting for over a quarter of the goal of 120 million new users that FP2020 aims to achieve.¹⁷ Governments can recognize and empower the health-seeking behavior of FP users through effective financing and stewardship arrangements.



A pharmacy staff member in Cambodia

Improved public-private engagement can enable better integration of FP/RH within strategic purchasing mechanisms

Where country-level strategic purchasing mechanisms exist—such as pooling-purchasing entities for UHC—FP/RH may be part of the benefits package but without explicit incentives to enable improvements in FP access and choice. Public-private sector engagement can work to structure payments and monitoring mechanisms so that FP/RH services and products are more strategically integrated into UHC mechanisms, which can then more effectively serve goals of expanded FP access. For instance, Latin American and Caribbean countries have made progress in integrating FP within UHC schemes. Many countries in this region provide “free and available” voluntary FP services at public facilities, and most UHC schemes are able to contract with private providers for the same benefits package.¹⁸

Private providers can help governments quantify demand and cost of inputs more comprehensively to meet national FP/RH commitments

In recent years, governments have often focused explicitly on commodities (drugs, equipment, consumables, and products) for FP, taking over from donors and funding budget line items to procure key inputs. This flow of commodities typically supports the public sector, though there are cases—such as in Kenya and Tanzania—where publicly procured FP commodities are channeled to private providers for subsidized service provision. Governments are accustomed to considering the costs to deliver services through their own outlets, and they benefit from economies of scale. But conceptualizing the full costs of private sector service delivery requires the government to take other costs into account, such as expenses for facility operations, health workers’ time, and community outreach. While some governments are increasingly committing domestic resources to commodities, these other costs of FP service delivery in the private sector have not been adequately considered.

1.2 How public-private engagement can benefit private providers

Public sector financing and stewardship can help improve the quality and comprehensiveness of care offered by private providers of FP/RH services, especially smaller for-profit providers

As countries roll out UHC mechanisms, such as national health insurance schemes offering FP benefits, they must contend with service delivery in the private sector. The role of small-scale facilities is crucial in the provision of privately-provided FP services, but these are often the very facilities that receive the least attention and are the most disadvantaged in PPE. Small-scale private providers tend to be atomized or poorly organized under umbrella associations, have limited or no access to financial or in-kind resources from the public sector, and may be variably and infrequently licensed, certified, or accredited. They also typically offer a limited set of PHC services. Effective PPE capabilities can help to enlist these providers in service of UHC goals and expanded FP access. PPE may also help standardize quality and service offerings. On the supply side, there are examples of contracting faith-based facilities and networks but fewer examples of contracting private-for-profit providers.¹⁹

Even without financing mechanisms, more functional public-private engagement can improve the competency and quality of care of private providers

Government training is typically focused on public sector health workers and does not routinely extend to private providers. For example, in Cambodia, midwives in the public sector must complete 120 hours of training to be relicensed every three years, for which they attend courses at the Technical School of Medical Care at the University of Health Sciences in Phnom Penh.²⁰ Private sector midwives delivering FP/RH services do not benefit from these routine trainings, are not licensed on such a basis, and are not included in supervision and data sharing arrangements.

In LMICs with mixed health systems, taking advantage of the capacities, reach, and resources of the private sector should inform strategies for expanded FP access, both now and beyond FP2020 commitments. But once the benefit and imperative for engaging the private sector have been established, what are the critical components of how to go about this? The next sections provide insights based on the experiences of SIFPO2.

2. SIFPO2’s approach to fostering private sector-led engagement with the public sector

PSI and affiliated country platforms work in over 50 countries to deliver key health services and are prominent providers of voluntary FP interventions in 25 of those countries. In many contexts, country teams act as “provider intermediaries,”²¹ aggregating private facilities into social franchise networks for the delivery of FP/RH and other PHC services. These platforms support franchised facilities with training, quality assurance, equipment and commodities, branding, community engagement, and demand generation, as a means of improving the volume, quality, and range of FP/RH services offered. The activities of these country platforms continue to be predominantly donor funded. There are growing examples of private providers engaged in third party financing, such as through social insurance schemes in Kenya or the Philippines. However, in most cases, outside of donor-supported inputs, franchised facilities themselves primarily rely on out-of-pocket payments from users of FP/RH services.

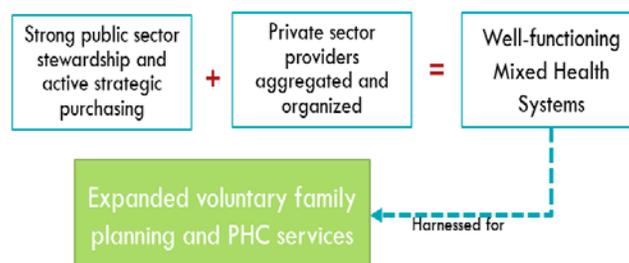
To enhance the sustainability of this support and to mitigate financial barriers to access, R4D and PSI supported the four country teams to explore how to access public funding and more effectively engage with the public sector within mixed health systems. The approach used by the SIFPO2 team was based on two interconnected assumptions:

First assumption: A “well-functioning mixed health system” for FP/RH is possible if private providers are organized and aggregated to engage with the public sector. This supposes that the transaction costs of engaging with diverse and fragmented private facilities pose a barrier to public sector engagement. It also assumes that better representation and advocacy by an organized private sector can address policy and practice more effectively with government planners, purchasers, and regulators.

Second assumption: “Evolving” this more collaborative dynamic between the public and the private sectors requires the aggregator to play a variety of roles to address health system barriers to better engagement. These barriers may include lack of data sharing between public and private sectors, fragmentation among private providers that results in operational inefficiencies, mutual distrust between the public and private sectors, and weak public sector stewardship.

Figure 2 provides an illustrative framework for the first assumption:

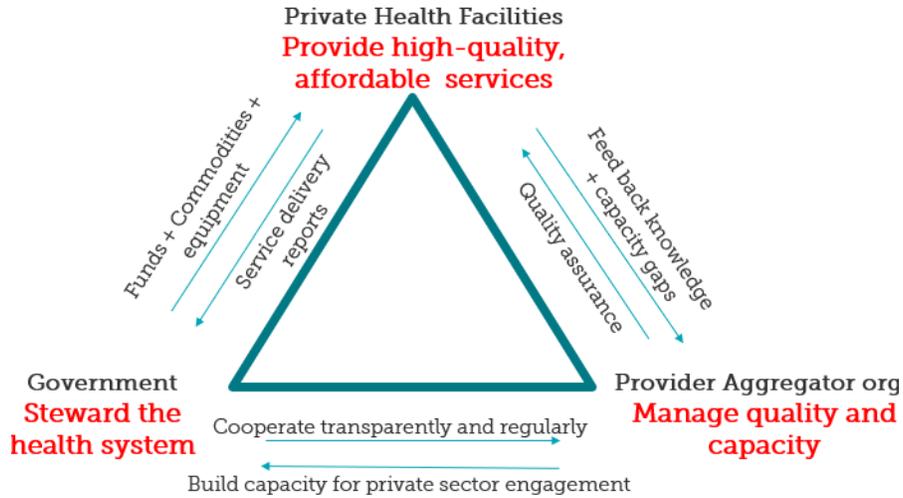
Figure 2: Evolving to a well-functioning mixed health system for FP/RH



Similarly, Figure 3 presents an illustrative framework for the second assumption and what role a private sector aggregator may play in brokering public-private sector engagement. In such an arrangement, the aggregator (or intermediary) may support private health care providers with quality assurance and training to better prepare them to participate in government systems. The aggregator can also assist

public sector purchasers and planners with developing the capacity for engaging private providers. The specific aggregator value proposition depends on the country context and is co-developed with providers and public sector actors through collaborative engagement.

Figure 3: Aggregator helping governments and providers navigate public-private engagement



The SIFPO2 team used these two frameworks to orient the support and guidance it provided to the selected country teams.²² As described in the introduction, to put this approach into action, the SIFPO2 team followed a two-step process:

Step 1: SIFPO2 provided targeted in-person assistance by facilitating a “Health Financing Options Analysis” exercise with the four PSI-affiliated platforms to generate and prioritize options for public-private sector engagement. The options analysis consisted of a set of four analyses: 1) an organization needs assessment of the platforms; 2) a health markets analysis; 3) a health financing analysis; and 4) co-production and ranking of health financing options.²³ The SIFPO2 team focused on the market for FP/RH and associated PHC services, rather than for FP commodities, where the dynamics of public-private engagement may be very different.²⁴ Examples of these PPE options developed by the PSI-affiliated country platforms are described in Section 3.

Step 2: The PSI/R4D team then coached the country teams remotely to pursue specific “*market facilitation*” and “*provider intermediation*” functions to further design and launch each team’s highest-priority option. These terms are defined here:

- **Market facilitation** includes several functions, but for the scope of the SIFPO2 project, it meant the PSI platforms carrying out a market landscaping process as a first step to identify key market constraints. Examples of these constraints might include lack of private provider data in information systems, or lack of regulation of private provider quality. After identifying these constraints, the platforms would then begin to facilitate key engagements with the public sector. Other facilitation functions that may come later—which were outside the scope of SIFPO2—include convening stakeholders as a neutral facilitator to develop capacity, tools, policies, and regulations that may mitigate market constraints. These interventions may include improved coordination, information exchange, financing, service delivery, and quality functions. Under SIFPO2, the focus was on support to PSI country and affiliated platforms, not to neutral brokers or other stakeholders.

Nevertheless, the early market facilitation work carried out by the country teams yielded insights about this function in evolving a “well-functioning mixed health system” to deliver priority programs.

- ***Provider intermediation*** refers to reducing the fragmentation of small-scale providers and addressing supply-side failures to enable improved service delivery—such as the work already carried out by social franchising organizations as aggregators of franchisees.

The SIFPO2 team’s underlying hypothesis was that combined, these two steps would foster partnerships between public and private actors that could 1) design and/or launch actual engagement opportunities and 2) simultaneously position FP/RH private providers to effectively take part in those opportunities.

3. What transpired at the country level

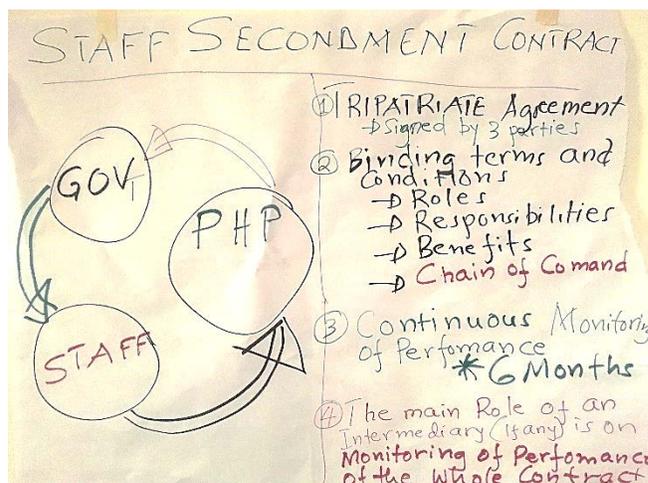
This section outlines what resulted from applying this approach under SIFPO2: the co-developed outputs generated from the first “health financing options analysis” step; the ongoing follow up coaching provided by R4D to country platforms pursuing market facilitation/intermediation; and examples of successes and challenges along the way.

3.1 Generation of public-private sector engagement options

In the first step, senior staff from the country platforms worked with the R4D-PSI team to co-develop options for engaging with the public sector. The options developed broadly fall into a few categories, with the aggregator playing different intermediary roles:

Securing partnerships with the government through supply-side contracts, agreements, and MOUs

Options covering supply-side partnerships with governments took different shapes, but the majority related to either a) PSI-supported private provider networks engaging in contracting-out mechanisms for FP/RH and broader PHC services, or b) PSI-affiliated platforms taking over the management and functioning of public-sector PHC centers (“contracting-in”) to make these functional with payment and other support from the government.²⁵ Other examples included accrediting private providers for involvement in donor-supported performance- or results-based financing initiatives channeled through the public sector, such as under the Health Equity and Quality Improvement Program in Cambodia.



From a 2015 co-creation session in Tanzania

Strengthening inclusion in demand-side financing mechanisms

These options related to facilitating and/or improving the inclusion of PSI-supported private providers within pooling-purchasing mechanisms, such as national health insurance, or with a private insurer interested in reaching under-insured population segments. In this category, the PSI-affiliated platform could aggregate private providers on behalf of pooling-purchasing mechanisms for: ease of contracting, support with provider accreditation, efficient payment processing, facilitation of data transfer, and monitoring and supervision activities. Some options also related to attaching private providers to more targeted purchasing initiatives, such as vouchers programs for FP/RH, which are often channeled through public systems with donor support.

Exploring cost recovery approaches

Looking toward greater sustainability, several of the options generated related to developing or building social enterprise models.²⁶ Within these, the costs incurred for services could be recovered via fees and other commercial revenues for more sustainable support to private providers.²⁷

Though many of the options related to public sector purchasing and stewardship mechanisms, some of the lower-priority options focused fully within the private sector—such as exploring possible

partnerships with private health insurers. Such options were not prioritized for follow-up, but they too could eventually contribute to better public sector engagement by helping providers to become better networked, to deliver higher quality care, and to deepen business management and governance capacities. However, the highest-priority options selected in each country related to direct engagement with the public sector.

Table 2 below recaps the full universe of options developed with the PSI-affiliated platforms. The highlighted cells in the first row contain the highest-priority options in each country, to be pursued via in-country engagement and follow-up actions.

Table 2: Complete set of public-private sector engagement options developed with PSI platforms

	Tanzania (2015)	Uganda (2015)	Nigeria (2016)	Cambodia (2017)
Contracts, agreements, & MOUs	1. Working with government contracts : Contract with Council Health Management Teams/Regional HMTs through Service-Level Agreements	1. Develop a maternal health PPP with the Kampala Capital City Authority (KCCA)* 2. Facilitate the participation of PSI Uganda providers in results-based financing with MOH-GFF	1. Franchising-in PHC: Add a new tier of full and/or partial public sector franchisees via PPPs * 2. Taking baby steps in PPE: Channel public FP/MCH commodities through franchised private maternity facilities	1. Help develop and implement routine accreditation protocols for private facilities by the public sector* 2. Pilot of private providers in Health Equity Funds via complementary vouchers
Demand-side Financing	2. Working with government-backed health insurance mechanisms: - Support the registration of franchisees with NHIF and Social Health Insurance Benefit - Support processes that increase the volume and efficiency of incoming revenues from insurance for providers	3. PSI Uganda providers participate in MOH voucher program	3. Accrediting facilities to help community-level maternity clinics register with insurance , empanel clients, and manage capitation	3. Support private providers in insurance schemes as an intermediary/agggregator
		4. Expand Partnership with Save for Health to pilot a CBHI scheme to demonstrate value for inclusion under NHIS 5. Explore developing a microinsurance product for PSI providers with a private health insurer	4. Referring from point-of-care: Link franchised drug shops (PPMVs) with PHC centers (North) and integrate into Nigeria's National Health Insurance Scheme and community-based health insurance schemes (South)	4. Partner with the National Social Security Fund (run by the Ministry of Labor and providing benefits including health care to workers) to increase health coverage for garment industry workers
Cost recovery	3. Working with private health insurers (PHIs): - Support the registration of franchisees with PHIs - Support the enrollment of more clients, especially targeting those in lower income quintiles	6. Formalize facility-based mechanisms to help women save for health care spending	5. Serve as a facility business partner : Support high quality/volume clinics at cost as a business-to-business partner	5. Evolve NGO project approach to a long-term business-to-business partnership with providers

**These options eventually materialized*

Once all of the options were developed and refined, the senior staff representing their platforms determined their highest priority through a combination of analysis, discussion, and voting, and assumed responsibility to move the agreed priorities forward.

3.2 Market facilitation and provider intermediation

While the country platforms led the pursuit of the high-priority options, the SIFPO2 team provided on-call support in three out of the four countries (Nigeria, Tanzania, and Uganda) in the form of analytics and/or front-end engagement with public officials. In Cambodia, the SIFPO2 team produced additional materials²⁸ to help the country team in proceeding on its own.

Sections 4 and 5 summarize and discuss learning and recommendations from the country-level work and ongoing technical assistance under SIFPO2.

4. What SIFPO2 learned from this approach

This section recaps SIFPO2's country-level experience supporting teams to develop and pursue their respective priorities. The findings are not based on a systematic evaluation of the work but draw on internal SIFPO2 reviews and retrospective interviews with PSI country affiliate managers.

4.1 What SIFPO2 learned about public sector-related enablers or barriers to public-private engagement

The public sector's attitudes toward private actors can help, or hinder, greater engagement

In all four countries, a consistent set of barriers to public-private sector engagement related to the public sector actors' openness (or lack thereof) to including private providers within stewardship and, especially, purchasing regimes.

First, country-level stakeholders fed back that public sector planners and purchasers in their countries are often distrustful of the private health care sector, considering it profit-minded, low quality, and limited in terms of the scale and provision of services. Stakeholders also reported that public officials—for instance in Cambodia—are suspicious of dual practice because they see it as diverting attention, resources, and clients away from the public sector, a cause of attrition or absenteeism in the public sector health work force, and possibly even misappropriation of public sector resources. PSI affiliates are typically trusted interlocutors to these government stakeholders—with access to key officials and any consultative forums or processes that might exist—but they still reported frequently encountering such opposition. These attitudes may at least partially explain why for-profit providers are not formally included in the planning or implementation stages of FP initiatives through CIPs, GFF ICs, or donor-supported FP/RH voucher schemes, such as in Cambodia (GFF) and Uganda (vouchers).

Further, stakeholders reported that resistance to openness and transparency in data sharing between the public and private sectors also undermines public-private sector engagement. Stewardship of and purchasing from the private sector requires the government to include private providers within health management information systems (HMIS), and importantly, review how private sector-provided services and products help to complement or supplement those available in the public sector. In settings like Cambodia, where the private sector is historically disjointed from these public mechanisms, the government is reluctant to provide access to government data systems that include information that is considered proprietary or confidential.²⁹

The capacity of public sector systems and staff can determine the success of public-private sector engagement

Even if public officials demonstrate political will to engage with the public sector, they often lack understanding of how to operationalize the engagement, and how to do so in a dynamic way. For instance, in Tanzania, stakeholders stated that even though the government developed national guidelines for public-private partnerships and launched a Public-Private Health Forum (PPHF), officials did not understand how to, for instance, involve the community in governing providers or to structure performance incentives to improve quality and coverage. The public sector viewed PPPs only as transfer of commodities, equipment, and staff to private facilities to support free FP/RH services. Even then, the PPP arrangements were not functional: providers reported that they did not receive adequate commodities and consumables, complained of the performance of seconded staff, and often charged fee-for-service payments to recover the full costs of service delivery. Moreover, local government

authorities in Tanzania did not involve private sector representatives in regular service review meetings to coordinate the existing provision of staff and in-kind support to providers in order to deliver on objectives contained in Comprehensive Council Health Plans. Across all four countries, the SIFPO2 and PSI affiliate teams found during stakeholder workshops and interviews that national, regional/state, and district officials were often largely unaware of the specific contributions of the private sector.

Public sector champions are critical for successful public-private engagement

In Uganda and Nigeria, respectively, the SIFPO2 team was able to work closely on co-designing options with critical public sector champions. In Uganda, PSI country affiliates worked closely with key officials from the Kampala Capital City Authority (KCCA) on a partnership to “decongest” maternal health services within public providers. In Nigeria, the SIFPO2 team and SFH Nigeria collaborated with the Lagos State Ministries of Wealth Creation and Health to make public PHC centers “functional” under private management. In both of these instances, strong interest and ownership by authoritative public officials with the ability to proactively co-design partnership modalities were crucial to advancing engagement. These countries featured better-resourced public sector champions who brought 1) decision-making authority to propose or greenlight a PPE option, 2) accountable and responsive staff to whom functional level responsibilities could be delegated, and 3) responsibility for stewardship mechanisms as well as budget and/or in-kind resources that could be strategically deployed in the private sector. In contrast, in Tanzania and Cambodia, the SIFPO2 team did not identify the same sort of champions with whom to collaborate. Given historical attitudes toward and inexperience in partnering with small-scale private for-profit providers in these two countries, further capacity building and advocacy was needed to approach the public sector for engagement.

4.2 What SIFPO2 learned from testing the provider intermediary/market facilitator functions

Successful stakeholder facilitation of public-private engagement priorities requires an actor with a clear mandate and convening authority

To test out the facilitation-intermediation approach under SIFPO2, PSI country affiliates played the role of health market facilitators with varying degrees of success.³⁰ In Tanzania, the lack of a coordinating actor with convening power and authority at the local level to align health system actors was a key limitation. For instance, in 2016, partnering with the national MOH, PSI Tanzania actively supported the rollout of the PPHF in four regions of Tanzania to promote PPPs. The PPHF successfully convened necessary stakeholders but lacked the authority, as a national MOH (versus regional) initiative, to implement the proposed PPPs at the local level.³¹ On the other hand, in Lagos State in Nigeria, SFH was able to successfully facilitate the development of a contracting mechanism to manage public PHC centers as mentioned above. Similar work is now being developed in Delta State. Market facilitation worked better in Nigeria where the most authoritative stakeholders empowered SFH (the



A ProFam franchise provider in Uganda

facilitator) to co-design a solution and facilitate alignment among different public sector stakeholders on implementation.

Channels for routine communication between the public and private sector actors are critical but were often non-functional in the four countries

All four countries had some established mechanisms to enable public and private sector actors to engage. For example, Tanzania has a PPHF, Cambodia has a sub-technical working group on PPPs under the MOH, the Uganda MOH has a PPP Desk, and the Nigeria Federal MOH has a PPP Unit. However, these forums or offices were often non-functional, under-resourced, or disempowered to implement partnership arrangements. This did not allow for routine strategic communication between public officials and private providers and/or aggregators to help facilitate trust and capture feedback.

The presence of a more capable intermediary, that can meet clearly defined needs by the public sector, helps to enable public-private sector engagement

Provider intermediation was a key selling point to interviewed stakeholders for PPE under the SIFPO2 approach, but the concept was more functional in some settings than in others. On one end of the spectrum, in Tanzania, the SIFPO2 partners observed that government was more focused on secondary and tertiary care than a PHC-level value proposition. In some focus regions in Tanzania, such as Mbeya, Shinyanga, and Iringa, the government routinely designates private not-for-profit facilities as Council/District Designated Hospitals and Regional Referral Hospitals to plug specific gaps in public infrastructure. PSI Tanzania did not offer a broad spectrum of secondary or tertiary services preferred by the government, nor was the network large enough to quickly scale up to plug existing gaps. This mismatch meant the provider intermediation role did not offer enough value to the public sector in Tanzania. In contrast, the KCCA in Uganda, as mentioned above, viewed the PSI affiliate as a ready intermediary that offered access to more than 50 urban and peri-urban nurse- and midwife-owned health centers providing FP/RH and MCH services across the city. As the KCCA sought to increase the provision of publicly sponsored maternal health services in Kampala, PSI Uganda could demonstrate their ability to organize enough providers and intensively support service delivery while ensuring satisfactory provision, quality, and utilization within a contracting arrangement.

SIFPO2's country experience demonstrated that instituting contracting arrangements between public planners and purchasers, and organized private providers, required a well-positioned intermediary 1) that is ready to contract on behalf of an adequate number of private providers able to deliver a consistent and somewhat broad package of care, 2) that can enforce performance terms and facilitate stronger governance, and 3) that can help carry out contract monitoring and reporting activities jointly with the public sector. Building up the private sector value proposition so it directly complements expressed public sector needs is also crucial to ensuring ownership and involvement from government officials.

5. Recommendations to public sector stakeholders on more effective public-private sector engagement

Through SIFPO2 support, the PSI country affiliates significantly increased their understanding of their local health financing contexts and refined specific ways to increase their engagement with public sector counterparts. However, the experiences of the country platforms suggest that private sector-led engagement is not sufficient by itself to develop well-functioning mixed health systems. Instead, actions and assistance on the public sector side must complement private sector-led engagement and partnership design initiatives. Here the R4D-PSI team recommends actions that local public sectors could feasibly undertake to help bridge this gap across two thematic areas: developing a conducive enabling environment and implementing deliberative processes³² and reforms to enable more successful partnerships.

5.1 Create an enabling environment for public-private sector engagement

Develop a capacity building and system strengthening agenda for public-private sector engagement

Routine and effective engagement of the private sector requires the development of key competencies and systems, such as costing and pricing of services and commodities, mapping private providers and evaluating their value propositions, negotiating contract terms and proactively managing contracts, and carrying out periodic baseline and end line monitoring and evaluation activities. The public sector can improve national and sub-national capacity with external support. Global guidance is available on private sector engagement within mixed health systems.^{33,34} Donor partners can also assist the public sector in strengthening stewardship and purchasing functions for public-private engagement.

Engage in strategic communication with private providers

As a first step, public sector planners and purchasers can engage private providers within strategic communication initiatives to listen, understand, explain, and act on their key issues, such as adequate and timely reimbursement, or costly and complicated accreditation and empanelment processes. Evidence already indicates that regular interactions, airing of feedback, and joint planning can help public and private actors to become more positively oriented toward each other.³⁵ As health system stewards, public sector actors must launch such communication mechanisms.

Build and support health market facilitation processes

To better harness the provision of private sector FP/RH services, governments can proactively promote coordination, transparency, and collaboration in the health system. In many LMIC contexts, suitable entities are often already present, which can grow to facilitate public-private sector engagement and aggregate and support private providers as intermediaries. Provider associations, health care federations and others may fill these roles more sustainably. Public sector patronage and targeted technical and funding assistance by development partners can help these actors grow.³⁶

5.2 Conduct deliberative processes to enable better leveraging of private sector providers

Define what support the private sector may provide to fill gaps in public sector delivery

Private actors seeking to support service delivery on behalf of public planners and purchasers will be more successful in doing so if the public sector proactively defines how the private sector may support,

supplement, or complement its service delivery activities and contribute to health sector goals. “Defining the gaps” can be done routinely as part of health planning and performance review processes. Such information can serve as basis for routine stakeholder consultations, tendering and procurement of services, and processes to co-design solutions. Ultimately, such information could help private actors fine-tune their value proposition vis-à-vis public sector needs, and spark interest and ownership with public officials for promising partnerships.

Position, develop, and leverage provider aggregators to support easier public-private engagement

Governments can help the evolution and growth of intermediaries in the health system by: channeling information, supervision, and financing through such aggregators; signaling willingness to enter into multiparty, umbrella contracting modalities; and reimbursing aggregators for networking providers and undertaking specific stewardship and financing functions on behalf of the government. This will help to organize fragmented, unsupervised, unregulated, and under-resourced private sector providers. There may already be actors in the private sector—such as franchising NGOs, provider associations, private for-profit/not-for-profit networks—who are well-positioned to grow into more full-service intermediaries meeting the needs of the public sector.³⁷ Public sector planners and purchasers, and their technical and funding partners, can collaborate on enabling intermediary organizations to play this bridging role and integrate private providers in stewardship and purchasing mechanisms to enable greater engagement.

Reform public financial management practices with consideration of the realities of working with private sector providers.

It is likely to take some time in many LMICs for prepaid-pooled financing mechanisms for UHC to optimally integrate FP/RH services.³⁸ These mechanisms are not often present in LMICs, and where they exist, they do not often cover FP services, or offer limited FP method choice. They may also inadequately monitor and track the delivery and quality of services.³⁹ Hence, reforming routine budgetary financing to target outputs, track resources, and reduce fragmentation is an important agenda for more strategic use of FP/RH funding.⁴⁰ As countries now embark on developing, resourcing, and aligning FP CIPs and GFF investment cases, budgetary resources for FP may become more predictable and better tracked. This provides an opportunity to better integrate private FP/RH providers within these financing regimes. Private providers need flexibility in resource planning, adequate funding, and clear performance standards. Program and activity budgets with clear output targets are more suitable for monitoring objectives and purchasing from diverse providers, as these give providers more flexibility and autonomy for internally planning and budgeting for service delivery.

Expand public oversight to better integrate FP/RH private providers into routine systems

Governments can routinely and reliably extend public sector planning, regulation, and reporting mechanisms to providers in the private sector. In the case of HMIS platforms, this may be less complicated in some settings where the public sector has reliable electronic mechanisms that simply exclude private providers. But it may be a much heavier lift in contexts where routine stewardship functions such as HMIS and monitoring are paper-based, infrequent, and unreliable. Provider aggregators may again have a role to play in preparing providers and enabling the flow of such stewardship relationships between the public sector and private providers. They can aggregate and present private sector service delivery data as a basis for planning and review. They can also create awareness, trust, and readiness among public officials to cooperate with private sector providers,

including those that are for-profit. This will concurrently help to build local officials' capacity as stewards of the health market.

6. Conclusion

Despite a strong rationale to both leverage and steward FP/RH in the private sector, active engagement of the private sector does not yet feature in many country-level FP/RH initiatives and service scale-up plans. Opportunities to do so differ across countries and geographies based on:

- The context of policies and the preferences and mindsets of stakeholders;
- The state of supply and demand in the health market;
- The evolution of broader health system financing and service delivery strategies; and
- The organization of private providers in the market—from fragmented individual providers to those under umbrella organizations or under networks involving active intermediaries with formal purchasing agreements.

The fact remains that women and girls in many LMICs rely significantly on private providers for FP/RH services—whether due to preference or to the public sector’s inability to meet their needs for various reasons. Many governments have recognized, at least at the policy level, that in order to meet ambitious commitments across the health system, and to expand access to voluntary FP/RH services, the public sector alone will not be enough—the private sector must be part of the solution.

Many of this report’s recommendations for greater and better PPE for FP/RH reflect the same systemic gaps and weaknesses that affect health systems overall. Governments frequently lack systems and capacity to purchase from and steward the private health sector to enhance the quality, access, and affordability of health care broadly—and FP/RH specifically—through a well-functioning mixed health system. Where efforts have been made, despite there being some promising examples of progress, such as PhilHealth insurance in the Philippines,⁴¹ FP/RH entitlements have frequently been ill-defined, insufficiently resourced, fragmented, inequitable, and unsustainable. Explicitly defining a targeted package of FP/RH services and integrating it into broader PHC delivery, with designated roles for the private sector, could be a first concrete step toward a more robust mixed health system for FP/RH. This will require institutional and system strengthening efforts around policy reform, financial commitments, and more expansive financing and stewardship mechanisms, as reflected in this paper. Encouragingly, strong market facilitators and provider intermediaries, such as social franchisors or business networks, already exist to help bring the public and private health sectors together.

The work under SIFPO2 sought to map and test how private sector FP/RH providers, particularly those with established capacity, quality and links to public sector counterparts, might better position themselves to expand access to voluntary FP and help contribute to national FP goals. With the shift in global health funding toward greater use of domestic resources, this work also intended to explore how donor subsidy can be more effectively leveraged to support these providers, e.g., through increasing their access to emerging domestic financing to assure sustainable high-quality FP/RH service delivery. While seismic shifts toward stronger mixed health systems in LMICs require a longer-term time frame, there were tangible wins from this work in terms of incrementally enhanced public-private engagement.⁴²

In Uganda, Cambodia, and Nigeria, SIFPO2 sparked conversations and ideas that eventually led to fruition within the life of the SIFPO2 project. In Uganda, SIFPO2 guided discussions between PSI Uganda and the KCCA, culminating in a concept note to decongest public maternal health services by leveraging the resources of the private sector. This document then served as a blueprint for an eventual USAID/Uganda-funded partnership in 2018 between KCCA, PSI Uganda, and the University of Makerere School of Public Health to lead a three-year implementation science project, called the

Maternal and Newborn Health (MaNe) Kampala Slum project, aimed at improving maternal and newborn outcomes in slum areas. Similarly, in Cambodia, the most highly prioritized health financing option co-developed with SIFPO2 support—developing and implementing routine accreditation protocols for private facilities by the public sector—is now being implemented by PSI Cambodia under USAID/Cambodia funding. Through this work, PSI Cambodia will develop, implement, and monitor a pilot of private-sector quality assessment and monitoring systems tied to initial steps for an accreditation framework and aligned with clinical standards accepted in the public sector. And in Nigeria, SFH succeeded in contracting with state governments to improve management of public PHC facilities.

While reflecting on progress and successes is heartening, reflection on challenges can be equally enlightening. A key learning, and challenge, experienced during this work is that multiple actors across the public and private spectrum need to be engaged for effective public-private partnerships to emerge. An approach that looks exclusively at public sector stewardship will likely struggle to reflect the realities of the private health care sector, just as an approach focused on the needs of the private sector will struggle to create traction in engaging the public sector. This dual path will likely be key for expanding voluntary FP/RH access and achieving FP goals over the next decade; progress will be contingent on continuous learning, regular adaptation, and an enduring commitment to partnership in all its forms within strong mixed health systems.

Endnotes

- ¹ FP2020 seeks to provide 120 million more women and girls access to modern family planning by 2020 across 69 focus countries; the Ouagadougou Partnership similarly aims to add 2.2 million additional women users of family planning across nine Francophone West African countries over 2016-2020; and the GFF is catalyzing country-led financing in 36 LMICs for investment in implementing high-impact health and nutrition programs and attendant system strengthening initiatives—including those for family planning. [Performance Monitoring and Accountability 2020. About FP2020; The Ouagadougou Partnership Acceleration Phase 2016-2020; The Global Financing Facility: GFF-supported countries].
- ² Declaration of Astana, WHO and UNICEF (2018). <https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf>; Holtz, J., & Sarker, I. (2018). *Integrating family planning into universal health coverage efforts*. Brief. Bethesda, MD: Sustaining Health Outcomes through the Private Sector Plus Project, Abt Associates.
- ³ Chaitkin, M., O'Connell, M., & Githinji, J. (2017). *Sustaining effective coverage for HIV, Tuberculosis, and Malaria in the context of transition in Kenya*. Washington, DC: Results for Development.
- ⁴ Lagomarsino, G., Nachuk, S., & Kundra, S. S. (2009). *Public stewardship of private providers in mixed health systems*. Results for Development. Washington, DC.
- ⁵ Blanchet, N.J., Ishtiaq, A., & Thomas, C. (2019). Engagement of the private sector in advancing universal health coverage: Understanding and navigating major factors for success. In *The road to universal health coverage: Innovation, equity, and the new health economy*. Baltimore, MD: JHU Press.
- ⁶ Mackintosh, M., Channon, A., Karan, A., Selvaraj, S., Cavagnero, E., & Zhao, H. (2016). What is the private sector? Understanding private provision in the health systems of low-income and middle-income countries. *Lancet*, 388(10044):596-605.
- ⁷ McPake, B., & Hanson, K. (2016). Managing the public–private mix to achieve universal health coverage. *Lancet*, 388:622-630.
- ⁸ Socha, K. Z., & Bech, M. (2011). Physician dual practice: A review of literature. *Health Policy*, 102(1):1-7.
- ⁹ Lagomarsino, G., Nachuk, S., Kundra, S. S. (2009). *Public stewardship of private providers in mixed health systems*. Results for Development. Washington, DC.
- ¹⁰ Rao, K. D., Paina, L., Ingabire, M. G., & Shroff, Z. C. (2018). Contracting non-state providers for universal health coverage: learnings from Africa, Asia, and Eastern Europe. *Int J Equity Health*, 17(1). doi:10.1186/s12939-018-0846-5
- ¹¹ Chaitkin, M., Blanchet, N., Su, Y., Husband, R., Moon, P., & Rowan, A., et al. (2019). *Integrating vertical programs into primary health care: A decision-making approach for policymakers*. Washington, DC: Results for Development.
- ¹² Aregbeshola, B. S., & Khan, S. M. (2017). Primary health care in Nigeria: 24 years after Olikoye Ransome-Kuti's leadership. *Frontiers in Public Health*, 5(48). doi:10.3389/fpubh.2017.00048
- ¹³ Clark, D., Doerr, S., Hunter, M., Schmets, G., Soucat, A., & Paviza, A. (2019). The private sector and universal health coverage. *Bulletin of the World Health Organization*, 97:434-435. <http://dx.doi.org/10.2471/BLT.18.225540>
- ¹⁴ Campbell, O.M., Benova, L., Macleod, D., Goodman, C., Footman, K., & Pereira, A. L., et al. (2015). Who, what, where: An analysis of private sector family planning provision in 57 low- and middle-income countries. *Trop Med Int Heal*, 20 (12):1639–1656.
- ¹⁵ Weinberger, M., & Callahan, S. (2017). *Data shows “private sources having the smallest share of sterilization services, implants, and IUDs, and the largest share of pills and male condoms.” The private sector: Key to achieving family planning 2020 goals*. Brief. Bethesda, MD: Sustaining health outcomes through the private sector project, Abt Associates.
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- ¹⁷ Ibid.
- ¹⁸ Rosen, J. E. *Family planning in Latin America and the Caribbean (LAC). What's universal health coverage (UHC) got to do with it?* HP+/USAID.
- ¹⁹ *Contracting-out reproductive health and family planning services: Contracting management and operations. Primer for policymakers*. (2006). PSP-One.
- ²⁰ Interview with Mrs. Chhay Sveng Chea Ath, President, Midwives Association of Cambodia. July 13, 2017.

²¹ Intermediaries are defined as organizations that form networks between small-scale providers to interact with governments, patients, and vendors. These organizations can perform key health system functions that are typically more challenging for individual private providers to do on their own (such as ensuring proactive population management and continuity of care, developing long-term management capacity, systematically improving quality of care, and integrating into overarching systems for payment and regulation). [Intermediaries: The missing link in improving mixed market health systems?](#) (2016). Results for Development.

²² As stated earlier, these consisted of Tanzania, Uganda, Nigeria, and Cambodia. R4D and PSI selected these countries after carrying out a landscape analysis reviewing criteria such as whether a country was included among USAID “Priority Reproductive Health” countries and had a PSI social franchise, level of key FP indicators (mCPR, unmet need, etc.), the role of the private sector, FP2020 commitments and government plans for FP, dependence on or transition from donor assistance, plans for national health insurance and the status of FP within such initiatives, and any key FP/RH or MCH projects of note. This was followed by a more decisional step of engaging PSI country platforms to gauge their interest and availability before finalizing country selection.

²³ This “Health Financing Options Analysis” approach is described in detail in an associated tool (“[A Practical Guide](#)”) for managers of PHC networks interested in enhancing the sustainability and equity of their operations through closer integration into public sector mechanisms. See: Hariharan, N., Ishtiaq, A., Eldridge, C., Moon, P., and Blanchet, N. J. (2018). *Linking private primary health care networks to sustainable domestic financing: A practical guide for network managers*. Washington: Results for Development and Population Services International.

²⁴ For instance, dynamics of supply chain management, quality assurance, and subsidy for drug shops and pharmacies (distribution channels for FP products) are distinct from facility-level service delivery concerns.

²⁵ Contracting-out refers to arrangements where the public sector (acting as the primary purchaser, or contractor) enters into a documented agreement to provide compensation to a private provider “in exchange for a defined set of health services for a defined target population.” Contracting-in on the other hand refers to governments contracting with private parties to provide services or equipment in public facilities. Liu, X., Hotchkiss, D., Bose, S. Bitran, R., & Giedion U. (2004). *Contracting for primary health services: Evidence on its effects and framework for evaluation*. Bethesda, MD: The Partners for Health Reformplus Project, Abt Associates Inc.

²⁶ [PSI defines](#) social enterprise models as “sustainable health impact delivered through a commercial business model.” For instance, an NGO or a for-profit entity may use commercial practices to deliver positive social impact and diversify its sources of funding.

²⁷ PSI is already innovating on the social franchise model to test such cost recovery (social enterprise) propositions in different setting. Examples include the Tunza Social Enterprise initiative in Tanzania, Malawi, and Uganda, and a “Network Management Organization” model in Kenya. [A review of social franchising innovations at PSI](#).

²⁸ Including a detailed assessment of advocacy needs and messaging to promote public-private engagement.

²⁹ Even though the electronic HMIS system extends to almost 100% of the public facilities and can be relatively easily extended to private ones. Retrospective interview: Cambodia. March 2019.

³⁰ Ideally, the market facilitator should be a neutral actor that can facilitate a deliberative process among health system stakeholders to design and help launch solutions (with capacity building, tools, etc.) to mitigate market failures.

³¹ PHC financing, delivery, and management responsibilities are highly devolved in Tanzania’s health system with Local Government Authorities (LGAs) taking primary responsibility for these functions. LGA (district/council) governments especially hold the most power and authority in contracting-out negotiations. Maluka, S., Chitama, D., Dungumaro, E., Masawe, C., Rao, K., & Shroff, Z. (2018). Contracting-out primary health care services in Tanzania towards UHC: how policy processes and context influence policy design and implementation. *Intl J Equity Health*, 17(1), 118. doi:10.1186/s12939-018-0835-8

³² The facilitation-intermediation approach under SIFPO2 was only a specific formulation of what R4D refers to as “deliberative processes that raise awareness and identify solutions through analysis and structured dialogue among key stakeholders to enable public-private engagement.” Blanchet, N.J., Ishtiaq, A., & Thomas, C. (2019). Engagement of the private sector in advancing universal health coverage: Understanding and navigating major factors for success. In *The road to universal health coverage: Innovation, equity, and the new health economy*. Baltimore, MD: JHU Press.

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- ³⁶ *Sustainable strategies for accessible, quality health care: Public-private sector engagement in Kenya*. (2018). Program brief. Rockville, MD: Sustaining health outcomes through the private sector plus project, Abt Associates.
- ³⁷ Mangone, E., & Gitonga, N. (2017). *Public-private partnerships for family planning: Case studies on local participation*. Primer. Bethesda, MD: Sustaining health outcomes through the private sector project, Abt Associates.
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- ⁴¹ Viswanathan, R., Avanceña, A. L. V. (2015). *Social franchises: the bridge between healthcare providers and national health insurance programs | Lessons learned from two initiatives in the Philippines*. San Francisco: Global Health Group, Global Health Sciences, University of California, San Francisco.
- ⁴² Noting that direct attribution for these wins can be difficult to assign when a range of implementers are working in the same space to strengthen public-private engagement.