SHOPS PLUS

Public–Private Partnerships for Family Planning Commodities

USAID
FROM THE AMERICAN PEOPLE

Summary

Many governments and donors support the use of public–private partnerships to distribute publicly managed commodities through the private health sector to overcome barriers to access for the full range of family planning methods. This brief draws on country experiences with commodity partnerships for family planning in Kenya, Nigeria, and Tanzania. It documents approaches used to place government–managed commodities into the hands of private providers and ultimately the women seeking the method. It examines factors that motivated public and private actors to pursue partnerships to enable private sector provision of long–acting reversible contraceptives, and how well the implementation of the partnerships aligned with those motivations. The brief discusses the challenges and lessons learned from this experience, and concludes with reflections about when and how donors and governments might decide to replicate, improve, or scale up these partnerships.

Keywords: contraceptives, contracting, family planning, implants, IUDs, Kenya, long-acting reversible methods, Nigeria, public-private partnerships, short-acting methods, Tanzania, total market approach

Cover photo: KC Nwakalor

Recommended Citation: Callahan, Sean and Jeanna Holtz. 2021. *Public-Private Partnerships for Family Planning Commodities*. Brief. Rockville, MD: Sustaining Health Outcomes through the Private Sector Plus Project, Abt Associates.

This brief is made possible by the support of the American people through the United States Agency for International Development. The contents of the report are the sole responsibility of Abt Associates and do not necessarily reflect the views of USAID or the United States government.

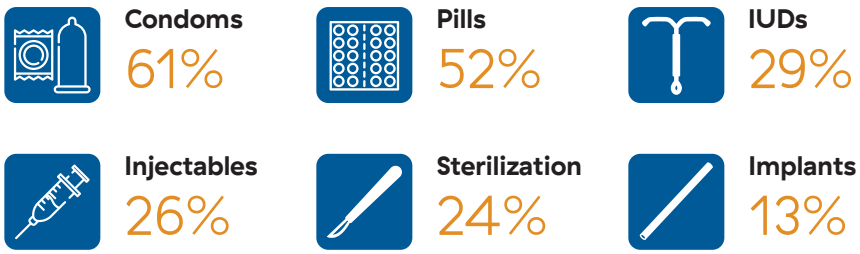
SHOPSPLUS
Public–private engagement for better health

March 2021

Public–Private Partnerships for Family Planning Commodities

Globally, the private health sector is an important source of family planning products, services, and information. An analysis of 36 countries' Demographic and Health Survey data demonstrates that private health care providers and retail outlets serve a substantial proportion of women using a modern method. Across all countries and methods examined, the private sector accounts for just over one-third of users, with its contribution varying by the method that women choose. The private sector provides relatively more short-acting methods (SAMs) than long-acting reversible contraceptives (LARCs) (Figure 1). For example, globally, 52 percent of women using pills obtain them from a private source, compared to 13 percent of users of implants (Bradley and Shiras 2020).[1]

Figure 1. Private sources deliver SAMs more than LARCs



Source: Bradley and Shiras (2020)

Reasons for this difference have been well documented (RESPOND Project 2014; SHOPS Project 2014; Armand and Warren 2020). They include challenges on both the provider and client sides that can lead to market gaps.

[1] Private sector sources include private clinical sources, such as a hospital, clinic, or maternity home; private pharmacies and drug shops; private shops or markets; and NGOs and faith–based organizations.

Provider-side challenges

- Government policies and regulations, such as scopes of practice or service delivery guidelines, narrowly define who can provide specific family planning services, particularly LARCs. This often limits the ability of private providers—especially those in lower-tier cadres—to offer a wider choice of methods. For example, private pharmacists are often unable to offer injection services of any kind, preventing them from delivering an injectable contraceptive even if they can sell the product.
- Some private providers have limited pre-service or in-service training opportunities to build the clinical skills needed to deliver LARCs, including a lack of access to government- or donor-sponsored clinical trainings, coaching, or mentoring opportunities.
- Global donor programs to introduce new products (e.g., the Implant Access Program) tend to focus on public sector and nonprofit providers, to the exclusion of private for-profit providers.
- Private providers may face difficulties in obtaining affordable, quality implants or sourcing IUDs through private supply channels.

Client-side challenges

- The price of obtaining IUDs and implants (service and commodities) from private providers, without some form of subsidy, can be prohibitive for many clients.
- Myths and misconceptions about newer methods may reinforce client preferences for methods with which they are more familiar.

Furthermore, client-side challenges can reinforce the supply-side challenges. If sufficient volumes of clients are not accessing these methods in the private sector, then the private sector lacks incentives to make necessary investments in their own skills and supply chains. In addition, without sufficient client flows for LARCs, private providers may not feel comfortable with the quality of their skills and opt to focus on methods they know better. While initiatives such as social marketing programs or private health care provider networks such as social franchises can mitigate many of the supply-side challenges, many private providers operate independently and do not receive support from these types of organizations.[2]

[2] Social franchises are globally recognized high-impact practices for improving access to family planning. In a social franchise, private providers are organized into branded, quality-assured networks under the auspices of a franchisor. Often, the franchisor will provide its member facilities with access to trainings, subsidized products, equipment, and other inputs needed to offer family planning services. Although social franchises will sometimes partner with governments to receive government-managed commodities, this brief focuses on partnerships with non-franchised providers since the experience with social franchises is well documented in existing literature, including USAID's High Impact Practice brief on the subject.

There are multiple strategies that aim to remove some of these barriers, address market gaps, and increase universal access to family planning. In the short term, investments can be made in private sector supply chains to increase product availability, or offer supply-side subsidies to lower the prices of contraceptives, such as implants. Over the long term, one strategy is to advocate to expand social health insurance programs that reduce financial barriers to access the full range of family planning methods with no (or low) out-of-pocket cost to clients. A number of conditions must be met for social health insurance to provide universal access to family planning, however. People must be enrolled in the insurance program, and the program must cover all family planning methods and services equitably and adequately, and contract with sufficient numbers of providers, including private providers.

Photo: KC Nwakalor

Some governments and donors have supported more immediate strategies to help satisfy unmet need for family planning. One approach pursued by multiple countries involves establishing public-private partnerships under which private providers receive government-managed commodities. These partnerships aim to overcome market barriers that prevent private providers from sourcing these commodities and prevent consumers from accessing them due to high costs.

The USAID-funded Sustaining Health Outcomes through the Private Sector (SHOPS) Plus project based this brief on a variety of sources. This brief draws on country experiences to distribute government-managed family planning and other priority health products to private health facilities. The authors conducted a desk-based review of publicly available global research and project records, and over 35 interviews with government, private, and implementing partner stakeholders who worked on commodity partnerships for family planning in Kenya, Nigeria, and Tanzania. Although the brief focuses on contraceptives, the authors also interviewed stakeholders who work on similar partnerships for HIV products in Côte d'Ivoire and tuberculosis (TB) in India to identify practices or considerations that could be adapted for family planning (Annex). The brief documents approaches used to place government-managed commodities into the hands of private providers and, in turn, the women seeking the method. It examines factors that motivate public and private actors to pursue partnerships to enable private sector provision of LARCs, and how well the implementation of the partnerships aligns with those motivations. The brief discusses the challenges and lessons learned, and concludes with reflections about when and how donors and governments might decide to replicate, improve, or scale up these partnerships.

The contexts in which the family planning partnerships were established and scaled up in Kenya, Nigeria, and Tanzania are especially relevant. All three countries have benefitted from substantial donor and government investments in their public supply chains and public sector family planning programs. They have substantial, vibrant private health sectors that are important sources of family planning, especially SAMs. Beyond those commonalities, however, there are notable differences in the countries' family planning markets. Nigeria has endured a long period of limited growth in modern contraceptive prevalence and persistently low use of LARCs; Tanzania has experienced steady growth in both overall use and private sector contributions, although private sector provision of LARCs has lagged; and Kenya has developed one of the most robust and mature family planning markets in sub-Saharan Africa partially as a result of its partnership (Ganesan and Callahan 2021).

Photo, facing page: DDC/Sama Jahanpour

Public–Private Partnerships for Commodities

Public–Private Partnerships for Commodities

The section outlines the roles and responsibilities of a public-private partnership for commodities, illustrates two models for this type of partnership, and shows where public-private engagement can occur in the health system.

Partnership roles and responsibilities

The commodity partnerships SHOPS Plus examined exhibited many similar elements. Private providers and public sector officials perform similar roles and responsibilities. Private providers agree to two things:

1. To submit regular reports and requisition requests in return for access to free government-managed commodities on a monthly, bimonthly, or quarterly basis.
2. To offer the product free of charge to clients. For services and consumable supplies delivered in conjunction with the commodity, such as consultations, syringes, or gloves, they agree to adhere to mutually accepted pricing guidelines established under the partnership.

As discussed further in this brief, the provision allowing private providers to charge nominal fees to deliver government-managed commodities contributes to the success of the partnerships. Importantly, for family planning, it helps offset service delivery costs that might condition providers against offering more costly per-client contraceptives, such as LARC methods. Additionally, the partnerships require providers to participate in some sort of oversight. Usually, this oversight requirement consists—on paper—of supportive supervision visits by local government officials to monitor stock levels, identify potential stockouts, and help redistribute surplus commodities. In practice, though, these visits often do not occur or were conducted by donor-funded implementing partners either in person or remotely.

In the partnerships analyzed, the public sector fulfills two functions, as commodity supplier and resource steward. As a supplier, it purchases or obtains donated commodities that it makes available to private providers. In some instances, it also provides additional equipment or resources needed to properly store the commodities, such as refrigerators. As a steward, the public sector supervises the use of the commodities and associated services, either directly with individual providers or through intermediaries such as associations.

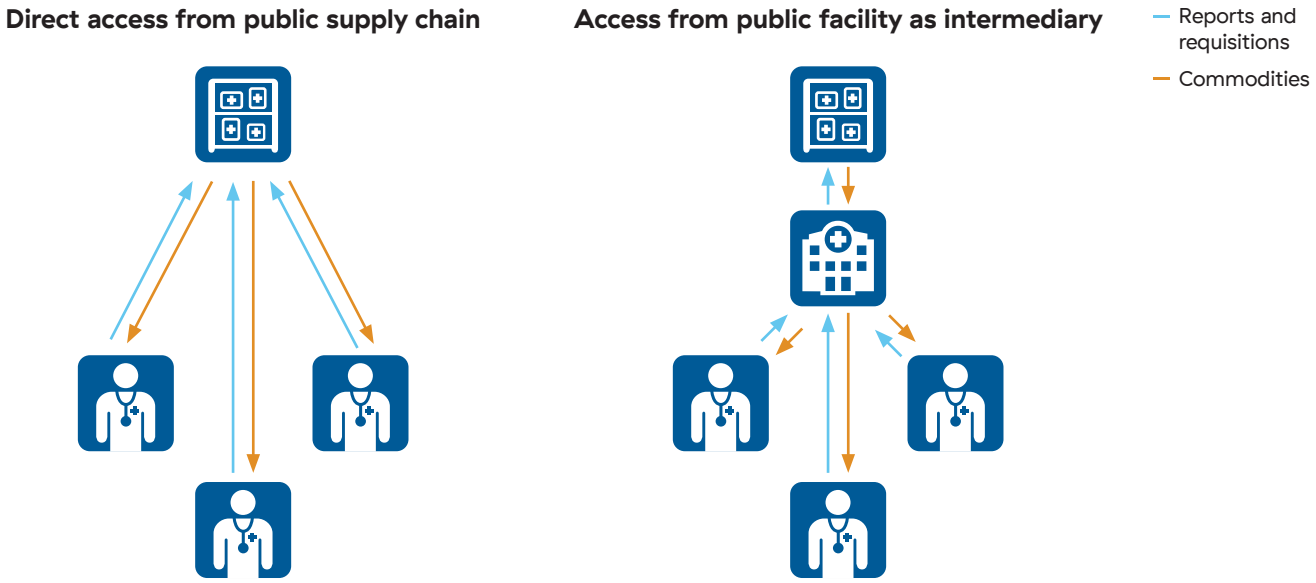
For their part, private providers must meet training and administrative requirements and comply with quality standards. In Nigeria, this includes completing a government-sponsored training on LARC provision, including insertion and removals of IUDs and implants. The private providers must submit timely requests in approved formats, and report provision of the government-managed commodities and related services at monthly or other prescribed intervals. In Kenya, providers submit the reports directly to the logistics management information system. In Nigeria, providers submit them to their local government authorities, and the facilities must adhere to certain criteria necessary for high-quality service delivery.

In Tanzania, providers are required to have a sufficiently large and confidential space to counsel and provide LARC services, as well as adequate and appropriate storage capacity to keep sufficient quantities of commodities securely and safely on site.

Two models for distributing government-managed commodities

The partnerships examined typically rely on the existing public supply chain to move government-managed commodities from the central medical stores to local governments. From there, the partnerships deploy one of two distribution models: private providers access the commodities directly from the local supply chain, or through a public facility acting as an intermediary (Figure 2). Most countries employ the first model. Tanzania is the only country that uses the second model in both its partnerships for family planning and HIV commodities.

Figure 2. Two ways for private providers to access government-managed commodities



Under the direct access model, private providers directly submit their orders to the local medical stores unit, usually through a local district medical officer or equivalent public official, and receive their order of government-managed commodities along with the local government's overall order. In Kenya, however, private providers can submit their orders directly through the government's logistics management information system and pick up their orders from their county medical store. Governments that permit private

providers to order government-managed commodities by direct entries into the government's procurement system tend to have more formal partnerships. For example, to receive government-managed commodities, Kenyan private facilities have to be registered on the government's master facility list. In Nigeria, participating providers enter into service level agreements (SLAs) with government counterparts at the state level. Private health care provider associations, such as the Private Nurse Midwives Association of Tanzania and the Association of General and Private Medical Practitioners of Nigeria, often help mobilize and support their members at the state level to participate.

Photo: DDC/Sama Jahanpour

Under the second, or intermediary distribution model, private providers access government-managed commodities from a public facility that acts as an intermediary between the private provider and the government's supply chain. Multiple private providers are matched with a public "mother" or hub site to facilitate commodity procurement. These private providers submit their requisitions and reports to the hub site, which then submits orders on behalf of the private facilities, as part of the public facility's requisitions. The hub site is responsible for ensuring that government-managed commodities are distributed to the private providers and that the providers submit all necessary documentation. The intermediary model creates flexibility in case of stockouts, as private providers can refer clients to the hub site if they cannot serve them. It allows the public facility to perform some functions similar to those that a social franchisor performs on behalf of networked providers. For example, when multiple private providers are linked to the same hub site, the public facility can redistribute government-managed commodities from a private facility with excess stock to one with shortages.

In Tanzania, officials use an intermediary model to help increase the number of private providers, especially from lower-level cadres, partnering with the government to offer implants. The country uses formal SLAs that spell out the terms and conditions for the government to partner with a private facility,

but the requirements for a private facility to execute an SLA are substantial. Stakeholders indicated that typically only higher-level private hospitals and larger facilities can meet these requirements, leaving out the majority of smaller private clinics and dispensaries where many women seek family planning services. Local governments can adapt SLAs to fit the needs of smaller private facilities and contract directly with them. In interviews with public and private stakeholders implementing commodity partnerships, though, most expressed a preference for more flexible partnerships that use a public facility as an intermediary. The intermediary facility often engages private providers more informally, such as through a non-binding memorandum of understanding or a verbal agreement.

Public–private engagement at multiple levels

Under both models, public-private engagement occurs at multiple levels of the health system as the partnerships evolves. Many of the partnerships began with donor-facilitated discussions between ministries of health (MOHs), national public health programs, and private provider associations to align on the need for a partnership and agree to the terms. For example, in Tanzania, the Reproductive and Child Health Section of the MOH and the National AIDS Control Programme were key stakeholders in determining eligibility criteria for private providers and for ensuring that they were adequately trained to participate in the partnerships. National-level organizations like the central medical stores were also key partners, as both managers of the national supply chain and as recipients of external technical assistance and commodity support to improve the supply chain's functioning. These national-level actors were key to ensuring that the government had sufficient capacity and resources available to manage the partnership.

As many of the countries with these partnerships operate decentralized health systems, responsibility for implementing the partnerships often occurs at the state or local level. State MOHs, local government authorities, and regional and county health management teams—depending on the country, all of these government bodies had a role to play in managing the partnerships. In Nigeria, providers signed agreements with the state MOHs in order to participate. As a result, donors and private sector actors had to spend time engaging the relevant authorities in each state to sensitize them to the partnership model and garner their support. In Tanzania, council health management teams have a great deal of discretion in how resources are used. Despite the existence of a template that was developed at the national level for an SLA to guide the implementation of these partnerships, council health management teams opted for the intermediary model as their preferred strategy for partnering.

Reasons for Partnering

Governments and private providers have different objectives and perceive different challenges when it comes to providing access to affordable commodities for family planning and other priority health services (Sutkowski et al. 2018). Governments may not have sufficient resources to supply both public and private health facilities; public and private sector stakeholders may not trust each other to uphold the terms of the partnership; or either side may not prioritize family planning. As a result, their motivations to enter into a public-private commodity partnership, and their perceptions of how the partnership performs will differ. In order for a partnership to be successful, each side will need to identify the reasons that make it worthwhile to overcome the challenges they face that could prevent their joining together.

Government perspective

Public stakeholders indicated that their main motivations for pursuing commodity partnerships derived from their role as stewards of mixed health systems. For them, commodity partnerships are a way to extend the reach of public health programs; gain insight into what the private sector is doing; and add points of access and reduce out-of-pocket costs for clients who seek health care in the private sector—in short, to increase access and improve equity.

Extending the reach of public health programs

In countries where commodity partnerships have emerged, government stewards generally acknowledge that public sector human resources for health and health facilities are insufficient to meet population needs. Countries like Kenya, Nigeria, and Tanzania, have large, vibrant private health sectors. Key informants viewed commodity partnerships as mechanisms to tap into existing private service delivery capacity that can increase access and complement the public health system. An official in the Reproductive and Child Health Section of Tanzania's MOH stated that the government "needs to reach more people and needs more providers to do so. Partnering with the private sector is the way to do that." The degree to which public officials proactively sought out these types of partnerships has varied by health area, though. Stakeholders revealed that vertical programs focused on communicable diseases—such as national TB or HIV responses—effectively convey a greater sense of urgency to increase access to commodities as quickly, efficiently, and effectively as possible. Family planning programs, on the other hand, usually have less visibility and clout than programs for "life-saving" services, particularly when they are embedded as a directorate within an MOH. This is one reason stakeholders cited to explain why family planning programs have been slower than other health areas to pursue commodity partnerships, or have operated at a smaller scale.

"[Government] needs to reach more people and needs more providers to do so. Partnering with the private sector is the way to do that."
—Tanzanian government official

Once established, though, commodity partnerships generally achieved a government's objective of extending the reach of family planning programs. As discussed in more detail below, these partnerships mainly benefitted LARCs even though the family planning partnerships tend to allow private providers to access the full range of methods if desired. In Nigeria, between 2018 and 2020, commodity partnerships helped 270 private providers begin offering a broader range of family planning methods, including insertion and removal of implants and IUDs. These private providers delivered family planning products and services to almost 11,600 new acceptors. In Tanzania, a pilot program to explore the potential of these partnerships trained 39 private providers in comprehensive family planning service offerings and began offering implants for the first time (Armand and Warren 2020). During a six-month period in 2019, the providers delivered implant insertions to almost 1,400 women. And in Kenya, where public-private partnerships are most widespread among the countries SHOPS Plus examined, the private sector maintains a substantial share of the family planning market. Demographic and Health Survey data indicate that one-quarter of women using a LARC method in Kenya access it from the private sector, which informants credit in part to these public-private partnerships. Stakeholders interviewed indicated that the partnerships were designed to allow private providers to access all family planning products. In practice, though, the partnerships had a greater impact on private provision of LARCs than of SAMs, for reasons discussed below.

Gaining insight into the private sector

A frequent challenge for government stewards is lack of knowledge of the private health sector. In many countries, government staff do not have sufficient data or information on who private providers are, where they are located, and what services they are providing (WHO 2017). By offering access to free government-managed commodities, government stewards offer an incentive for private providers to share their data.

Government stakeholders place value on receiving data from the private health sector for two main reasons. Most relevant to the commodity partnerships, they need data to ensure that there are adequate supplies available along the supply chain to manage stock and support resupply efforts. Private sector data also give government stewards insight into the full scale of resources at their disposal in the health system and can lead to more efficient and better targeted government programs (Johnson, Graff, and Choi 2015).

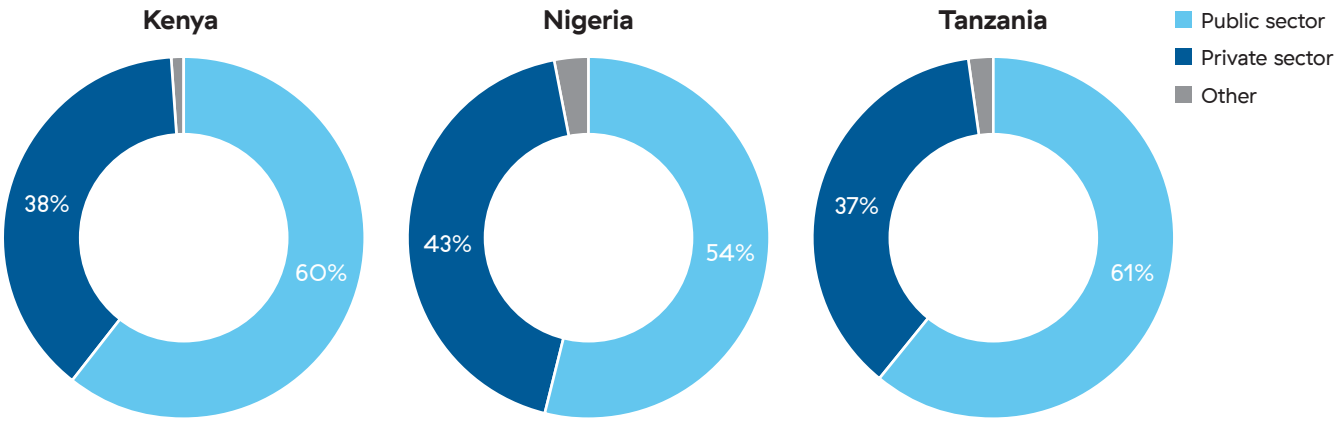
Ease of reporting may influence private providers' ability and willingness to share service delivery and commodity consumption data under these partnerships. In Nigeria, government reporting was paper-based, while many private providers were using computer-based recordkeeping. The duplicate

recordkeeping of the paper-based system placed an additional management burden on private providers. In Tanzania, reporting and refill orders are linked to the national registers that all providers must maintain as part of the country's health information system. This practice fosters accuracy, efficiency, and compliance. Participating private providers stated that they appreciated this practice and were generally willing to share their data. One provider in Nigeria relayed that reporting actually helped improve inventory management at her facility, stating, "If you're using your tally cards well, you know what [stock] you have." However, because of time pressures and a lack of dedicated recordkeeping staff, some private providers cited supportive supervision visits from a donor-funded project, public staff, or representative from a professional association as a best practice that helped them to submit complete, accurate, and timely reports. Similarly, public sector staff voiced appreciation for external support to collect data. As the commodity partnerships grew in scale, government capacity to oversee them did not always keep pace. In some cases, donor-funded projects and private sector intermediary organizations stepped in to help fill the gap.

Reaching women and couples where they are with lower out-of-pocket costs

A key feature across the countries where commodity partnerships have been implemented is a recognition among public officials of the private sector's importance to the health system. The public sector officials interviewed in Kenya, Nigeria, and Tanzania all recognize that the private sector is—and has been—a substantial source of family planning and other health services (Figure 3).

Figure 3. The private sector is a substantial source of family planning services in Kenya, Nigeria, and Tanzania



Source: Private Sector Counts, accessed at www.privatesectorcounts.org

Just as importantly, the governments in these countries acknowledge that many women and men choose to obtain health services in the private sector. One Kenyan government official stated that, because of the private sector's prominence, the government has "a vested interest in making sure that those who go to the private sector will have access to high-quality, affordable commodities." Providing free government-managed commodities to private providers as part of these partnerships, then, is seen as a strategy the government can pursue both to reduce financial barriers and increase access to the full range of family planning methods for women/couples who prefer a private source. In general, stakeholders in Kenya, Nigeria, and Tanzania agreed that the partnerships allow them to achieve these objectives.

While the partnership reduces the cost of the LARC services by eliminating the cost of the product, it does not remove all costs in the private sector. Some partnerships allow private providers to charge a fee for services such as a consultation or insertion that accompanies the LARC product. However, that fee is substantially lower than usual and customary ("market") fees the providers would charge for the same services if they used privately procured commodities. In this way, the partnership terms help more women who prefer a private facility to access a wider range of methods there.

Many stakeholders indicated that they originally anticipated that stockouts would be a key challenge that could limit the ability of these partnerships to reach women who preferred a private sector source. As a result, they developed strategies to minimize the impact on clients of their monthly stock of government-managed commodities being depleted. They could refer clients to a nearby public facility for their method, which the client might or might not access depending on her preferences. Or they could procure the commodity in the private sector; when they did, they would charge the client the full price. This did not work for implants, though, because providers lacked access through private channels and could only offer referrals until they were restocked. The providers indicated that, fortunately, supplies were generally reliable and stockouts did not occur frequently.

Private provider perspective

Private providers were motivated to participate in commodity partnerships to improve their clinical and business performance. Essentially, they viewed the partnerships as an opportunity to improve and expand their clinical skills, to attract and retain clients by offering a wider range of desired services, and to increase their revenue and sustainably serve their clients' health needs.

Improve and expand clinical skills

Many private providers lack access to in-service training that enables them to offer the full range of modern family planning methods (SHOPS 2014). Government stakeholders indicated that this gap limits providers' scope of clinical practice, and encourages bias against LARCs in favor of the SAMs with which the providers were familiar. Recognizing this gap, governments in Tanzania and Nigeria—with support from donor partners—provided clinical training as part of partnership programs. These trainings were sometimes packaged with demand creation to increase client flows to newly trained providers so they could practice and maintain clinical skills. Together, with the access to government-managed commodities, the trainings allowed private providers to improve and expand their clinical skills, beyond what they could do on their own. This sense of professional development was a key motivator for private providers. One private nurse from Nigeria stated, "we want to advise women fully, including about LARCs, and help them choose wisely." A nursing officer at a private facility in Dar es Salaam, Tanzania, similarly noted that "I was [previously] lacking knowledge and skills to offer [implants and IUDs]. Now I work as a mentor and am trusted at my facility—I even get consulted by other providers and have never received any complaints from my clients."

"I was [previously] lacking knowledge and skills to offer [implants and IUDs]. Now I work as a mentor and am trusted at my facility—I even get consulted by other providers and have never received any complaints from my clients."
—Tanzanian private nurse–midwife

Attract and retain new clients through more comprehensive service offerings

Linked to their professional development, private providers viewed commodity partnerships as a way to provide more comprehensive, convenient services to current and prospective clients. By offering the full range of family planning methods, clients would view them as higher-quality service providers who can address a greater range of health needs, including the full choice of family planning methods. This motivation seemed especially relevant for members of lower-level cadres, such as nurse-midwives, whom stakeholders viewed as more committed to family planning. One nurse in Plateau State, Nigeria, who received training as part of a commodity partnership, conducted step-down trainings to pass on knowledge to community health workers at her facility so that they could better advise women on the available methods and refer them accordingly.

In general, participating providers reported that the partnerships helped them expand and improve service offerings. One provider in Plateau State, Nigeria, noted that the number of family planning clients she saw per month tripled after entering into a commodity partnership, with more women opting for implants rather than the SAMs they had previously accessed. Another provider, also in Plateau State, noted that training helped build awareness, dispel myths, and promote male involvement, calling it "a miracle in this part of the country." Another noted that training allowed her to better counsel clients on the full range of methods.

Private providers generally felt that the partnerships—once up and running—were reliable, and the processes to obtain commodities straightforward. They reported that stockouts were not typically a problem, and when one did occur, the public sector prioritized restocking public facilities. In the absence of other support, providers relied on the two strategies noted previously: they would refer clients to a nearby public site or procure commodities from the private supply chain and charge higher fees to offset the higher procurement costs. However, providers also cited the importance of intermediary organizations in addressing stockouts. In Tanzania, as noted earlier, the public hub facility was able to redistribute excess stock among its associated private clinics to mitigate stockouts. In Nigeria, the SHOPS Plus project served a similar role, helping to redistribute stock when needed.

Financial viability

Private providers are generally willing to participate in public health programs—but they need to do so in a financially sustainable way. Private health care providers differ from those in the public sector in that they need to generate enough revenue to pay salaries, purchase commodities and other supplies, cover their overhead costs, and otherwise ensure the functioning of their facilities. Providers were therefore most interested in partnerships that helped them better serve family planning clients without incurring unviable costs. Specifically, multiple providers cited policies that allowed them to charge nominal fees for related services as a key motivator. In Nigeria, previous efforts to build a public-private commodity partnership for TB treatment failed to attract private provider participation because they did not permit providers to charge reasonable fees for services associated with provision of the government-managed commodity. A private nurse in Nigeria noted that without the partnership, "it would be difficult to recover the costs" of offering LARCs.

Importantly, neither for-profit nor nonprofit private health care providers saw such provisions as a profit-making opportunity. Instead, they appreciated the potential to offer needed health services in a way that allowed them to recover some or all of the costs incurred to deliver the free commodity. In Nigeria, a public sector reproductive health coordinator revealed that many providers in his state charged below the maximum allowed fee, indicating a commitment to provide access to clients based on their ability to pay. Providers also recognized potential spillover effects from providing family planning, even at or near a breakeven price. These effects include additional revenue from other services provided to a family planning client or family members, or word-of-mouth referrals that bring new clients to the provider's practice.

The relevance of commodity partnerships varies by family planning method. One reason for this is that the financial viability of each method differs. For LARCs, private providers face challenges in accessing the commodities from private suppliers, including high costs or limited availability. The partnerships mitigate these challenges by allowing providers to access the commodities through public sector channels for free, or at a lower-cost, subsidized level. In Kenya, Nigeria, and Tanzania, private providers could access the commodities for free. In Côte d'Ivoire, the public sector allows NGO facilities to pay a reduced fee to purchase subsidized implants. In parallel with access to free or lower-cost commodities, many partnerships allow providers to charge a reasonable fee for related services and consumables, with the aim to make LARC services affordable for clients, yet economically viable for providers.

For SAMs, commodity partnerships were less relevant. In partnerships that covered both SAMs and LARCs, such as in Tanzania, stakeholders reported that private providers still prefer to procure SAMs from the private supply chain. They stated that, relative to LARCs, SAMs are delivered with fewer associated services and consumables. As a result, a provider's ability to recover overhead costs incurred to deliver free SAMs would be limited—making the provider more likely to accrue losses when providing SAMs procured from the public sector. In addition, providers indicated that they had sufficient access to affordable, quality SAM commodities through private channels. Because there is already a viable and sufficiently large private market for these methods, they find little to no financial incentive for private providers to access SAM commodities through the public-private partnerships examined here. One global supply chain expert reflected that commodity partnerships should therefore be viewed as a strategy to grow the market for a specific product large enough so that it becomes viable for private sector investment.

Photo, facing page: Jessica Scranton

Challenges

Challenges

While successful in many ways, these public-private partnerships for commodities are not without challenges. By understanding these challenges, others interested in designing and implementing similar partnerships can do so more successfully.

Need for complementary investments: In theory, public-private commodity partnerships could exist solely to provide government-managed commodities to private facilities. Kenya is the only country that currently comes close to operating such a partnership, and it is at this point because of the decades of government and donor investments in building demand and strengthening public and private sector family planning programs (Ganesan and Callahan 2021). The other countries examined all required complementary interventions—clinical and non-clinical trainings, demand creation, facilitating public-private engagement, and other areas needed to support the operations of the partnership. This need adds to the cost and can dissuade stakeholders from pursuing a partnership model if resources to support these complementary interventions do not exist. In Nigeria and Tanzania, the necessary resources came from external donors.

Sustainability: The partnerships examined in this brief rely on access to donated commodities, donor investments in training, and/or other technical assistance from donor-funded projects. These external subsidies have contributed substantially to the government's ability to procure sufficient quantities to supply both public and private sites, but they are not expected to continue indefinitely. As countries become more self-reliant, support from donors will decline and governments will need to mobilize more domestic resources for health care provision, and, ultimately, all funds needed to procure sufficient levels of commodities. These efforts will be supported by the evolution of health care financing mechanisms to draw on resources from a larger tax base, as well as employer and employee contributions to insurance programs. The reforms will take place over a longer time horizon though.

In Kenya, which has one of the longest and most successful public-private partnership for family planning, government stakeholders indicated that this transition is underway, with the country beginning to finance a larger proportion of the family planning commodities it procures. Part of the transition requires the Kenyan government to mobilize sufficient revenue to independently finance the procurement of commodities for both the public and private sectors. The government is considering how it can invest in a total market approach to strengthen private markets for LARC commodities. It sees an opportunity to lower costs and ensure private providers have continued access to affordable, quality commodities from private channels. So far, purely private markets have not developed fully because private providers have enjoyed widespread access to free LARC commodities in partnership with the government, and private suppliers cannot compete on price. These same Kenyan stakeholders stated that in the future, the government is likely to focus public procurement exclusively on public facilities—another reason to build better-functioning private markets.

Scale: Most of the partnerships examined for this brief began with a proof-of-concept phase, and grew from there. Stakeholders highlighted the significant and ongoing investment of time, money, and other resources required to scale up these partnerships as a key challenge. Financial costs included paying for additional commodities, trainings, and supportive supervision visits as the number of participating providers grew. Donors generally paid the upfront training costs to launch the partnerships and support them to reach a certain scale, but they expect to reduce and eventually stop their support as countries become more self-reliant. In decentralized settings, stakeholders cited substantial investment needed to advocate for public sector support in each new locality. Even in the presence of supportive national policies, the partnerships need buy-in from local government officials since that is where commodity access and reporting happen. In Nigeria, stakeholders indicated that in each state where they expanded a public-private commodity partnership, they had to dedicate time to persuade public officials to support the partnership.

Supportive supervision: Supportive supervision is a central element of all partnerships. Governments want to ensure that the commodities they supply to private providers are delivered with acceptable quality. In most cases, though, governments lacked the capacity to consistently fulfill the supervisory obligations outlined for them under the terms of the partnership. They often conducted visits less frequently or more irregularly than what was specified. This challenge grew more acute as the partnerships scaled up to include more providers. To surmount these capacity gaps, at times donor-funded implementing partners, provider associations, and other intermediaries stepped in on behalf of the government.

Lack of urgency: Family planning programs face greater challenges in securing and retaining sufficient funds than do programs for infectious diseases such as TB and HIV. In Nigeria, Côte d'Ivoire, Tanzania, and India, stakeholders highlighted that a key motivator for government to actively seek partnerships with the private sector for TB and HIV services was to increase access more quickly by increasing the number of service delivery points. In contrast, family planning programs do not always engender the same sense of urgency from decision makers who must decide how to allocate scarce public resources. Stakeholders indicated that at the local government level, there can be a sense that while a private facility may not offer all family planning methods, it is at least likely to offer some, and that can be sufficient when government lacks the resources to make larger investments. To generate commitment and momentum for family planning, stakeholders revealed that they lobbied key government decision makers on the ability of family planning to improve maternal health and promote economic development. Such campaigns helped persuade the government to prioritize funding for family planning and create a sense of urgency to scale up access to all family planning methods.

Lessons Learned: When and How to Pursue Partnerships

It is equally important to understand when to pursue a public-private commodity partnership as it is to understand how to do so. The experiences of these partnerships highlight several lessons that governments, donors, and private providers should note when pursuing public-private partnerships to increase access to LARCs or other family planning methods through the private sector. These experiences demonstrated that:

- **Commodity partnerships are stronger when governments and private providers co-create formal terms of engagement**. Partnerships work best when the terms are clearly defined and partners understand what is expected of them. Engaging private providers or their representatives in the design of partnerships leads to terms that reflect government and private provider perspectives and needs. Early engagement can ensure that data reporting and financial terms are feasible for providers, thereby encouraging them to participate. It can also encourage government and private providers to view each other as true partners, rather than a purchaser seeking a vendor. This view helps build trust between the two sides, aligns them toward common goals, and enables the parties to identify more effective and sustainable ways to collaborate.
- **Commodity partnerships require comprehensive investments in capacity-building interventions**. Commodity partnerships are not just about the supply chain. They also require building clinical skills of providers, supportive supervisory capacity of government stewards, and enabling environments and policy frameworks for public-private partnerships, and improving collection and use of data by both sides. Gaps in these capacities should be identified and addressed to ensure that clients can be confident that the facility they choose will have a trained clinician who can deliver the method of their choice, using quality-assured products in stock.

- **Intermediaries can facilitate commodity partnerships**. A well-organized private sector can strengthen the implementation of a public-private commodity partnership, especially where government stewards lack capacity to perform all of their functions. Where strong franchises, provider networks or chains exist, such organizations can provide support to their members. For independent, non-networked providers, another intermediary organization such as a provider association, public hub site, or other alternative can step in to support providers and government counterparts, ease reporting, manage communication, and help address stockouts.
- **Demand creation supports commodity partnerships**. Demand creation helps increase community awareness of new family planning access points in the private sector. Awareness is a first step toward increasing use of services that allows providers to maintain skills acquired through training.
- **Governments and stakeholders need to understand the specific challenges they want to address and design appropriate interventions**. Commodity partnerships can address short-term gaps in the private sector for specific methods, but they are not a universally appropriate solution. Commodity partnerships can bring down costs or increase market access, when these are the barriers that providers face to offering a family planning method. When there is a viable private supply chain or sufficiently large market, they are less important. Governments and donors therefore need to understand the specific challenges they are facing and coordinate their strategies and investments to target them appropriately.
- **Partnerships need a vision for long-term sustainability**. Public-private commodity partnerships rely heavily on donor support to pay the significant upfront costs for training, commodity subsidies, and other technical assistance. As donor support winds down or refocuses, public-private partnerships can be imperiled. Donors and governments working on commodity partnerships should develop a mid- to long-term plan at the outset showing how the private sector can grow at all points along the supply chain for sustainability. Potential options include allowing providers to purchase the commodities at a discounted—but no longer free—price from the public sector, or covering the methods through social health insurance programs.


Nutriben
Nutribén
VAPORAL
Inhalador
CONTAINS 12 INHALERS
150/1
350/1 (Lucozade)
Pepsodent
SENSODYNE
Longrich
KIDS
HERBAL
SANTANA

Conclusion

Public-private commodity partnerships come with trade-offs for governments and private providers. On the one hand, they can lower costs and increase access to family planning and other essential services in the private sector. On the other, they can be costly to start, maintain, and scale up. They may unintentionally delay or disrupt the development of a more sustainable private commodity market. Policy makers and donors need to reflect on these tradeoffs and the goals of their family planning programs when deciding if a partnership makes sense, and if so, how to move forward. Key considerations are listed below.

- **The level of demand for family planning overall and for LARCs specifically**: Are there enough women demanding these products and services to warrant investment in public-private commodity partnerships? In a setting where demand is low and donor funding is insufficient to cover both demand creation and establishing a partnership, governments might prioritize building demand and strengthening public capacity to meet demand first.
- **Specific barriers limiting availability of LARCs in the private sector**: Is access to or cost of private suppliers of commodities the main challenge limiting private providers from offering LARCs—or are other barriers more pressing? If the former, governments and donors should consider whether the potential market is large enough to attract private sector investments needed to overcome these barriers without government or donor intervention.
- **Capacity of public supply chains to manage procurement and distribution**: Does the public sector have logistics and oversight capacity and sufficient supplies to serve both public and private facilities and minimize stockouts?
- **Availability of complementary investments**: Are there sufficient human and technical resources, as well as sufficient trust between public and private sectors to oversee and support the functioning of these partnerships?

By taking into account the country contexts and lessons identified in this brief, governments and donors can design better-functioning partnerships that meet the needs of providers and clients, and strengthen national family planning programs.

Photo, facing page: KC Nwakalor

Resources

Armand, F. and A. Warren. (forthcoming). *Increasing Access to Implants through the Private Sector: Lessons Learned from Tanzania*. Brief. Rockville, MD: Sustaining Health Outcomes through the Private Sector Plus Project, Abt Associates.

Bradley, S. E. K. and T. Shiras. 2020. *Sources for Family Planning in 36 Countries: Where Women Go and Why It Matters*. Brief. Rockville, MD: Sustaining Health Outcomes through the Private Sector Plus Project, Abt Associates.

Ganesan, R. and S. Callahan. 2021. *Factors Influencing the Private Sector's Contributions to Family Planning Market Growth: A Synthesis of Six Country Analyses*. Brief. Rockville, MD: Sustaining Health Outcomes through the Private Sector Plus Project, Abt Associates.

Johnson, D., K. Graff, and S. Choi. 2015. *Facility Censuses: Revealing the Potential of the Private Health Sector*. Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates Inc.

RESPOND (Responding to the Need for Family Planning through Expanded Contraceptive Choices and Program Services) Project. 2014. *LA/PM Community of Practice Technical Consultation: Expanding Choice and Access to LARCs and PMs through Social Franchising*. Washington, DC: PSI.

SHOPS (Strengthening Health Outcomes through the Private Sector) Project. 2014. *LA/PM Community of Practice Technical Consultation: Expanding and Improving Access to LARCs and PMs through the Private Sector—Meeting Report*. Bethesda, MD: Abt Associates.

Sutkowski, A., D. Glandon, Y. Madan, M. Coe, and Y. Rajkotia. 2018. *Public-Private Partnerships (PPPs): Why, What, and How for Sustainable Immunization Financing*. Washington, DC: ThinkWell.

WHO (World Health Organization). 2017. *Engagement of Private/Nongovernmental Health Providers in Immunization Service Delivery: Considerations for National Immunization Programs*. Geneva, Switzerland: WHO.

Annex. Overview of Country Partnerships

Country	Commodities	Distribution model	Partnership SLAs or MOUs*	Provider procurement and reporting	Provider prerequisites	Fees allowed?	Supervision structures	Complementary support
Kenya	All family planning products	Direct	No	Procurement requests, stock-level reports submitted to district warehouse; report use with each resupply request	Must meet all requirements to receive master facility list number (trained, meet basic qualifications, etc.)	Yes—for non-commodity costs (not specified)	Built into broader supervisory structures of the health system at the county level	
Nigeria	All family planning products	Direct	Yes—MOUs	Monthly service delivery reports and bimonthly commodity requisitions submitted to local government authorities	Complete required training on LARCs, and other clinical and data management skills Complete registration	Yes—specific fees listed for each method in MOU	Local government authorities monitored stock level and facility performance Provider associations support organizing, advocacy, oversight	Donor projects provide training, demand creation, and data reporting: assistance
Tanzania	All family planning products, antiretroviral drugs for HIV	Intermediary facility	SLAs available, not routinely used	Monthly reports, requisition requests submitted to "mother" site; mother site submits procurement request to the logistics management information system and distributes to private facility	Complete government-sponsored, government-approved training on LARCs or HIV services Have private space to deliver family planning or HIV services and to store commodities	Yes—to offset non-commodity costs "as appropriate"	Regional/county health management teams conduct supportive supervision visit 6 weeks after training (for HIV sites, usually conducted by PEPFAR implementing partner) Mother sites monitor stock and address stockouts through redistributions, referrals	Clinical trainings sponsored by SHOPS Plus Supervisory visits by PEPFAR implementing partner (HIV), SHOPS Plus (family planning and HIV), county health management teams (family planning)

* = memorandum of understanding

Country	Commodities	Distribution model	Partnership SLAs or MOUs*	Provider procurement and reporting	Provider prerequisites	Fees allowed?	Supervision structures	Complementary support
Côte d'Ivoire	HIV products, including antiretroviral drugs and test kits	Direct	Signed MOUs between provider and network; between network, project, and MOH	Use regular national antiretroviral drug tracking and reporting tools to request and receive supplies through health district pharmacies monthly	Complete government-sponsored training on antiretroviral therapy	Yes—for consultation only	District Health Teams provide regular and spot-checks to examine stock level and quality	Donor projects adapt training for private providers, organize trainings, and provide additional supportive supervision
India	TB tests and medicines	Indirect through e-Pharma platform		As needed, providers request/order commodities from government supplies, which are then delivered to clients	Complete government-sponsored training on TB clinical and reporting skills	Yes—consultation fee only	Created 2 subcommittees at the district and state levels	Engagement support and logistics costs covered by donor projects
Nigeria	TB medicines	Direct	Signed MOUs between state MOH and private facilities	Submit quarterly requisition requests and reports on current stock levels into the logistics management information system; receive 3-month supply + 2-month buffer stock	Complete required training on TB clinical skills, commodity storage and procurement	Yes—specific fee ceilings listed in MOU	Local government authorities, state TB program provide quarterly supportive supervision visits Provider associations and intermediary organization help states reach more providers at scale and use WhatsApp to identify and address stockout issues	Stock management support: SHOPS Plus

* = memorandum of understanding

Find Us SHOPSPlusProject.org

Sustaining Health Outcomes through the Private Sector (SHOPS) Plus is a five-year cooperative agreement (AID-OAA-A-15-00067) funded by the United States Agency for International Development. The project strategically engages the private sector to improve health outcomes in family planning, HIV, maternal and child health, and other health areas. Abt Associates implements SHOPS Plus in collaboration with the American College of Nurse-Midwives, Avenir Health, Broad Branch Associates, Banyan Global, Insight Health Advisors, Iris Group, Population Services International, and the William Davidson Institute at the University of Michigan.

Abt Associates Inc.
6130 Executive Boulevard
Rockville, MD 20852 USA
Tel: +1.301.347.5000