

Public Private Partnerships for Reproductive Health – What does it take to succeed?

Report of the seminar of 21st November 2018, DGD

Organized by the WG on SRHR of Be-cause Health, with the support of DGD

1. Objective of the event

Presentation of lessons learned and open discussion on the topic of partnerships between public and private sectors (including between public and civil society actors): How to assess risks and how to overcome challenges of working together in the field of Reproductive Health?

2. Background of the seminar

Private sector partnerships are high on the political agenda as Belgian and other European Government promote partnerships between the for-profit private sector and non-for-profit development actors. The ongoing revision of the law on Belgian Development Cooperation is likely going to result in a stronger involvement of the private sector in development cooperation, through public-private partnerships among other types of collaborations. The Be-Cause Health SRHR Working Group started a reflection on partnerships with the private sector in SRHR during a 2017 seminar entitled '[Reproductive health supplies: a question of availability, quality and affordability](#)'.

3. Notes

Opening – welcome note by Ignace Ronse of DGD

Ignace Ronse started off the meeting by recollecting some of the main recommendations of the 2017 seminar on reproductive health supplies, which included universal access to quality medicines, the importance of capacity building of regional and local authorities and procurement systems and the importance of preventing out-of-pocket expenditures for reproductive health. Ronse stressed that a rights-based and positive approach to sexual and reproductive health, as well as ensuring sustainable results, are paramount to the Belgian Development Cooperation. Sustainable results includes ownership, inclusiveness (and thus including the private sector), ensuring domestic resources, affordability and the prevention of dual health systems with differing quality standards.

Reproductive Health Partnership - case of Informed Push Model, Senegal, presented by Loveday Penn-Kekana – London School of Hygiene & Tropical Medicine, LSHTM.

Loveday Penn-Kekana shared the main findings of the LSHTM evaluation of Merck 4 Mothers' Informed Push Model that had been presented at the 2017 seminar by Merck (presentation accessible at: <https://www.be-causehealth.be/wp-content/uploads/2017/09/Belgium-SRHR-11-7-2017-Final-without-notes-.pdf>).

Key findings of the evaluation included that working with the private sector does not work without huge input from the public sector. Public sector officials' efforts to reach those most hard to reach helped the private actors.

In terms of results, the push model did not impact on the contraceptive use on a national level. Modern contraceptive prevalence was already increasing in Senegal, and the IPModel did not have a real effect on this. There was no higher uptake of the contraceptives, even though they had become available. What improved though was the range of different contraceptives available to women and



thus their choice of method. Instead of only 1, women would now have 8 types of contraceptives available. This was mainly appreciated and enjoyed by women of higher income quintiles, who would previously have stayed away from the health centers because they could not find their preferred method there.

Actually, the model departed from a misunderstanding, that stockouts would have been the biggest problem in Senegal. Stockouts were indeed a problem in Dakar – where a consultant had done an assessment ahead of the project – but not so much in the rest of the country. The main idea was that health workers were wasting their time on stock management, yet, this disregarded the fact that so-called ‘stockagers’ were responsible for the stock management and not the health workers themselves. There was thus a poor understanding of the needs at the onset of the intervention. The evaluation as presented by L. Penn found out for example that there were problems with the operating hours of the clinics, inhibiting women’s access to contraceptives, that there were stockouts and that consultations were not always affordable.

What became clear in the evaluation was that the initiators had wanted a simple intervention but that this turned out to be complex. The key components of the push model were to outsource the distribution of contraceptives to private partners, to have a payment in arrears and introduce electronic data systems locally.

What characterized the push model was the strong control of the private operators by Intrahealth Staff, the NGO that made up the main coordinating body and was heavily funded by the donors. The private operators did not work independently. It was thus very much a mixed system, rather than a private sector driven system. The private operators were well accepted yet their entrance was facilitated by public actors and they fell under a very tight supervision.

Because IntraHealth was concerned to meet the goals, there was a temptation to ‘overstock’, so as not to be penalized. It was also observed that health providers stopped handing out contraceptives so as to prevent stockouts. Because IntraHealth wanted to monitor closely, there were also delays in the information flows.

What were the success factors of the push model?

- The commitment of the Ministry of Health and the public health providers
- The time intensive supervision and support for private operators from public actors.

What key lessons can we derive from this case for PPPs?

- “The private sector” doesn’t exist. It is very diverse and not always active to reach those at the last mile. They often do not operate in remote places (don’t go ‘the last mile’)
- Many PPPs involve dedicated staff and NGOs who put a lot of efforts to make things work. This comes at a high cost and thus brings questions of sustainability along.
- The regulation of the private sector requires highly skilled people
- There is a lot of experience in the public health system that needs to be recognized
- Contracting and regulating private health care providers is challenging and needs financial and intellectual resources. We can wonder if as much time was invested in public sector supply chain, maybe the project would have been as successful?

- It is important to allow external evaluators as we lack research on PPPs, yet, even though the problems were known to the donors, they did not necessarily communicate about them, but continued to talk only about the 'success'.
- There is a lack of learning from previous PPPs and interventions.
- There is little research on how governments are working with the private sector.

Q&A : lessons learned on how to manage risks and overcome challenges of working in partnership of public actors and/or CSO with private (for-profit) actors

- Was it really necessary to contract out to the private sector? Maybe not, but there was no donor money for the improvement of the public sector, only for the private sector... The donor also believed that supply chains are better managed by the private sector and this is the case in many places (yet not in Senegal, it seems).
- There has been a handover of the IPModel to the Ministry of Health but that is suffering difficulties. The problem with the handover is that it didn't come with the huge financial support an NGO like IntraHealth enjoyed. The Ministry needs to do the same on the normal national budgets, which it can't. Good quality care costs money and resources and there is no 'technical fix' for this.
- The project was not cost effective, not a good business model.
- A robust evaluation was needed and should have been foreseen from the start (including possibly a "Theory of change" model).
- Hogerzeil commented: 2/3 of the projects are badly designed and 1/3 are very badly designed. We lack baseline studies and evaluations tend to be very expensive.

Reflections on potentials and challenges of public private partnerships for health, by key note speaker – prof. Hans Hogerzeil

Hans Hogerzeil shared his insights based upon 30 years of experience and his work for the WHO Action Programme of Essential Drugs specifically. He conveyed the following messages:

The industry loves to be a partner in public private 'partnerships', and particularly the pharmaceutical industry. They want to counter negative perceptions by the public. Yet there is not 'one industry' but the pharma is very diverse, as it involves the research industry, generic production, etc. For drugs development and research it is often fruitful to work in a close collaboration with the private sector, yet, when it comes e.g. to the essential drugs committee, you want to keep the private sector as far as possible from the meetings. There is a need to have clear policies around that, to prevent private interests undermining the public ones.

For development and research on medicines, collaboration with the private sector works, but at the same time a lot of research is missing and certain medicines are not being developed because business interests are lacking. E.g. vaccines and antibiotics are not very profitable. Yet, this is not a 'market failure' but a 'policy failure': you cannot expect the market to take it up but there is a need for the government to step in and for strong public health policies.

When it comes to donations, the guideline should be to give what is needed and not what you want to give. Development aid by the private sector is trade promotion, not development.

In many cases there is a conflict of interest, think of many patient groups funded by the private sector and not by the government, whereas governments should be supporting this type of CSOs, to prevent conflicts of interest.

With certain industries, such as the tobacco, food and alcohol industries, engagement should simply be banned. They seek to undermine the scientific evidence and try to influence the decision making of important bodies, like the WHO (directly and/or through the WHO donors). We should always think carefully as to what is in the public interest and what is not.

In the Netherlands health sector is private but publicly funded. This is not necessarily wrong. Supply chains are privatized in most countries but patients should get refunded and hospitals need to buy generic drugs centrally, to limit prices.

As to family planning, the fact that it is often freely available makes it difficult to find private sector actors who want to step in.

For reproductive health supplies there are big problems for instance with the quality of oral contraceptives. Not many of those pass the WHO qualification process. Yet NGOs are pushed by donor to take cheap suppliers.

We often talk about the 'last mile' but the problem is often the 'last meter' between the doctor or nurse and the patient, e.g. bad prescriptions, wrong uptakes... Contracting out is possible but the more one decentralizes the stronger the health center needs to be.

The experience is that the private sector needs huge public investments and that we lack machinery to make and reinforce good contracts with the private sector.

We shouldn't count on the private market for prevention, for universal health coverage or the quality of medicines. In health the market doesn't work. Patients cannot judge the quality of medicines the way a consumer can judge the quality of a shoe. What's more, it not about choices but about people's needs. Holistic patient centered care is not going to be delivered by the private sector.

Open exchange moderated by Brian McKenna, Reproductive Health Supplies Coalition and Thérèse Delvaux, ITM

Closing – Marlies Casier, SENSOA chair of working group on SRHR

Marlies Casier concluded the seminar by listing the most important take away messages from the presentations and the exchange:

- Private sector is 'costly': it demands huge public sector investments to be successful, as showed the IPM as well as other projects.
- There are no 'simple' interventions, the situation is always much more complex and thus the interventions need multiple and continuous adaptations (especially if they are not well designed).
- 'The private sector' doesn't exist. It is very diverse and there are different types of engagement, some fruitful, some not.
- Need to be wary of 'conflicts of interest'. Need to continuously ask the question 'what is really to the benefit of the public'? This question is hard to answer without adequate research into what works and what doesn't.

Working group on sexual and reproductive health and rights

- More independent research is needed, ahead, during and after PPP so that we know better how and who to partner with, and for what (and what not); robust evaluations are needed.
- Strong regulations by the public sector and public health authorities is needed. Belgium needs to see how it can support this work.
- In many cases we should not think of 'market failure' but 'policy failure' and thus the importance to keep on investing in health governance and (supporting) of building institutional capacity. Working bilaterally in fragile states – as Belgium is doing - makes this even more of a challenge.

