SHOPS PLUS

Stewarding the Private Sector for Family Planning

USAID
FROM THE AMERICAN PEOPLE

Summary

In many countries, public sector stewards are increasingly interested in working with the private sector to help achieve family planning goals and universal health coverage, but they often lack the skills, information, and resources to do so. This primer highlights examples of successful efforts by public stewards to engage the private health sector in the areas of policy and strategy development, regulation, and supervision. Based on these examples, the primer recommends approaches for donors, implementing partners, and governments to consider as they seek to improve public stewardship of private providers for better family planning outcomes.

Keywords: family planning, policy, private sector engagement, reproductive health, stewardship

Recommended Citation: Callahan, Sean, Nelson Gitonga, and Micah Sorum. 2019. *Stewarding the Private Sector for Family Planning*. Primer. Rockville, MD: Sustaining Health Outcomes through the Private Sector Plus Project, Abt Associates.

SHOPSPLUS
Public-private engagement for better health

January 2019

Acknowledgments

The authors thank Carolina Quijada, Bettina Brunner, and Jeanna Holtz of Abt Associates, as well as Lois Schaefer and Kuyosh Kadirov of USAID for their thoughtful guidance and review. In addition, the authors gratefully acknowledge the significant technical inputs provided by Lucy Nyaga and Ambrose Nyangao of Insight Health Advisors. Finally, the authors thank Dr. Awori Martin of the Kenyan Ministry of Health for allowing his picture to be used in this primer.

Introduction

As countries look toward 2020 and beyond, the importance of the private health sector for achieving family planning goals becomes increasingly apparent. Demographic and Health Survey data reveal that the private health sector is an important source of modern contraceptive methods. For example, private outlets currently deliver almost 48 percent of implants across Latin America and the Caribbean; 54 percent of injectable methods in Asia; and 49 percent of oral contraceptive pills in sub-Saharan Africa (SHOPS Plus, n.d.). With many looking to expand the private sector's already significant role to help achieve FP2020 goals, it is important that private sources offer a broad range of quality products and services that contribute to a growing, and more efficient and sustainable market. As stewards of the health system responsible for overseeing both public and private providers, it is the responsibility of government actors to ensure that these ends are met.

Public stewardship of health systems encompasses government policies and strategies, as well as regulatory mechanisms for ensuring guidance and accountability in which health care services are delivered in order to protect the public interest (WHO, 2007). It involves issuing policies to guide the whole health system, regulating and coordinating between actors of different functions and levels, and promoting an optimal allocation of resources and accountability systems for all stakeholders (van Olmen et al., 2010). Public stewardship helps health systems achieve family planning goals in several ways:

1) It aligns private providers with public health goals to increase access to a full range of family planning methods.

2) It addresses concerns that clients may have about the quality of care in the private sector. This clarity helps decision makers develop better policies and strategies to:

   - Build public-private partnerships for more effective and efficient family planning programs; and
   - Give the public sector greater insight into what the private sector is doing, which in turn improves targeting of government subsidies for improved equity and targeting of public service delivery and outreach to increase access among underserved populations.

Government stewards face many challenges in overseeing their health system. In many cases, they lack knowledge of where private providers are located, the nature and level of the services they

Pictured here: Dr. Awori Martin, Kenya Ministry of Health.

Photo: Jessica Scranton

provide, and specifically which family planning products and services they offer. Even when this information is available, government stewards often do not use it—either because the data are not presented in an easily digestible format or because stewards lack the skills to translate the data into actionable steps. Government stewards also may lack the systems and human resources needed to build and implement effective monitoring and supervision systems. These gaps can lead governments to design inadequate and inefficient policies, regulations, and strategies (Lagomarsino, Nachuk, and Singh Kundra, 2009). They can also prevent public stewards from effectively engaging private providers in family planning programs.

To help governments design better stewardship models for family planning, the USAID-funded Sustaining Health Outcomes through the Private Sector (SHOPS) Plus project has developed this primer. The primer focuses on three aspects of stewardship—policy and strategy development, regulations, and supervision—and presents successful country efforts in each area. It then concludes with a forward-looking discussion of key considerations for donors, implementing partners, and governments to consider as they seek to improve public stewardship of private providers for better family planning outcomes.

Government leaders in Kenya review family planning reports.

Photo: © 2012 John Kihoro/ Tupange (Jhpiego Kenya), Courtesy of Photoshare

Stewardship functions for family planning

This primer deals with three interrelated stewardship functions (Figure 1). Policies and strategies create an overarching framework for the functioning of the health system. Strategies lay out the vision and goals for what governments want to achieve while policies specify the high-level principles under which they will act. Regulations operationalize those frameworks, providing specific guidelines for what public and private actors can and cannot do. Supervision encourages actors to adhere to those regulations. While there are other tools that stewards can employ, these three functions help private providers understand how they are supposed to operate and support providers to act in those ways. The subsequent sections of this primer provide a general overview of these functions, discuss how they are adapted to address family planning concerns, and illustrate key concepts with positive country experiences.

Figure 1. Three interrelated stewardship functions

Developing family planning policies and strategies

Policies and strategies are general statements in which governments describe their vision for the health system as a whole or for specific areas of the system. Governments use them to set goals, provide a framework for their actions, and create a basis for coordination with other stakeholders including donors, implementing partners, and the private sector. Specific to family planning, these documents usually outline the government's objectives for increasing the modern contraceptive prevalence rate (CPR) and for addressing gaps in equity, access, quality, and other aspects of service delivery. They also define target populations for whom these goals are relevant and prioritize family planning strategies that can help achieve those goals. For example, Nigeria's *Family Planning Blueprint* (*Scale-Up Plan*) specifies that the government's overarching goal is to increase the overall CPR by 21 percentage points between 2014 and 2018 and outlines seven strategic priorities for achieving that increase (FMOH, 2014). It is important that governments accurately understand the full range of resources available in the health system as they develop these policies and strategies, but they have historically neglected to consider the resources of the private sector (Sharma and Dayaratna, 2005). Failure to take into account data on the private sector in policy design may lead policymakers to develop plans and ensuing guidance that do not help achieve their stated goals.

Once private sector outlets in Afghanistan, such as the one pictured here, were found to provide a significant source of contraceptive commodities, the Ministry of Public Health developed a more comprehensive strategy for engaging the private sector.

Photo: Naimat Rawan

Acknowledging the presence and role of the private sector in these strategies is an important, but incomplete step. Government strategies and policies also should define a platform and process for public-private engagement. This should include a clear framework for how and where to distribute public subsidies to support a robust private family planning market that complements government efforts. In Afghanistan, increased specificity and details in each subsequent iteration of the country's national reproductive health strategy helped the government and donors work with private providers by outlining the types of outlets to engage, the services and products to target, and the mechanisms for that engagement (see following text box).

Building strong family planning policies in Afghanistan

Starting in 2003, the government of Afghanistan developed a series of documents that included the country's first national reproductive health strategy. While an achievement in itself, the *National Reproductive Health Strategy for Afghanistan, 2003–2005,* was relatively silent on the government's view of the private sector's role. Surveys completed at that same time began to highlight the private sector as a major source of health products and services. Social marketing organizations in particular, especially the Afghan Social Marketing Organization, were found to provide a significant source of contraceptive commodities. At the same time, public sector infrastructure was in poor repair after decades of instability and the private sector was plagued by capacity gaps that lowered the quality of care. The government therefore recognized the importance of engaging and regulating these outlets. In partnership with donors, the Ministry of Public Health began a concerted effort to improve its stewardship of the sector, starting with the development of a sound policy framework. Over subsequent iterations as the government gained more experience with private providers and updated data on their role in the family planning market, the Ministry of Public Health developed a more comprehensive strategy for engaging the private sector. In the decade between the development of the *National Family Planning/ Birth Spacing Strategy, 2006–2009* and the *National Reproductive, Maternal, Newborn, Child and Adolescent Health Strategy, 2017–2021,* engagement progressed from a pilot concept with private providers to a detailed plan for integrating family planning methods into all levels of private outlets. As a result, by the end of 2017, the Ministry of Public Health had developed and disseminated minimum standard guidelines for family planning in the private sector, and had signed memoranda of understanding with approximately 40 private hospitals and clinics to deliver free short-acting methods and heavily subsidized intrauterine device and implant insertions (Anwari 2018).

It is not enough to mention the private sector in family planning policies and strategies. As in Ethiopia, the private sector should have a regular, formalized role in developing those policies and strategies (see text box on page 6). This involvement serves multiple purposes. It keeps government stewards more up-to-date on the resources available in the private sector. It creates a greater sense of ownership and willingness to participate in public health programs among private providers. It facilitates dissemination of the policies and strategies to a broader set of private sector stakeholders (Cross et al., 2017).

Including the private sector in the family planning policy framework in Ethiopia

Since the end of its socialist military period in 1991, Ethiopia's private health sector has grown to account for 40 percent of all health facilities in the country. Through efforts by the government to create a more conducive policy environment for public–private partnerships, the private sector has become an important player in addressing unmet need for family planning (MSI, 2010).

Motivated by findings from the first National Fertility and Family Survey in 1990 that revealed the nation's CPR was only 2.3 percent, the Federal Ministry of Health (FMOH) began comprehensive efforts to increase use of family planning (USAID, 2012). Between 1995 and 1998, the Ethiopian government developed its first Health Sector Development Program (HSDP) to define health policies and strategies for the country. In HSDP II, developed in the early 2000s, Ethiopia committed to family planning as a priority: creation of an enabling environment for private sector participation, coordination, and mobilization of funds was one of its four main objectives (WHO, 2018). As a result, use of modern CPR doubled between 2000 and 2005, reaching 13.9 percent. To further expand access, especially in rural areas, the FMOH adjusted its approach in HDSP III (2005—2010) to focus on strengthening government, donor, NGO, and private sector collaboration, improving the logistics management system, and enabling health extension workers to provide short-acting methods and single rod implants (USAID, 2012). HDSP III provided the framework for Ethiopia's government and NGOs to work together to expand family planning services throughout the country. In line with the policy, the FMOH revised supply chain management systems to increase the availability of contraceptives, and Parliament removed all duties and taxes on imported contraceptives; combined, these initiatives reduced costs in the private sector (Olson and Piller, 2013). These reforms helped for-profit franchises, social marketing organizations, and NGO clinics expand their roles in the family planning market.

By 2016, Ethiopia's modern CPR further increased to 35 percent, making it a family planning success story (CSA and ICF, 2016). To continue this growth, the Health Sector Transformation Plan 2015/16–2019/20 commits to include the private sector in health system planning and coordination, gather feedback from the private sector to inform planning, improve quality of health care in both public and private facilities, and invest in public–private partnership initiatives (FMOH, 2015).

Private sector involvement in policymaking can take many forms, ranging from ad hoc meetings to formalized working groups (Sharma and Dayaratna, 2005). One positive example is the experience of the contraceptive security committees in Latin America, also known as the *Disponibilidad Asegurada de Insumos Anticonceptivos* (DAIA). As part of their graduation from USAID family planning assistance, many Latin American countries created these committees with USAID support to enable governments to meet the family planning needs of their population. Membership included government, donor, implementing partner, and private sector representatives. The DAIA committees helped catalyze improvements by analyzing family planning markets, seeking to understand contraceptive needs, improving logistics systems, conducting policy analyses, and

advocating for policy changes and political commitment (USAID, 2008). In Nicaragua, the DAIA committee took a market-driven approach that emphasized private sector participation in order to fill the gaps in providing access to affordable family planning services and commodities (Drake, 2013) (see following text box).

Market-driven approaches to affordable family planning services and commodities in Nicaragua

In Nicaragua, the DAIA committee convened private and public sector actors to discuss challenges facing the family planning sector and how to increase private sector involvement. Private sector representatives reported challenges such as the lengthy process for registering new products, the sales tax applied to condoms, and marketing restrictions on commercial entities. The public sector also noted challenges, such as the perception that engagement with the commercial sector was not consistent with the national health policy. This dialogue led to the creation of joint goals for better public–private coordination and joint strategies aimed at increasing family planning use (Drake, 2013).

The DAIA committee also successfully used market data to inform decisions and planning. Using market segmentation and stakeholder analyses that identified new opportunities and key family planning players in Nicaragua, the committee gained critical insight into the private commercial market, clients' choice of providers, and information on the obstacles that the private sector faced to growing their market and responsibly serving their populations (Drake, 2013).

The Nicaraguan DAIA committee's inclusion and stewardship of the private sector helped the country navigate through a transitional period in the health system while facilitating continued access to family planning services. The public–private collaboration in the committee fostered strategies that helped the government better target the distribution of free contraceptives, shifting those who are able to pay to the private sector to purchase contraceptives with little or no government subsidy. Nicaragua successfully graduated from USAID funding in 2012, and in 2015, Nicaragua's modern CPR reached 75 percent, making the country's family planning program a shining example for the region (USAID, 2016).

Creating regulations for the family planning market

Regulations are another tool that governments can use to steward the health system. Generally, they aim to translate government policies and strategies into actionable guidelines and attempt "to control the distribution, price and quality of products and services within a market" (Caulfield and Hort, 2012). Regulations generally fall into two categories: economic and social. Economic regulations focus on promoting competitive, healthy markets, and social regulations promote the achievement of collective goals related to health, education, and other public services (Antenor and Brigit, 2016). Stewards can use both economic and social regulations to steward health systems for family planning. Generally, these regulations establish the criteria that providers must meet to enter a health market or to operate in it. Regulations focused on the former include pre- and

in-service training requirements, formalized scopes of practices for different health cadres, and licensing and accreditation regimes. Regulations focused on the latter include anti-monopoly rules, taxes and tariffs, price controls, restrictions on advertising, and quality standards.

Regulations in a mixed health system must balance the financial incentives that private providers face with the need to achieve public health goals (McPake and Hanson, 2016). Striking this balance requires recognizing that private providers must be able to generate sufficient revenue from their services to sustain their businesses. This means that regulations designed to increase access to family planning in the private sector, like price controls, can actually be counterproductive. If price controls are set too low, private providers may not be able to earn enough to cover the costs of their commodities and staff time, and therefore, decide not to offer the service. Government stewards can promote regulations that address these concerns by "specifying a role for commercial product promotion and distribution of family planning products and services; relaxing laws about advertising of pharmaceutical products including contraceptives; [and] standardizing product registration procedures" to make it less costly for private suppliers to introduce new family planning commodities (Sharma and Dayaratna, 2005). More broadly, stewards should ensure that regulations do not create artificial restrictions to family planning across the health system by imposing constraints on a client's ability to use a specific method or access a specific source for products. Jordan provides an example of how government stewards can reform their regulatory regime to align market incentives with family planning goals (see following text box).

Dr. Nawal Humoud speaks with a social worker at the Jordanian Association for Family Planning and Protection. In Jordan, successful lobbying helped ease regulations and reduce fees on contraceptives available through such private sector organizations.

Rationalizing regulations to bring down costs of private sector family planning in Jordan

During the second half of the 20th century, Jordan's country's population increased by over 800 percent due to a combination of high population growth, reduced mortality rates, and increased migration (Higher Population Council, 2015). Recognizing the stress that this rapid change placed on the country's resources, the Jordanian government has long emphasized the importance of increasing access to modern family planning methods. With donor support, the government's investments saw modern CPR among married women rise from 26.9 percent in 1990 to 41.2 percent in 2002.

Jordan's private health sector played an important role in this growth, especially the Jordanian Association for Family Planning and Protection, as well as other smaller NGOs and private clinics, hospitals, and pharmacies (Higher Population Council, 2013). During this period, the private sector's share ranged from two–thirds to three–quarters of the family planning market. Given this large role, government stakeholders grew concerned about the financial burden that women might face in accessing their preferred method from their preferred source. To bring down prices and make private family planning options more affordable, the National Population Commission successfully lobbied the Minister of Finance, Minister of Industry and Commerce, and General Director of Customs, as well as the Council of Ministers, to ease specific regulations for the family planning market. As a result of this lobbying, the Jordanian government removed all taxes, duties, and tariffs on imported contraceptive commodities, with the exception of intrauterine devices based on their categorization as a non–pharmaceutical product (Sharma and Dayaratna, 2005; Sharma et al., 2009). While intended to reduce costs, this policy revision also reshaped market incentives for the private sector: with the reduction in fees, the private sector was able to introduce newer generations of oral contraceptive pills at more affordable and cost–competitive prices than they previously would have, thereby further expanding the range of options available to women (Sharma et al., 2009).

Government stewards are also increasingly using licensure and accreditation to regulate the private health sector. Many countries are developing and expanding these mechanisms in tandem with efforts to achieve universal health coverage. For example, social health insurance programs often require private providers to be formally licensed and accredited by a government or parastatal organization before they can contract with and receive payment from the insurance programs. The goal of these regulatory mechanisms is to ensure that services delivered by contracted providers—regardless of whether they are private or public—are of sufficient quality. The evidence on the effects of accreditation is mixed though, with some studies finding positive effects on clinical quality and patient outcomes, whereas others find no effect (Montagu and Goodman, 2016). For family planning, these effects can be less evident since family planning is often excluded from health insurance benefit packages (Holtz and Sarker, 2018a). The Philippines presents an example of the opportunities and challenges posed by licensure and accreditation schemes (see text box on page 10).

Using accreditation to improve family planning quality in the Philippines

The Philippines presents an example of the opportunities and challenges posed by licensure and accreditation schemes. PhilHealth, the Filipino national health insurance scheme, has grown to cover 93 percent of the population. To serve this growing membership base, it has increased the number of private providers—primarily doctors and midwives—contracted to deliver care (PhilHealth, 2018). PhilHealth reports that approximately 60 percent of its accredited and contracted facilities were private at the end of 2017 (PhilHealth, 2018). For midwives especially, participating as an accredited provider in PhilHealth presents a significant revenue generation opportunity. Midwives report that they view PhilHealth as a stable and secure source of funding for their core set of services, including post-partum family planning, compared to out-of-pocket payments (Callahan et al., 2017). Therefore, they have a financial motivation to make any needed investments and upgrades in their facilities, clinical capacity, staffing, and equipment to comply with PhilHealth's accreditation requirements so that they can continue to access this revenue source. In this way, having requirements helps increase supply of quality family planning services in the private sector.

Some requirements for accreditation can pose challenges, however. For example, to become accredited, providers and facilities must first have a license to operate from the Department of Health. While PhilHealth and the Department of Health are both government agencies, providers note that their timelines and requirements are not optimally aligned (Holtz and Sarker, 2018b).

Increasing the quantity of regulations does not automatically lead to higher-quality family planning services. Where there are more and more complex regulatory frameworks, there are also increased opportunities for discrepancies among these rules and regulations. When such discrepancies emerge—such as those between the PhilHealth accreditation and Department of Health license to operate requirements—private providers can face additional costs, more burdensome documentation requirements, and unnecessary confusion about what they must do to comply. In extreme cases, these burdens can have negative unintended consequences. Providers may choose to forgo licensure or accreditation, or they may close their facilities altogether. While it usually makes sense for different government agencies to oversee different functions of the health system, it is incumbent upon stewards to routinely review and align their regulations to ensure harmony. This process of review and harmonization also makes it easier for government stewards themselves to effectively supervise private providers and enforce their regulations.

Supervising private providers

Supervisory systems help government stewards ensure that providers across the health system adhere to the policies and regulations they develop. Successful supervision includes disseminating information about requirements and expectations outlined in government policies and regulations to appropriate audiences, gathering accurate and up-to-date information from providers to measure adherence to those rules, and providing support to help providers course correct as needed. Government stewards responsible for supervision

can include professional councils, ministries of health, or local government authorities. As they carry out their supervisory functions, stewards can focus on two levels: the overall health system level to monitor how polices and regulations are implemented, and the individual level to make sure that providers are delivering health care with sufficient technical skill.

Successfully supervising providers from different sectors requires different approaches. Within the public sector, supervision is relatively straightforward since both supervisors and providers are employed by government agencies that often are under the purview of the ministry of health. For private providers, government stewards lack that same direct access. Also, they often lack the basic information to know who private providers are and where they are located to plan supervisory visits. Stewards therefore require different supervisory approaches that can require significantly more resources in terms of staff time, technical capacity, and data systems. They are often stymied by poorly functioning reporting structures that prevent supervisors from understanding what the private sector is doing (Lagomarsino, Nachuk, and Singh Kundra, 2009). Government agencies tasked with supervision typically focus on developing and enforcing standards that apply across a wide range of primary health services under a specific cadre's scope of practice. Outside of donor-funded programs, stewards may not have the skills or capacity to address issues that are specific to only one health area such as family planning. Effective supervision in both the public and private sectors may therefore require investing in building the capacity of supervisors to understand regulations and requirements specific to family planning. In Malaysia, the government has partnered with the private sector to build its supervisory capacity through accreditation programs (see following text box).

Partnering with a private association in Malaysia to accredit private providers

In Malaysia, government stewards employ a mixed supervision model that involves both public and private bodies. In the public sector, the Ministry of Health (MOH) employs dedicated personnel at the national and sub–national levels to supervise health care providers, enforce regulations, and promote quality (Tarantino et al., 2016). At all levels, though, the government lacks sufficient human resources to directly oversee all facilities on a regular basis. To address this gap, it has partnered with Association of Private Hospitals and the Malaysian Medical Association since 1997 to create and operate the Malaysian Society for Quality in Health (MSQH). MSQH is an independent nonprofit organization tasked with accrediting public and private health facilities. In this role, MSQH "develops standards, plans and implements accreditation programs, promotes safety and quality improvement in health care facilities" so as to relieve the MOH of some of the direct, regular supervision burden (MSQH, 2018).

MSQH uses its accreditation role to promote continuous quality improvement in both the public and private sectors. Prior to its initial review of a facility, MSQH educates the facility's staff on the requirements that it must meet and shares the assessment tools. The facility undergoes a series of self–assessments to prepare before it can request a formal review (MSQH, 2017a). While the tools used in this process do not include a family planning–specific component, they do include a

Continued on next page

more general obstetrics and gynecology one (MSQH, 2017b). During this review, MSQH confirms that the facility's staff has the necessary training, supplies, and support to deliver the services that the facility offers in accordance with MOH protocols and guidelines. Where minor infractions are found, MSQH can offer a one–year probationary period during which it follows up with the facility to address performance shortfalls. Once a facility is awarded its full accreditation, MSQH conducts routine and surprise compliance checks to encourage the facility to continue to adhere to the standards and guidelines identified by the MOH (MSQH, 2017a). Through this partnership, the MOH is able to leverage resources from the two partner associations that constitute MSQH to address its own resource gaps for effective supervision.

Where countries lack the resources or political will to make the investments required for direct supervision of the private sector, alternative models have emerged. Self-regulation occurs when private sector bodies perform the supervisory functions that government stewards would typically do (Lagomarsino, Nachuk, and Singh Kundra, 2009). In Malawi, for example, professional councils are tasked with enforcing the MOH's guidelines and protocols. Usually, these bodies are voluntary organizations that providers can join or leave at will, such as professional associations, provider networks, or federations of associations. The providers typically pay a membership fee, and in return, get access to a range of benefits that can include access to training and commodities, participation in policy dialogue, or marketing and branding support. For family planning, social franchises have been one of the most effective forms of self-regulation (Montagu and Goodman, 2016). However, self-regulation has its own challenges in addition to lacking the resources or information needed to provide effective support. If providers view the supervisory relationship as too onerous or negative, they can withdraw from the organization.

In Malawi, private providers, such as the one pictured here, must be registered with and licensed by professional councils.

Photo: Jessica Scranton

Using professional councils to regulate the private sector in Malawi

In Malawi, professional councils, including the Medical Council, the Nurses and Midwives Council, and the Pharmacy and Poisons Board, are the key regulatory bodies. These organizations are parastatals that, although tasked with enforcing the MOH's guidelines and protocols, operate and make decisions independently from it. By law, all private providers must be registered with and licensed by these councils. This requirement is intended to promote quality and oversight of the private health sector. Due to limited capacity (human resources, logistical, and budget) for direct oversight, the councils incorporate elements of self–regulation into their practices, including by distributing "checklists to facilities to monitor the infrastructure and quality of service provision" in line with Ministry and Council standards (Tarantino et al., 2016). Providers typically carry out a self–assessment, complete the checklists, and submit them to the regulatory councils with their applications for re–licensure. The councils also partner with private associations to promote registration. To maintain this status, providers must obtain yearly continuing professional development credits. The Medical Council works closely with the National Private Paramedical Practitioners Association of Malawi (NAPPPAM) to increase access to training. The council has approved NAPPPAM to offer training and other activities to its members to earn continuing professional development credits. NAPPPAM verifies the credits and reports them to the Medical Council Secretariat to assist with the registration (Gilbert Mwandira interview with authors). While these activities are not specific to family planning, NAPPPAM works closely with the PSI–Tunza and BLM social franchise networks to provide members with access to training and continuing professional development opportunities focused on family planning standards and quality. NAPPPAM also assists its members to submit monthly activity reports and engage with the Medical Council to raise issues that could affect quality of care or patient safety with the MOH.

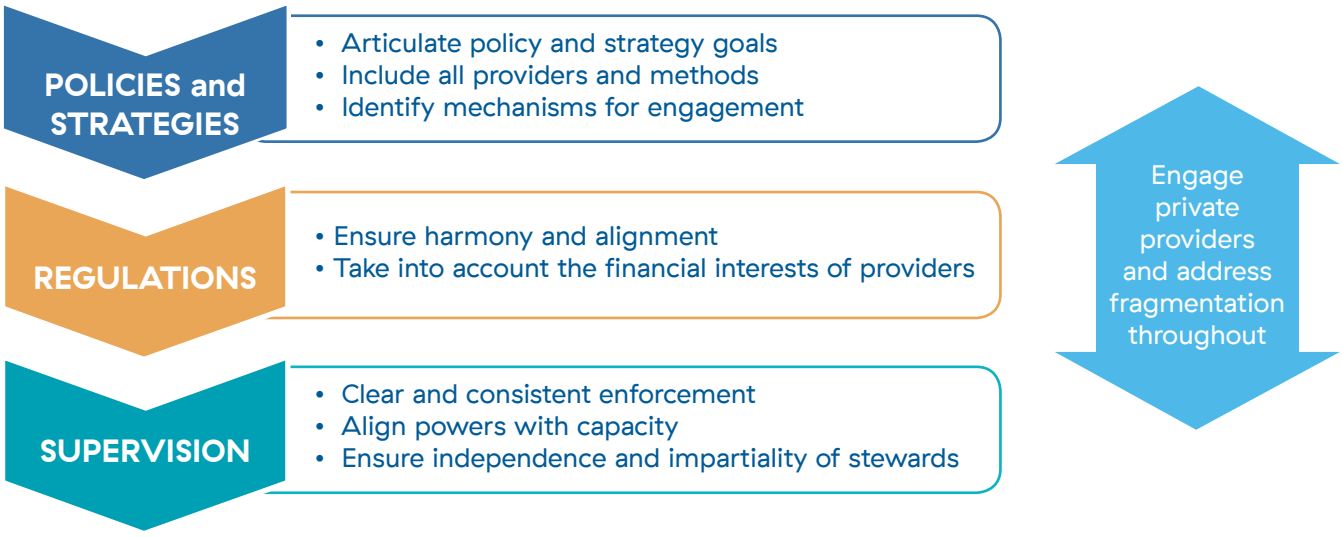
Regardless of the model—public supervision or private self-regulation—there are several best practices to consider. The supervisory body must be independent from political influences—from both the providers it is overseeing and the policymakers (Cico et al., 2016). This separation facilitates impartial adjudication of disagreements and infractions and increases providers' trust in the supervisor. To support this independence and impartiality, stakeholders should define the exact roles, responsibilities, and powers of the supervisory body (Hallo de Wolf and Toebes, 2016).

Looking forward: Improving stewardship of the private sector for family planning

To be effective stewards, governments must take a more proactive role in establishing a clear vision for how a health system will achieve family planning results (Figure 2). Private providers need to know what is expected of them and understand how those expectations will affect their business operations. To that end, government stewards should first and foremost promote a stable policy environment that is conducive to private sector involvement. This includes:

- Articulating medium- and longer-term family planning goals and objectives that include the private sector;
- Defining clearly the roles of public and private actors at all levels of the health system to deliver family planning information, products, and services;
- Developing policies and strategies that include the full range of provider types and cadres and the full range of family planning services to promote access to the full range of modern methods; and
- Identifying the regulations and institutional arrangements needed for the public and private sector to work together to achieve the stated family planning goals.

Figure 2. Recommendations for better family planning stewardship



Government stewards have to ensure a proper fit between policy objectives and the resulting regulations and supervision structures that flow down from those objectives. Policymakers and regulators should be judicious with the amount and types of regulations they develop to avoid over-burdening providers. Keeping regulatory regimes simple and straightforward will also help stewards as they review and ensure harmony among the various rules and requirements. The overall focus of countries should be to develop regulatory frameworks for family planning that ensure that the full range of high-quality modern methods are geographically and financially accessible. This view recognizes that private providers must generate revenue to sustain themselves. Therefore, attempts to mandate low prices to promote affordability for clients in the absence of other interventions can backfire, causing providers to stop offering unprofitable services. The Philippines and Jordan examples demonstrate that effective stewards can design systems that balance providers' financial interests and objectives with public health and family planning goals.

Government stewards need the right supervisory tools to promote accountability to help foster quality, fairness, and inclusivity in the health system. Private providers expect that stewards' responsibilities are commensurate with their capacity. Mismatches between the two aspects due to lack of staff, technical know-how, or other resources can cause providers to disregard stewards' attempts to engage them. Supervision strategies that incorporate private actors—such as those illustrated by Malaysia and Malawi—can help ensure that expectations match reality by tapping private sector resources to complement limited government capacity. They can also help improve relationships between regulators and providers by improving communication between the public and private sectors. As stewards set and enforce rules and sanctions, a strong line of communication and oversight will help them to do so uniformly and fairly.

Finally, public stewardship is easier with a private sector that is organized. An organized private sector can better participate in policy and strategy formulation. It can help disseminate information about regulations throughout the sector. Also, it can develop and implement self-regulation mechanisms that reach beyond the areas where stewards have formal authority. However, in many countries, private providers are heavily fragmented. They lack information about how and where to organize. As stewards seek to better use the private sector for family planning, they can help the private sector to build coalitions and partnerships. By considering all of these factors, government stewards can design and implement systems that better engage the private sector for improved family planning outcomes.

References

Antenor, H. and T. Brigit. 2016. "Assessing Private Sector Involvement in Health Care and Universal Health Coverage in Light of the Right to Health." *Health Human Rights* 18(2): 79–92.

Anwari, Z. 2018. *2018 Afghanistan FP2020 Commitment Update Questionnaire*. Kabul: Ministry of Public Health.

Callahan, S., C. Quijada, J. Holtz, I. Estevez, R. Amper, M. Reidy, P. Riley, and I. Sarker. 2017. *Philippines Private Health Sector Assessment*. Bethesda, MD: Sustaining Health Outcomes through the Private Sector Plus Project, Abt Associates Inc.

Caulfield, T. and K. Hort. 2012. *Governance and stewardship in mixed health systems in low- and middle-income countries*. Melbourne: The Nossal Institute for Global Health.

Central Statistical Agency (CSA) [Ethiopia] and ICF. 2016. *Ethiopia Demographic and Health Survey 2016: Key Indicators Report*. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF.

Cico, A., S. Nakhimovsky, L. Tarantino, K. Ambrose, L. Basu, S. Batt, R. Frescas, K. Laird, K. Mate, L. Peterson, C. Sciuto, and R. Stepka. October 2016. *Governing Quality in Health Care on the Path to Universal Health Coverage: A Review of the Literature and 25 Country Experience*s. Bethesda, MD: Health Finance and Governance Project, Abt Associates Inc.

Cross, H., O. Sayedi, L. Irani, L.C. Archer, K. Sears, and S. Sharma. 2017. "Government stewardship of the for-profit health sector in Afghanistan." *Health Policy and Planning* 32: 338–348.

Drake, J.K. 2013. *Developing Total Market Strategies for Family Planning in Nicaragua: Enhancing public-private coordination for equity and sustainability*. Seattle: PATH.

Federal Democratic Republic of Ethiopia Ministry of Health (FMOH). October 2015. *Health Sector Transformation Plan 2015/16-2019/20*. FMOH.

Federal Ministry of Health (FMOH). 2014. *Nigeria Family Planning Blueprint* (Scale-Up Plan).

Hallo De Wolf, A. and B. Toebes. 2016. "Assessing Private Sector Involvement in Health Care and Universal Health Coverage in Light of the Right to Health." *Health and Human Rights* 18(2): 79–92.

Higher Population Council. 2013. *National Reproductive Health/Family Planning Strategy, 2013-2017*.

Higher Population Council. 2015. *Jordan Agenda Setting for Sexual and Reproductive Health and Rights Knowledge Platform*.

Holtz, J. and I. Sarker. 2018a. *Integrating Family Planning into Universal Health Coverage Efforts*. Brief. Bethesda, MD: Sustaining Health Outcomes through the Private Sector Plus Project, Abt Associates.

————. 2018b. *Opening the door to health insurance programs: Experiences of small and medium private providers*. Brief. Bethesda, MD: Sustaining Health Outcomes through the Private Sector Plus Project, Abt Associates.

Lagomarsino, G., S. Nachuk, and S. Kundra. 2009. *Public stewardship of private providers in mixed health systems: Synthesis report from the Rockefeller Foundation-sponsored initiative on the role of the private sector in health systems*. Washington, DC: Results for Development Institute.

Malaysian Society for Quality in Health (MSQH). 2017a. *Process Guide*. www.msqh.com.my/home/process-guide. Accessed 30 August 2018.

————. 2017b. *5th Edition Hospital Accreditation Standards*, 2017. Kuala Lumpur: MSQH.

————. 2018. MSQH – Who are we? www.msqh.com.my/home/msqh-who-are-we-3. Accessed 29 August 2018.

Marie Stopes International (MSI). January 2010. *MSI Clinical Social Franchising Case Studies Series: BlueStar Healthcare Network Marie Stopes International Ethiopia*. Nairobi, Kenya.

McPake, B. and K. Hanson. 2016. "Managing the public-private mix to achieve universal health coverage." *The Lancet* 388(10044, Aug 6):622-30. doi: 10.1016/S0140-6736(16)00344-5.

Montagu, D. and C. Goodman. 2016. "Prohibit, constrain, encourage, or purchase: how should we engage with the private health care sector?" *The Lancet* 388(10044): 613-621.

Olson, D.J. and A. Piller. 2013. Ethiopia: an emerging family planning success story. *Studies in Family Planning* 44(4): 445-459.

PhilHealth. 2018. *Annual Report 2018*.

Sharma, S. and V. Dayaratna. 2005. Creating conditions for greater private sector participation in achieving contraceptive security. *Health Policy*. 71: 347-357.

Sharma, S., T. Pandit-Rajani, R. Sanders, A. Krishna, and I. Almasarweh. 2009. *A Trend Analysis of the Family Planning Market in Jordan: Informing Policy and Program Planning*. Amman: Futures Group International, Health Policy Initiative, Task Order 1.

SHOPS Plus. n.d. "Private Sector Counts – Family Planning." Private Sector Counts. Accessed August 14, 2018. https://www.privatesectorcounts.org/.

Tarantino L., K. Laird, A. Ottosson, R. Frescas, K. Mate, V. Addo-Cobbiah, C. Bannerman, P. Pacheco, D. Burssa, A. Likaka, M. Rahimzai, M.R. Massoud, and S. Syed. 2016. *Institutional Roles and Relationships Governing the Quality of Health Care: Country Experiences, Challenges, and Lessons Learned*. Bethesda, MD: Health Finance and Governance Project, Abt Associates, and USAID Applying Science to Strengthen and Improve Systems Project, University Research Co., LLC.

USAID. 2012. *Three Successful Sub-Saharan Africa Family Planning Programs: Lessons for Meeting the MDGs*. Washington DC.

USAID. October 2008. *Safeguarding Contraceptive Security in Latin America and the Caribbean*. https://www.k4health.org/sites/default/files/contraceptivesecurityLAC.pdf.

USAID. May 2016. *Issue Brief: USAID's Partnership with Nicaragua Advances Family Planning*. https://www.usaid.gov/sites/default/files/documents/1864/nicaragua-508.pdf.

van Olmen, J., B. Criel, W. Van Damme, B. Marchal, S. Van Belle, M. Van Dormael, T. Hoeree, M. Pirard, and G. Kegels. 2010. *Analysing Health Systems to Make Them Stronger*. Antwerp ITG Press.

World Health Organization (WHO). 2007. *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes. WHO's framework for action*. Geneva: WHO.

————. 2018. Ethiopia. http://www.who.int/countries/eth/coop_strategy/en/index1.html. Accessed August 20, 2018.

SHOPSPLUS
Public-private engagement for better health

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 (USAID). 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 William Davidson Institute at the University of Michigan.

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