



# **Technical Brief**

## Private Sector Engagement in Service Delivery

**Allocation Period 2023-2025**

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# Introduction

## Objective

The purpose of this document is to provide guidance which will support countries in improving the effectiveness of their engagement with the private sector and non-state actors with respect to service delivery.

Private sector engagement will be key to maximizing the impact of programs to fight AIDS, tuberculosis (TB), malaria and to building resilient and sustainable systems for health (RSSH). This technical brief details key interventions and activities that can be carried out by private sector organizations and can be included in funding requests and Global Fund grants.

## Audience

This technical brief is for country-level stakeholders, whether involved in developing funding requests or in implementing grant activities<sup>1</sup>.

## Content

This document sets out key concepts and opportunities and suggests other useful resources, as follows:

1. Key concepts and definitions related to private sector engagement (PSE).
2. Key interventions of engagement and the practical frameworks to support countries in the design of engagement programs.
3. Good examples of PSE that countries can adapt to their context.

Additionally, there are practical guides on how to include PSE in the grant, the budget, and in reports with links to other Global Fund documents (such as the HIV, TB, malaria and RSSH information notes and the Modular Framework). A list of useful resources and reference materials is also available [here](#).

## Definitions

The Global Fund adapts the WHO definition of “private sector”<sup>2</sup> and considers that the private sector can be classified as both for-profit and not-for-profit, formal and informal, domestic and international. In this document the terms “private sector” and “non-state actors” are used interchangeably.

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<sup>1</sup> Stakeholders can be considered to include representatives of private sector organizations, government departments, consultants, technical partners, technical assistance providers and community and civil society advocates as well as relevant decision-making bodies such as Country Coordinating Mechanisms (CCMs).

<sup>2</sup> the individuals and organizations that are neither owned nor directly controlled by governments and are involved in health services.

## Background

The private sector accounts for more than half of all health care delivered worldwide.<sup>3</sup> WHO's Private Sector Utilization report (2019) analyzed 65 countries over the period 2010 to 2019 and found that the private sector provides nearly 57 percent of outpatient and inpatient services in Southeast Asia, 62 percent in the Eastern Mediterranean, and nearly 40 percent in Latin America and the Caribbean, Africa and the Western Pacific. A similar picture emerges for the three diseases, albeit less pronounced for HIV. Assessments show that 75 percent of TB patients in high-prevalence countries initially seek care in the private sector, and that in some countries 54 percent of all anti-TB drugs are prescribed by private sources (WHO 2018a). Strategic engagement with the private sector by the public sector and donors can help to better align and coordinate efforts within and across fragmented health systems and ensure effective management of the three diseases.

Private sector health care providers will include, in addition to large, privately owned clinics and hospitals, small, widely dispersed or unregulated health providers such as pharmacies, drug shops, private clinics, and community-based organizations. In many countries, these are the first and sometimes only source of health care for many - especially poor and vulnerable populations, whether urban or rural. Successfully addressing the three diseases and building resilient health systems will require a large-scale shift from siloed interventions to more integrated, people-centered models of prevention, treatment and care so that individuals' holistic health needs are met. This calls for reaching people through their preferred service providers. In many countries these preferred service providers will be private sector facilities. A holistic health system view which incorporates both public and private service providers is necessary to ensure quality of care and financial protection for all irrespective of where people seek care.

The private sector in health is engaged in a broad range of activities across the health system and governments can harness the potential of the private sector by:

1. identifying shared interests, respective capabilities, and experiences;
2. bringing innovation, technology, research and development, industry expertise, and/or entrepreneurial skills to achieve desired outcomes;
3. mobilizing private-sector resources and action, including philanthropy and corporate social responsibility (CSR) assets, to address a specific issue and/or objective;
4. building the capacities of government institutions;
5. training and developing the health workforce;
6. reaching more people by expanding service delivery; and
7. improving quality of care and management through outsourcing many auxiliary functions.

Ministries of health are strongly encouraged to steward the whole health sector (both public and private) to ensure quality of care and financial protection for all irrespective of where people seek care.

<sup>3</sup> Montagu, D., & Chakraborty, N. (2021). Standard Survey Data: Insights Into Private Sector Utilization. *Frontiers in Medicine*, 8, 624285.

# 1. Problem statement

This section discusses some of the issues faced by programs for the three diseases and efforts to build RSSH that can be addressed by effective engagement with the private sector:

## A. Tuberculosis Programs

. Most national tuberculosis programs seek to expand capacity by engaging with the private sector to ensure people have access to high-quality, affordable services. Innovative approaches such as contracting, result-based payments and the use of intermediary agencies have been shown to enhance the effectiveness and efficiency of the system.

Gender, poverty and social isolation are among the key factors leading to inequalities in risk with regards to developing TB, accessing TB services, and getting desired outcomes from care. Stigma and human rights violations intensify this inequality by influencing the care-seeking behaviors of those affected. This means that it is important for people to have affordable access to quality TB services wherever they seek care, whether it is in the public sector or in the private sector, including in smaller, fragmented and poorly resourced PS outlets.

Despite some success, as seen in the increasing number of people diagnosed and treated for TB each year, the number of people with TB that are never diagnosed or treated (and reported) remains high.

Private clinics or hospitals are often the first point of contact in these cases, so it is essential that these providers to be engaged in appropriate treatment provision and reporting in order to reduce the number of people left undiagnosed and untreated. Equally important is for national TB programs to collect, analyze and use the data collected from and through private sector health care providers.

## B. Malaria Programs

Providers of health care services in the private sector who are the first point of contact with people impacted by malaria are often in the informal sector, including unlicensed drug shops, with limited monitoring of the quality of the medicines dispensed, very low levels of diagnostic confirmation, and limited adherence with national guidelines. They may not have received the latest training, or have been educated by uncertified providers. Countries are encouraged to ensure these private providers (drug shops, pharmacies, or private practices) are providing quality diagnostic and treatment services for patients with malaria aligned with national policies and guidance, including quality medicines and that they are equipped to provide quality data.

Another common challenge of malaria programs is prevention programs such as the distribution of long-lasting insecticidal nets (LLINs). This is another area where governments can, through effective engagement, harness the power of the private sector – particularly in terms of supply chain management – to achieve national program goals.

## C. HIV Programs

To close coverage gaps in HIV prevention, testing and treatment, people who need services and commodities must have access where and when they are needed. Services should be provided from a range of service delivery platforms, including public and private sector facility-based platforms as well as through community-based and community-led service delivery, differentiated to address the needs and preferences of relevant subpopulations.

The private sector has capabilities, infrastructure, convenience, and funding that can be harnessed to catalyze new delivery models and drive system efficiencies. Countries can expand access to HIV services through private sector outlets to address the following gaps:

- reaching populations who are marginalized from mainstream health services or criminalized by laws that prohibit sex between men, personal drug use and commercial sex;
- expanding HIV community- and home-based testing, including self-testing;
- alleviating pressure on public facilities in providing HIV services;
- effective HIV testing and patient follow-up, including HIV case management and adherence counseling for patients within their communities;
- integrating HIV-related data and reporting from private sector actors enables a national program to better understand the service landscape and service coverage, which in turn enables more effective targeting of resources and interventions.

Leveraging the private sector's capacity for HIV service delivery requires input from policymakers, ministries of health, donors, civil society, and private providers. While there are many existing examples of effective expansion of services through private sector actors, these need to be expanded in order to meet current and future needs for service coverage. Broadening these approaches will promote greater choice for people and improve sustainability, aligned to national policies and guidelines.

## D. Resilient and Sustainable Systems for Health

The core objective of a RSSH is increased equitable access and utilization of integrated, people-centered, quality services without experiencing financial hardship. Almost all countries have mixed health systems, where health services are provided by a mix of public and private service providers. Ministries of health need to improve their capacity to steward and engage with the private sector to ensure affordable access to quality health care services and products.

As part of this, many countries are working to enhance the efficiency and effectiveness through better models of public-private engagement. These include innovative approaches such as public-private partnerships, strategic purchasing, and output-based contracting (see Table 1). Areas of where private sector engagement has to potential contribute substantially to national health outcomes include:

- 1) **Data:** Strengthening the generation and use of quality, timely, transparent, and disaggregated digital and secure data at all levels, aligned with human rights principles.
- 2) **Human Resources for Health (HRH):** Partnerships are being implemented with private training institutes to improve health workers' pre-service education and implement continuous professional development and digital platforms for blended learning. However, most efforts are small scale and scaling-up has proven difficult.
- 3) **Supply chains and laboratory systems:** Improving the end-to-end management of national health products and laboratory services requires strengthening the ecosystem of quality supply chain management and needs effective engagement with the private sector. It can also include outsourcing of services such as diagnostics, waste management and sample transportation.
- 4) **Quality of care:** Health care in the private sector is often assumed to be of higher quality, but the evidence doesn't support this, at least in the field of maternal and newborn health.<sup>4</sup> Engaging with private sector providers to apply lessons learned from the public sector can help drive improvement in health outcomes by aligning with national guidelines and policies, provides a quality service including with GMP standard commodities, and reports data to the MOH.
- 5) **Transition situations:** To ensure transition from relying on the Global Fund support toward self-reliant health systems governments require to have the necessary capacities, policies, procedures and facilities in place to engage with the private sector through systematic approaches, such as social contracting, inclusion in health insurance mechanisms and better regulation and monitoring.

#### **PSE activities that can be included in the Global Fund's funding request and link with the Modular Framework:**

Activities related to engaging private sector entities in service provision and other health sector functions through applying market approaches and innovations, such as:

- Creating an enabling environment to encourage the private sector to use market-based approaches to promote use of health products and services.
- Assessment of government capacity to effectively engage with the private sector.
- Removing legal or policy barriers to effective engagement with the private sector.
- Development of planning, regulations and guidelines to enhance private sector health service provision.
- Coordination with the private sector in relevant policy discussions, strategy formulation or implementation.
- Creating an enabling environment for private sector to expand their reach to more people through franchising, networking and other innovations.
- Technical assistance and institutional capacity building for systematic engagement with the private sector (policy dialogue, information exchange, regulation and financing).

Activities with a focus on a specific disease or component could be budgeted under the specific disease or component, while any technical assistance (TA) need can be budgeted according to [RSSH Modular Framework](#), under the **Module** - RSSH: Health sector planning and governance for integrated people-centered services, and within the **Intervention** on supporting private sector engagement.

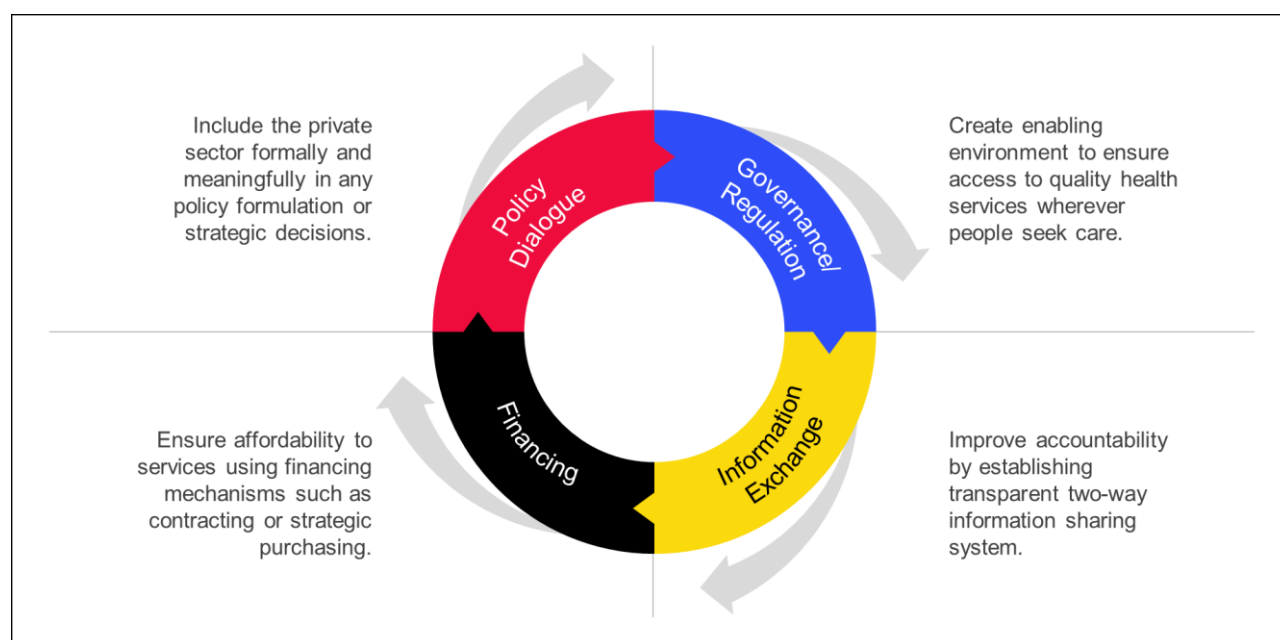
<sup>4</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3378609/>; <https://pubmed.ncbi.nlm.nih.gov/27358250/>



## 2. Systematic engagement with private sector

Global Fund grants can be used to support efforts by governments, PRs and sub-recipients (SRs) to engage with non-state actors using a systematic approach based on four engagement pathways that harness the potential of the non-public sector in a more effective and efficient manner. The following diagram summarizes this systematic approach which is more effective, efficient and sustainable.

**Figure 1: Systematic engagement with private sector**



Each of the four engagement pathways includes several interventions in which engagement with the private sector can be advanced. Countries can select which pathway and which intervention to use according to the country context and country needs. It is recommended, however, that countries adopt a holistic approach, looking at all the engagement pathways and adjusting them to address their public health issues.

**Table 1: Private Sector Engagement Pathways and Interventions**

Pathways	Interventions	Description
<b>Policy &amp; Dialogue</b>	Policy	Include the private sector formally and meaningfully in any policy formulation, change or implementation. This can include professional associations representing private providers and large private networks.



<b>Pathways</b>	<b>Interventions</b>	<b>Description</b>
	Strategic decisions	Developing national private sector engagement strategic plan.  Include the private sector in strategic decision-making on important health issues at national and sub-national level dialogues.
<b>Governance (Regulation)</b>	Licensing	Review licensing requirements to ensure fair and standardized protocols to regulate entry of private sector entities to the market and inspect those criteria during their activity (this may include pricing).
	Certification	Certify health care providers based on meeting some required standards and competencies
	Accreditation	Enable third-party accreditation bodies to apply approved standards and oversight mechanisms, which ensure quality of services/products are delivered continuously at private sector facilities.
	Monitoring and oversight	Increase oversight and monitoring of private sector services through supervision and on-the-job training to ensure quality of service/product as per set standards.
	Networking/ franchising	Support and engage smaller or dispersed private sector outlets to create an enabling environment for the private sector to expand their reach through networks and franchisees.
	Social Marketing	Facilitate the private sector to use market approaches such as branding to promote use of health products and services.
<b>Exchanging Information</b>	Outflow of information to the private sector	Include the private sector in information flows. This can include technical capacity building through training or secondment, and sharing updated guidelines through accessible means (e.g., digital platforms).
	Private sector as part of health management information systems (HMIS)	Establish transparent mechanisms to receive information from private sector activity and achievements.
	Private sector as disease surveillance system	Include the private sector in the national integrated diseases surveillance and response (IDSR) system, especially for health emergencies of international concerns.
<b>Financing</b>	Incentives	Provide financial incentives and subsidies to private sector entities, including the provision of land, electricity, tax reductions etc. to reduce cost of service provision, especially in distant and under-served areas.
	Contracting	Reduce barriers for engagement with the private sector through standardized, accessible contract agreements

<b>Pathways</b>	<b>Interventions</b>	<b>Description</b>
		applicable to service delivery, case finding, distribution of supplies etc.
	Outsourcing	Enable parts of public health services to be outsourced to external contractors who assume responsibility for managing one or more of a health care organization's business, clinical, or hospitality services.
	Public Private Partnership (PPP)	Provide improved access for the private sector through formal structures in ministries of health for PPP <sup>5</sup> and expand access for health services.
	Strategic Purchasing	Enable strategic purchasing mechanisms which provide arrangements where the government (or an institution on behalf of the government) purchases particular health services from the private sector, for example through a health insurance scheme.
	Market shaping	influence the market to ensure availability of quality and affordable health services and products by providing financial opportunities.

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<sup>5</sup> PPP for health is an approach to address public health problems through the combined efforts of public, private, and development organizations. Each partner contributes to its area of special competence, bringing in expertise (or resources). Partners in a PPP rally around a common cause, while at the same time pursuing their own organizational objectives.

## 2.1 Policy dialogue

Policy dialogue can be conducted at any level of the health system where a problem is perceived and a decision, policy, plan or action needs to be made. Examples include:

- At the outcome level (e.g., low coverage or low quality of services).
- At the output level (e.g., low number of health facilities for a specific category of population, or low health workforce deployment in a geographical area).
- At the process level (e.g., lack of policies/procedures on placing of publicly procured GeneXpert devices in private facilities, or engaging with private pharmacies in rural areas to provide quality diagnostic or treatment services to patients with HIV, TB or malaria).

Non-state actors can provide valuable inputs to develop, revise or improve implementation of policies regarding any of these health problems.

To engage the private sector in policy dialogue and strategic decisions, countries are encouraged to shift their mindset and involve the private sector as a co-investor/thought partner for health systems<sup>6</sup> at the government level. The government and the private sector should work together to put the people who use the health care at the core of their work, which aligns with the objectives laid out in the Global Fund Strategy (2023-2028). Once the private sector is effectively engaged and is working with the government towards the same goal, a meaningful and impactful dialogue can begin, which considers the following:

1. **Balanced representation:** The private sector is heterogenous, comprising several sub-sectors including for profit hospitals and clinics, non-government organizations (NGOs) including community-based organizations (CBOs), faith-based organizations (FBOs); private pharmacies; informal, unlicensed drug sellers and many others. The private sector also includes a wide range of actors that may be well resourced with good capacity, and adhere to regulatory standards and reporting, or smaller, under-resourced providers of varying quality. It should be noted that having a representation of all stakeholders may not be possible, especially of those fragmented, lower-level providers. To ensure proper inclusion of appropriate sub-sectors of the private sector, it is important to ensure:
  - a. Those relevant to the issue at stake are represented.
  - b. The selected representatives accurately represent their sub-sector<sup>7</sup>.
  - c. The number of representatives is balanced between public and private sectors.

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<sup>6</sup> Towards better engagement of the private sector in health service delivery: a review of approaches to private sector engagement in Africa. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO.

<sup>7</sup> For example, these representatives may be selected or elected by their fellow members, have the authority to speak on behalf of their sub-sector and have the proper communication with their fellow members. To achieve this point, some preparatory activities may be necessary to work with the private sector to organize them and make them ready for a policy dialogue.

d. Where possible, meetings can be accessed virtually for inclusion and convenience of more stakeholders.

2. **Decision making:** Policy dialogue is not just for information sharing, but a process in which decisions must be made. The crucial point is to make the decision-making method clear from the beginning. A few examples of decision-making methods include:

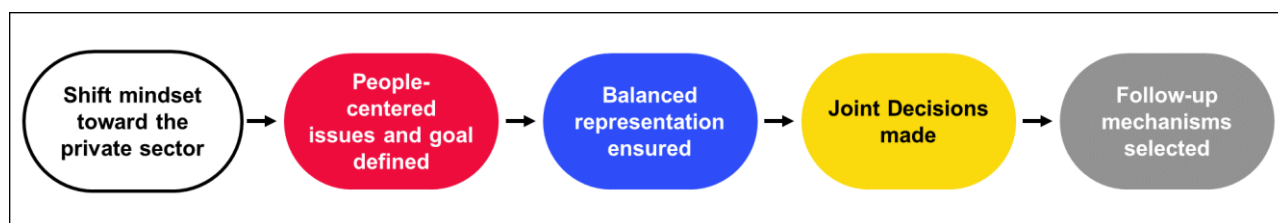
- Consultative: the participants provide their inputs, but the chair will make the final decision based on the evidence and justifications provided.
- Consensus-based: all participants agree to a common decision or decision by vote, in which the majority votes will be counted as the final decision.

Additionally, all limitations on the decision-making must be clearly communicated at the beginning. This may include lack of robust data and evidence, political environment, and donors' conditions that could have some implications. It is also important to note that decisions may take a longer time to reach and may require several meetings over a period and further consultations with relevant stakeholders. Another critical issue is managing conflicts of interests in light of the overall goal of the policy dialogue and the fact that the primary beneficiaries are the consumers (patients and communities), not the government or the private sector (those sitting around the table).

3. **Follow-up:** Once a decision is made to the satisfaction of the participants, a mechanism for follow up and implementation should be agreed upon. A mechanism can be established, or an existing coordination mechanism can be selected to follow up progress on the issue. Those responsible for execution of the decision must report back on the progress and update the parties through this coordination mechanism.

The policy dialogue with the private sector can be summarized in the following diagram:

**Figure 2: A framework for private sector engagement in policy dialogue**



## 2.2 Governance and regulations

It is critical to ensure the entire health sector, both public and private, are governed to ensure people access to quality and affordable health services wherever they seek care. Regulation

entails a “spectrum of rules, procedures, laws, decrees, codes of conduct, and standards” that guide a health system.<sup>8</sup> The purpose of regulation in the health industry is to ensure the minimum level of quality health care services and products is provided to the population and to avoid harmful practices or products. There are debates about the role of regulation in improving people’s access to quality health care and products and about the dangers of over/under regulation. However, experience shows that regulation can work best when combined with at least one other engagement pathway. The Global Fund will support this holistic or systematic approach for engaging with private sector works through country grants.

There are many forms of regulation in different countries, such as licencing for entities (regulating market entry for new entities), licensing related to different health workforce elements and the range of services each can provide, licensing on drugs and medical supplies (for example anti-TB drugs, or HIV and malaria tests), accreditation (regulating the quality of care), pricing (regulating the maximum price for health care products and services, as well as aligning incentives with the required behavioral change). Regulations also guide marketing approaches in health care (e.g., social marketing and social franchising). Accreditation and social franchising approaches are described in [Annex 1](#).

## 2.3 Information Exchange

Another pathway that governments use to engage with the private sector is the exchange of information. Governments want private sector entities to transparently provide data on their services, while the private sector wants the government to share updated guidelines, policies, strategies and other information relevant to their work and feedback on their reporting. However, the process does not always work perfectly.

Additionally, private sector providers, along with their patient populations, may benefit from access to training and continuing education opportunities or the ability to access free or reduced-cost essential medicines that are typically reserved for public sector practitioners, to increase distribution of these essential commodities to the public.

Countries are encouraged to strengthen a two-way information sharing mechanism with the private sector by: **(1)** using a holistic approach and **(2)** considering practical steps and frameworks.

1. **Governance:** Government behaviors regarding use of data (policies, rules, and regulations) can influence information exchange. It is important to address the following:
  - a. What incentives are linked with the reporting? (e.g., a precondition for accreditation, licensing, contracting, or purchasing services)
  - b. What barriers are linked with the reporting? (e.g., taxation, inappropriate use, or dissemination of data unfairly to competitors)

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<sup>8</sup> Private Sector Landscape in Mixed Health Systems. Geneva: World Health Organization; 2020. Licence: CC BY-NC-SA 3.0 IGO

- c. Are there regulations on mandatory reporting of notifiable diseases? (Examples vary across countries but may include HIV, TB, and malaria data points, as well as information on other infectious diseases, including emerging pathogens. Some countries have developed and implemented such regulations and have involved private sector actors in their development to improve the impact of disease programs.)

## **2. System readiness**

- a. Does the government have the systems, processes, procedures and resources to collect, analyze, use and manage data? (e.g., the HMIS unit is equipped with tools and resources, enough capacity and human resources, clear standard operating procedures and guidelines. A readiness assessment of private sector data integration is encouraged to facilitate adequate planning.)
- b. Do the private sector actors have the resources (human resource, time, capacity, and guidelines) to register, collect, compile and report on health services being provided? (e.g., many small private sector players such as pharmacies, laboratories or private practices are run by one or two people. This makes it challenging for them to engage in lengthy training sessions or adhere to onerous reporting requirements. At the same time, there are unregistered actors with unlicensed workers operating in the country. To address this, countries could encourage networks of providers (such as pharmacies, clinics, hospitals, franchisors, etc) to either develop simple mobile-based reporting tools or hire an intermediate entity to collect, compile and report.
- c. How is the quality of data ensured? (e.g., hiring a third-party verifier or incentivizing accurate data may raise concerns where the accuracy of data may be compromised due to incentives that are linked with over or under-reporting. Countries are encouraged to extend all data quality-related activities from the public sector to the private sector.)
- d. How is confidentiality of patients protected? (e.g., many patients, especially people living with HIV or TB, prefer to use private sector services because they believe their privacy is protected. The data management system must consider this fact and support confidentiality of patient's records.)

## **3. Implementation**

- a. How frequently is data collected? (e.g., a weekly reporting system may be required for immediately notifiable cases, such as cases involving potential public health emergencies. Monthly or quarterly reporting may be needed, according to national guidelines. These timelines should be aligned with those of public sector reporting, to the extent possible.)
- b. Is there sufficient capacity and resources available? (e.g., reporting software, forms and formats, digital tools and guidelines can be provided with continuous capacity building through on-the-job training. Countries are encouraged to consider the limited capacity of many small private providers and adjust the

reporting templates or alternatively hire an intermediary organization to provide continuous support.)

#### **4. Feedback**

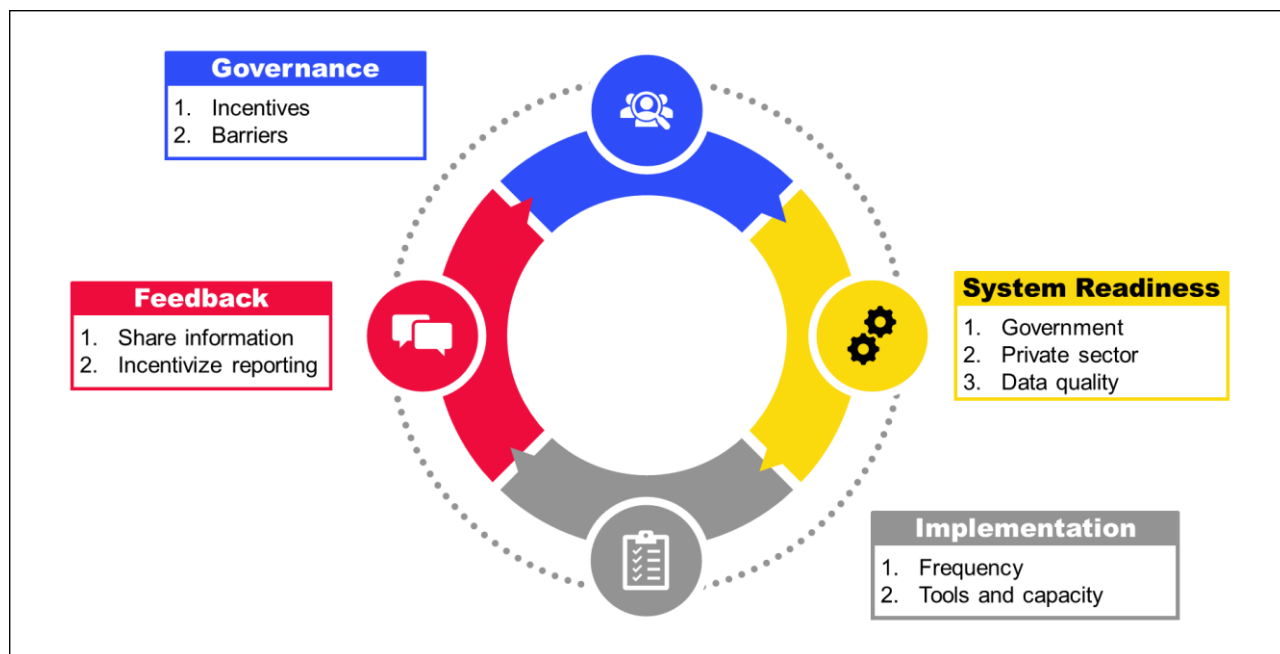
- a. Does a feedback mechanism and regular information sharing method exist? (e.g., the private sector needs to access relevant information through widely available channels such as regular newsletters, web-based reports, media updates, and mobile apps. Countries are encouraged to improve data use for decision-making at all levels of the private health sector, and in an integrated fashion.)
- b. How to incentivize reporting? (e.g., linking proper reporting to other engagement pathways such as financing and regulation, as it sustains the integration of private sector reporting into national systems.)

In summary, the main milestones of integrating data from private sector into the national information system may include:

- Setting up an enabling environment through appropriate policies, regulation and dialogue and developing a road map for integration.
- Providing evidence through a situational analysis to support planning and implementation of data integration, including the development and/or updating of a Master Facility List that includes private sector providers, and engaging private health facilities into the process (including with the support of incentives for that).
- Setting up a reporting system that includes the full spectrum of private health facilities, designing and/ or adjusting adequate tools and procedures for the private sector, configuring the reporting system on their end, and potentially providing access to national data platforms to private health providers' users for direct reporting, provide the necessary training and continuous support.
- Monitoring the reporting system in place through regular reviews and feedback to users, public and private, including the private sector into data analysis & validation mechanisms to ensure data quality and use.



**Figure 3: Framework on integrating the private sector in a national reporting system**



## 2.4 Financing

Financing is one of the most important pathways for government engagement with the private sector. There are several interventions and interventions around financing that governments can use, but this document addresses performance-based contracting. Approaches using public-private partnership and strategic purchasing are detailed in the annex.

### 2.4.1 Performance-based contracts (activity-based contracts)

Performance-based contract or activity-based contract (ABC) is a contracting arrangement where suppliers or service providers agree to deliver specific output(s) within an agreed time and price, with less focus on processes or inputs to be deployed to achieve the desired output.<sup>9</sup>

Performance-based contract must fulfil the following criteria:

#### 2.4.1.1 Appropriate Justification:

The project design or operation manual must provide theory of change, taking into consideration programmatic, sustainability, value for money, fiduciary perspective, and risk management perspectives.

#### 2.4.1.2 Appropriate Outputs:

The outputs must be pre-defined, relevant to programmatic objectives, measurable, verifiable and a credible link between the funds and criteria must be articulated. The evidence each output generates must be explicitly defined in the contractual vehicle, as it comprises a portion of the fund eligibility criteria and constitutes audit evidence of adequate basis for payment.

#### 2.4.1.3 Appropriate Price and Payment Terms

The price paid for the outputs must be credibly justified and demonstrate due consideration for value for money – economy, efficiency, and effectiveness. The amount paid per output may be established using any credibly justified and documented method of pricing, including - but not limited to - inputs-based budgeting, activity-based costing, policy decisions.

The payment terms (or reconciliation terms in the case of advances) explicitly articulate the relationship between level of performance against pre-defined outputs and payment decision, how verification results impact final payment calculation, and consequences for under-performance or over-reporting.

#### 2.4.1.4 Appropriate Implementers and Verifiers:

The entities selected to deliver or verify results, under performance-based contracts modality must be assessed (e.g., via a capacity assessment or procurement process) on their ability to deliver the outputs at desired quality and on time.

#### 2.4.1.5 Appropriate Controls & Verification of Outputs:

Payments must be based on an adequately relevant, reliable, and sufficient control model for output verification. The contracting vehicle must explicitly articulate how the results of

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<sup>9</sup> Guidelines for Grants Budgeting, December 2019, the Global Fund, Geneva, Switzerland

the verification will impact payment decisions (or other consequences, such as penalties, step-in-rights, etc.)

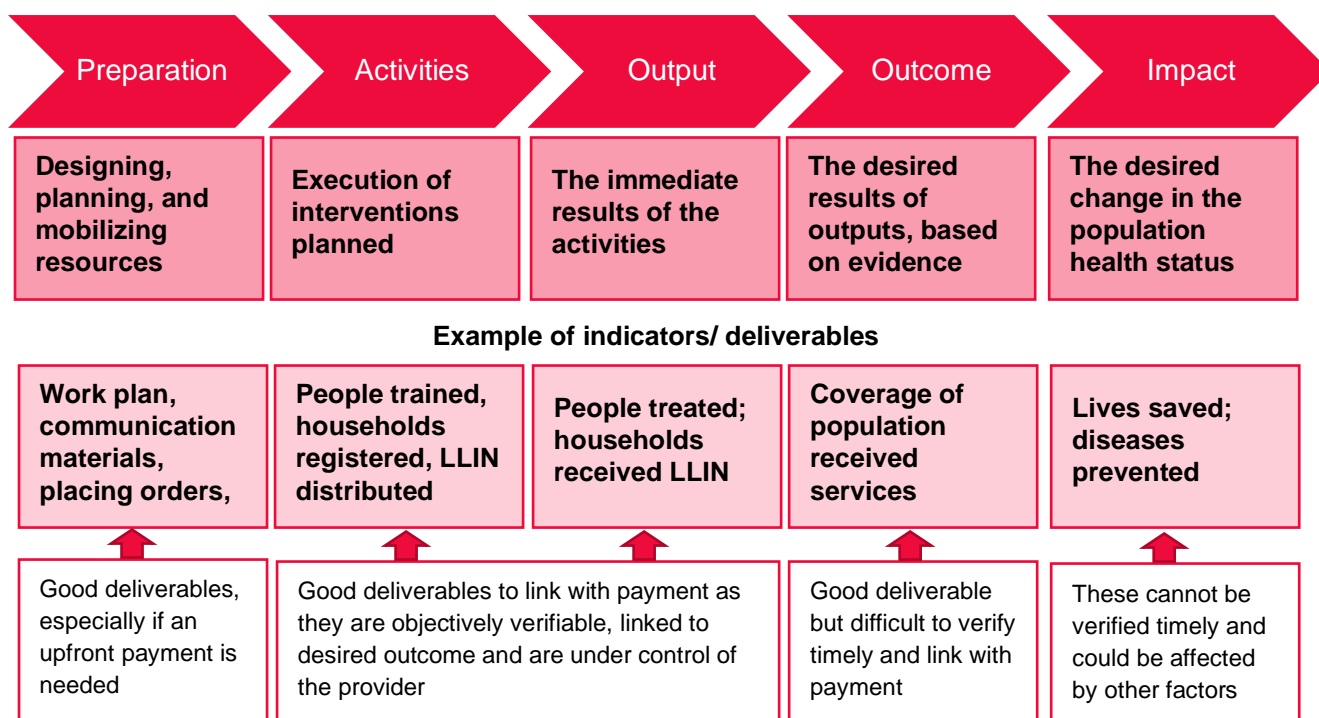
### 2.4.1.6 Clear Risk Trade-Off Analysis:

The project design must demonstrate that risks to achieving the desired objectives have been identified and optimally mitigated, with due consideration for efficiency (e.g., in terms of time, opportunity costs, and financial costs), and a comprehensive risk-return analysis articulates residual programmatic and fiduciary risk.

### 2.4.1.7 Comprehensive Assurance:

The model is supported by a tailored assurance plan which assures the operational effectiveness of the OBF modality’s controls for pricing, payment, and performance.

**Figure 1: Selecting payment-link deliverables in the result chain**



## 2.4.5 Examples of activities to include in funding requests

The table below provides some examples of activities that can help governments address some of the issues mentioned above while also improving private sector engagement. All of these activities can be funded through the Global Fund.

Please note that this table is neither prescriptive nor exhaustive and provide some examples that countries can choose and adapt to their contexts:

**Table 2: Example of activities and engagement interventions**

Area of investment	Example of activities	Example of primary engagement interventions <sup>10</sup>
TB	Increasing case finding and improving treatment outcome in private hospitals/clinics	Public-private partnership, performance-based contracts, mandatory case reporting regulation, training of private providers
	Increasing case finding, reporting and treatment on the part of dispersed, fragmented small-scale providers (doctors' practices, pharmacies and CHWs)	Engaging with an intermediary organization (i.e., local NGOs) through a performance based contracts, accreditation or social franchising approach
	Increase access to diagnostic lab services	Outsourcing of diagnostic lab services, vouchers for lab services
	Certification and accreditation of private providers/facilities	Regulation (certification and accreditation) by the government or through an intermediary firm or professional associations to facilitate this on behalf of the government through a performance-based contract
Malaria	LLIN mass distribution campaign for prevention	Engaging with NGOs or logistics companies through a performance-based contract
	Increasing case finding, improving surveillance and treatment outcomes in private hospitals	Engaging through public private partnership, and exchange of information, training of private providers
	Increasing diagnosis, reporting and treatment on the part of small-scale providers (doctors' practices, pharmacies informal private sector and CHWs)	Engaging with an intermediary organization (i.e., local NGOs) through a performance-based contract and social franchising approach to improve accreditation and quality of services or strengthening regulatory environment.
HIV	Sexual and reproductive health services	Engaging through performance-based contracts

<sup>10</sup> This illustrates the main engagement pathway, but to make it successfully work it should be supported by adjusting other engagement pathways such as policy dialogue, regulation financing and exchange of information.

	HIV prevention services for key populations (needle and syringe programs, condom programs, PrEP, PEP, OST) and related health communication and demand creation programs	Engaging through performance-based contracts; social marketing, accreditation of pharmacies
	Private pharmacies increase access to HIV testing access and use of ARVs for populations which may not be reached through public health facilities.	Engaging through performance-based contracts.
	Private laboratories have the potential to expand capacity for viral load and other tests.	Engaging through performance-based contracts
RSSH	Integrated sample transportation	Engaging through performance-based contracts
	Waste management	Engaging through performance-based contracts
	Human resources for health, including CHWs	Performance based contracts on training, accreditation, certification,
	Integration of data generated by private providers	Engaging through PPP, performance-based contracts, social franchising, accreditation, and financial incentives, development of simple applications/mobile-based for standard reporting, sharing of guidelines, simplified access to information

### 3. Strengthening the sustainability of health systems

To ensure that Global Fund grants are strengthening the sustainability of health systems through increasing engagement with non-state actors, the following must be considered:

**Improve outcomes** for HIV, TB and malaria and related conditions, including coinfections and comorbidities. The focus should be to shift from more siloed interventions to more integrated, people-centered models of prevention, treatment, and care, so that individuals' holistic health needs are met. Focusing on the poorest and most marginalized will help countries as they progress toward delivering truly universal health coverage. Ensuring that engagement with non-state actors will result in better health outcomes (especially for key and vulnerable populations) is the first prerequisite for sustainability.

**Build government capacity** to engage and contract non-public actors and, where needed, make the case for why strong partnerships between the public and non-public sector are required to meet national disease targets and to build better systems for health. Based on a country-led description of needs, Global Fund grants will provide targeted technical assistance for the performance management and contracting of non-public sector actors, particularly CSOs that implement programs for key and vulnerable populations. Mechanisms should be explored to incentivize and catalyse partnerships between governments and non-public sector actors, through more long-term partnership approaches (public-private partnerships).

**Identify and advance removal of legal and policy barriers** to public financing of non-public sector actors, including laws that affect sourcing, procurement and contracting, using publicly procured equipment and supply through private sector, as well the ability for community-based, community-led, and civil society organizations to formally register and be recognized by government. It should be emphasized that in most countries the health system is a mix of public and private providers and the governments, especially the ministries of health, need to steward the entire system and not just the public sector.

**Use appropriate financing mechanisms** (such as output based contracting, strategic purchasing and other long-term public-private partnerships) and focus on verifying quality of data to ensure accountability. The purpose is to ensure resources are used efficiently and effectively -- to achieve desired outcomes.

A holistic approach to PSE and choosing appropriate engagement interventions based on the country's specific disease profile and context, will take into account these four main considerations for sustainability of the health system.

## 4. Best Practice Examples

### 4.1 Improving case management of malaria in Nigeria

One-quarter of all malaria cases globally are in Nigeria, where 50% of the population will experience at least one episode during their lifetime. According to Nigeria's National Malaria Elimination Program (NMEP), in 60% of the cases, people (particularly in rural and peri-urban areas) will seek medical assistance from formal and informal pharmacies and drug shops, where the quality of diagnosis and treatment is frequently sub-standard.

In order to increase the quantity and quality of testing, treatment and reporting of malaria in these outlets, the NMEP launched a pilot project involving a minimum of 2,250 informal private patent and proprietary medicine vendors (PPMVs) and community pharmacists (CPs) in remote Local Government Authorities (LGAs) with US\$2.9 million in funding from the Global Fund malaria grant. The pilot will run for a total of 15 months – a three-month start-up period, followed by 12 months of implementation.

An Activity based contracting (ABC) model was designed and implemented as a pilot study in five states (Kano, Kwara, Gombe, Delta and Ogun), with TA provided through the Private Sector Engagement Strategic Initiative. Under the ABC, a facilitator has been contracted who identify and recruit participants for the pilot, develop materials and conduct trainings and provide ongoing business support to the participants. An evaluator has also been engaged with the responsibility of conducting a baseline assessment exercise prior to commencement of the pilot as well as undertaking an end-of-project evaluation

The payment is linked to specific milestones as follows:

- 30% of the contract value has been tied to the inputs of the first three months, linked to the evidenced achievement of certain key deliverables (e.g., training sessions delivered and number of PPMVs and CPs accredited)
- 70% of the contract value will be tied to the performance/activities during the subsequent 12 months, with unit prices set for each of the three payment triggers – test, treat and report.

The intermediary contractor collecting the report from PPMVs and the NMEP analyze it on a monthly basis, providing feedback to improve performance. The PPMVs tested and treated 45,000 cases of malaria in one month. The quality of their report will be verified by a third-party verification agent.

### 4.2 Public-Private Partnership for improved TB case management in India

India has the highest TB and drug-resistant TB (DR TB) burden in the world, which includes the estimated 3.4 million “missing people with TB” globally. Over 50 percent of TB treatment in India is provided by pharmacies and other private sector providers, both formal and informal.<sup>11</sup> An example of a successful PPP model is the partnership that the government of

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<sup>11</sup> <https://tbcindia.gov.in/WriteReadData/NSP%20Draft%202020.02.2017%201.pdf>



India made with private sector organizations to address case detection and treatment of TB<sup>12</sup>. Another program started in 2014 with funding from the Bill & Melinda Gates Foundation which covered three cities was adapted and expanded through the contribution of the Global Fund. Program management has since been transitioned to the government of India and was further expanded to 345 districts by 2019 (with additional financing through a loan from the World Bank wherein the Global Fund contributed to a loan buy-down).

In this partnership, the government recognized the economic interests of and the motivation for the private sector. Rather than just asking the private sector providers to refer TB patients to public facilities, the government provided training, free diagnostic services, free anti-TB medicine, free sample transportation, and follow-up of the patients seeking care in private sector facilities, to ensure the treatment was completed as per standard national protocols. Patients received e-vouchers to enable them to access all necessary diagnostic and treatment services based on their preferred facilities in the private treatment centers without need for a referral to public facilities.

In this partnership, the private sector providers contributed to the national TB program goals for increased case detection and treatment of TB patients (social interest) while still retaining their patients and business interests. As most of the private sector providers are small, dispersed outlets, the government contracted an intermediary NGO to work closely with the private providers and represent their interests with the government.

Although India had instituted guidelines for public-private mix (PPM) in 1999, uptake was low. The lesson learned was that putting in place regulations and guidelines was not enough. This required an understanding of private sector behavior and the need for incentives. This led to the development of an intermediate model, based on an interface between government and the private providers. This model was initially tested on a small scale with experienced private sector partners. Cost calculations and generating cost-effectiveness analysis of the PPM model is part of the successful model<sup>13</sup>. To scale up the initial pilot, the government of India then adopted output-based contracting to standardize results while at the same time giving providers budget flexibility to deliver. Some capacity building was required to enable local NGOs to operate under ABC.

#### **4.3 Increasing Access to Care in East Africa**

Goodlife, East Africa's largest pharmacy chain in Kenya and Uganda, served 1.1 million people in 2017. It positions stores in convenient locations such as near bus stops and health clinics, and inside shopping centers and other retail outlets frequented by KPs. In 2018, it launched its "health hub" care services concept by adding laboratory and telemedicine services. Patients can have blood drawn in dedicated private spaces at the pharmacy for several conditions, including for malaria and HIV testing. The samples are analyzed by Lancet Laboratories, a leading and well-regarded private provider of pathology services across Africa.

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<sup>12</sup> <https://www.path.org/case-studies/private-sector-tb-india-ppia/>

<sup>13</sup> Arinaminpathy N, Nandi A, Vijayan S, Jha N, Nair SA, Kumta S, Dewan P, Rade K, Vadera B, Rao R, Sachdeva KS. Engaging with the private healthcare sector for the control of tuberculosis in India: cost and cost-effectiveness. *BMJ Glob Health*. 2021 Oct;6(10):e006114. doi: 10.1136/bmjgh-2021-006114. PMID: 34610905; PMCID: PMC8493898

Patients can choose from two options to use Goodlife's telemedicine platform to access a licensed doctor. The first option uses Goodlife's mobile application which can be used from anywhere with Internet connectivity. It connects patients with a doctor who provides advice, prescribes medication and can recommend a consultation at a Goodlife pharmacy or a referral to a specialist. The second option facilitates access for those who find it more convenient to have a tele-consultation from a dedicated private space inside the pharmacy (IFC 2018).

#### **4.4 Ukraine: Leveraging Pharmacies for Harm Reduction Programming in Ukraine**

The turning point for a harm reduction program in the Ukraine came when private pharmacies were used to dispense clean syringes and needles. Pharmacies offered greater convenience with longer operating hours, the ability to privately pick-up medications. Drug users received a voucher with a code so they could get supplies without providing their names, increasing trust, knowing they would not be identified to the police. It was a neutral system where patients were not lectured and were treated like any other customer. For their part, pharmacies were paid per client served. The new system meant that the Global Fund did not need to fund service points around the country, but rather could utilize the existing network provided by private pharmacies. Similar schemes could be used to dispense antiretroviral or TB medications paid for by public or donor-funded programs. In countries where there are pharmacies with in-store primary care nurse clinics, public or donor funded vouchers could be distributed to populations that could be redeemed at such pharmacy clinics for HIV or TB testing to improve case identification.

#### **4.5 South Africa: Unjani Clinics, Franchise Model of Primary Care Clinics**

Unjani Clinics have developed an innovative solution with low-cost clinics that are owned by nurses who deliver primary care. The franchise model is a hybrid of non-profit (parent company) and for profit (individual clinics), targeting 10-12 million low-income people who are employed but uninsured, serving the same patients who attend public primary care clinics. Unjani is able to provide affordable care that is conveniently located within high-burden and low-income communities – saving patients travel costs and keeping wait times short. Patients pay OOP for bundled services (consultation + medication, which costs US\$13). The clinics also offer lab tests, including HIV testing and counselling, which costs US\$5.20.

Each of the 80 Unjani clinics are modular, consisting of 12-meter shipping containers converted into a standard clinic design, allowing for rapid expansion of existing sites or the addition of new ones. Unjani is growing at an annual rate of 30% and has a growth target to reach 1,000 clinics by 2030, augmenting South Africa's 3,500 public primary care clinics (Schneider et al 2015). Unjani plans to expand their target market in and possibly eliminate user fees with the arrival of National Health Insurance, which will enable them to address all 48-49 million uninsured patients.

Unjani typically sees patient volumes averaging 500 consultations per month, while some of the busiest sites can reach up to 2,500 per month. They receive funding through CSR donations, and also secure funds from the National Treasury to establish clinics. After

establishment, they transition to self-funding through patient fees (Unjani Clinics and Toussaint 2020).

# Annexes

## Annex 1: Engagement interventions under governance and regulation pathway

### 1.1 Accreditation

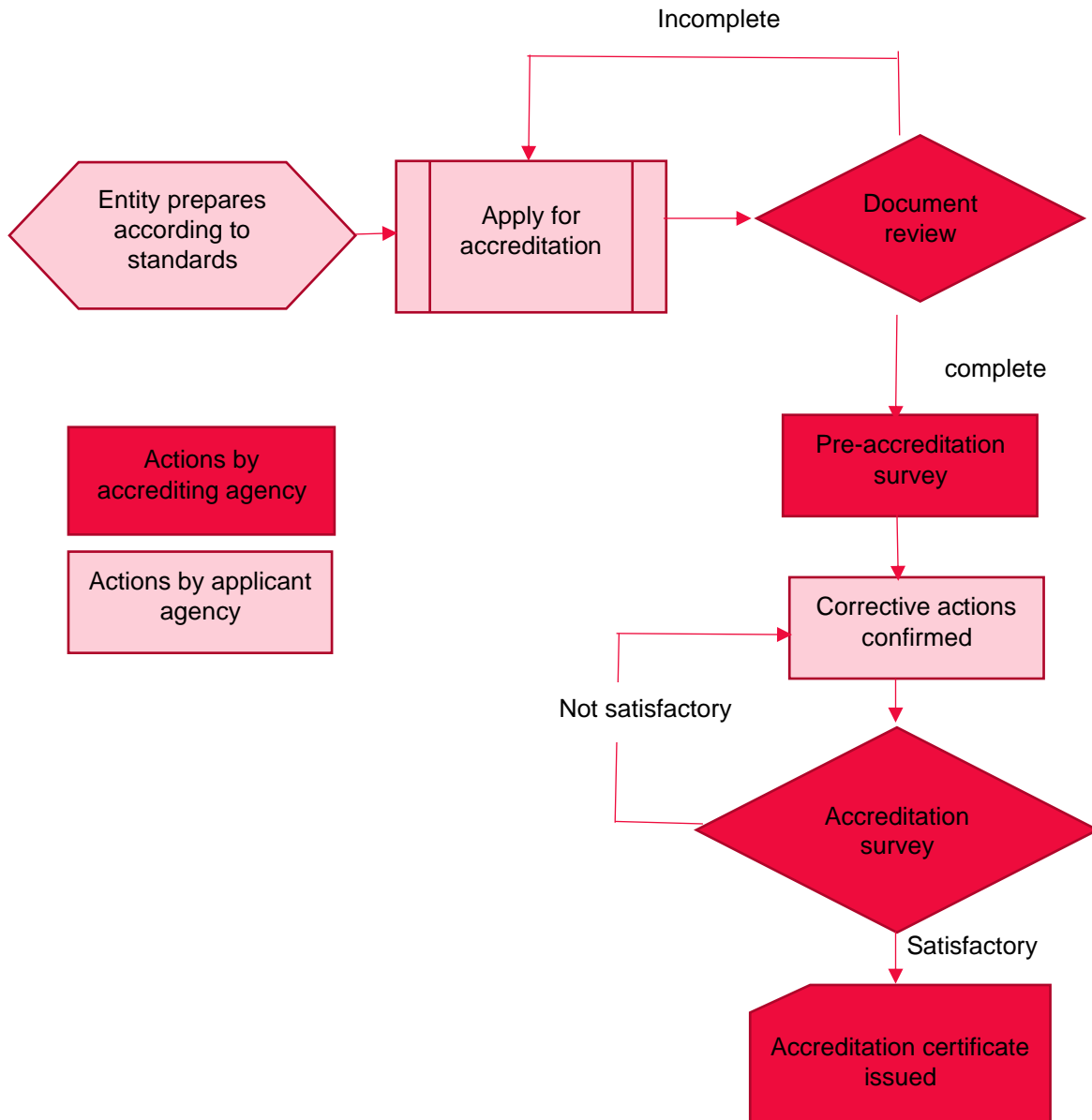
Accreditation is a regulatory process through which the government or an independent entity, approved by the government for this task, sets quality standards for the health care process or products and then observes, monitors and measures to ensure standards are met in practice. Once all or most standards are met, the accrediting entity will give the organization under accreditation a certificate showing that the specific services or products are accredited and meets certain level of standards. This certificate is valid for a period usually 1-3 years and should be renewed by that time. The accrediting entity also conducts monitoring visits from time to time ensure the accredited organizations remain committed to meeting standards. Accreditation is usually a voluntarily process, and it works together with other engagement pathways for example, financing (insurance, contracts, strategic purchasing etc). In these cases, the private sector providers will participate in the financing mechanisms only if they are accredited, so this makes accreditation attractive.

For example, PhilHealth<sup>14</sup> accredited DOTS clinics in Philippines, to be eligible for participation in the social health insurance program (be reimbursed for their diagnosis and treatment of TB patients). The agency has developed a set of quality standards, once a DOTS clinic meets those standards, it can apply for accreditation through online application forms, the applicant has to submit several required documents to ensure the application is complete, the PhilHealth schedules a pre-accreditation survey, during the survey any improvements needed are noted and the DOTS clinic is given a time (usually 60 days) to implement the needed improvements, then the DOTS clinic provides evidence of the improvements and PhilHealth conduct their observation. Upon satisfactorily compliance with the standards, the DOTS clinic will receive a certificate of accreditation which is valid for a period of time. The clinic must apply for reaccreditation before the expiry date of the certificate.

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<sup>14</sup> PhilHealth is a tax-exempt Philippine's Government Corporation attached to the Department of Health for policy coordination and guidance.

Figure 2: Flowchart of accreditation process



## 1.2 Social Franchising

Franchising is a marketing approach through which a company expands its services or products to reach more people using the same standards and branding. When similar approach is undertaken for the marketing and expansion of health products or services it is called social franchising, as it expands a social good.

## What challenges are addressed by social franchising?

Before describing social franchising in greater detail, it is important to know how this approach can address some of the public health challenges and why governments adapt their regulatory framework to allow and encourage social franchising in health. Here are examples of the main challenges that can be addressed by social franchising:

- An unmet need for greater access to quality, affordable health **services**: The clear examples of such services are maternal and child health, family planning, TB, malaria, and HIV/AIDS. Many people in developing countries do not have access to such services or the current public service channels are not able to reach them due to several reasons.
- An **overburdened** public health system: Most public health systems in developing countries are overburdened and under-resourced, unable to reach all of the people who need the services, especially the basic services.
- An **under-regulated** private sector: This can be due to both a) lack of capacity of the governments to enforce regulations and b) the fact that it is difficult to engage with the private sector and influence their behaviors.
- Low participation of the private sector in the delivery of **preventive** and promotive health care: In many countries people seek health care only when they are severely sick, for curative care, which is usually too late and too expensive. This care seeking behavior shapes the health markets and that is why the majority of for-profit providers focus on curative services, which are more profitable.
- Lack of incentives for health providers to deliver **quality** health care: This is mainly seen in the periphery level, in rural areas or where people do not have access to affordable quality care. In those settings the quality of care is always compromised by its accessibility and affordability.
- Limited **professional development** opportunities for health care professionals, particularly in the private sector: This is seen especially when the quality of health care is compromised.

## How does social franchising address these challenges?

Social franchising works together with accreditation. A private entity which is accredited for the quality of its services or products can expand its services or products through establishing many other periphery outlets across the country using the same branding and the same quality. The original entity is called the franchisor and the periphery new entities that work under its brand are called franchisees. It works based on the four Ps of marketing (Product, Price, Place and Promotion) model.

**Product:** Here products cover both health services and health commodities that the franchisor provides and wants to expand through franchising. For example, it can be condom distribution, rapid diagnostic tests for malaria, case detection for TB, or treating patients diagnosed with HIV etc. The franchisees are selected based on demand for the services/products and they may be allowed to add these new services/products into their

existing services or work solely for the franchised services/products. The franchisor agency is responsible for providing technical assistance to the franchisees to ensure the staff is trained on the services/products, the infrastructure and equipment needed exist and are functional, and processes through which the franchising services/products are delivered are according to the standards.

**Place:** The area where services are needed the most will be targeted. Here the emphasis is to ensure the people who need the services/products have them accessible (geographically and practicably) and use it as per their demand. Available outlets will be selected for service delivery. For example, in some areas CHWs or pharmacies (and in some places a drugstore or a medical doctor’s private practice) can be selected as a franchisee, while in another area hospitals and clinics can be selected, based on their availability and willingness to join the franchise.

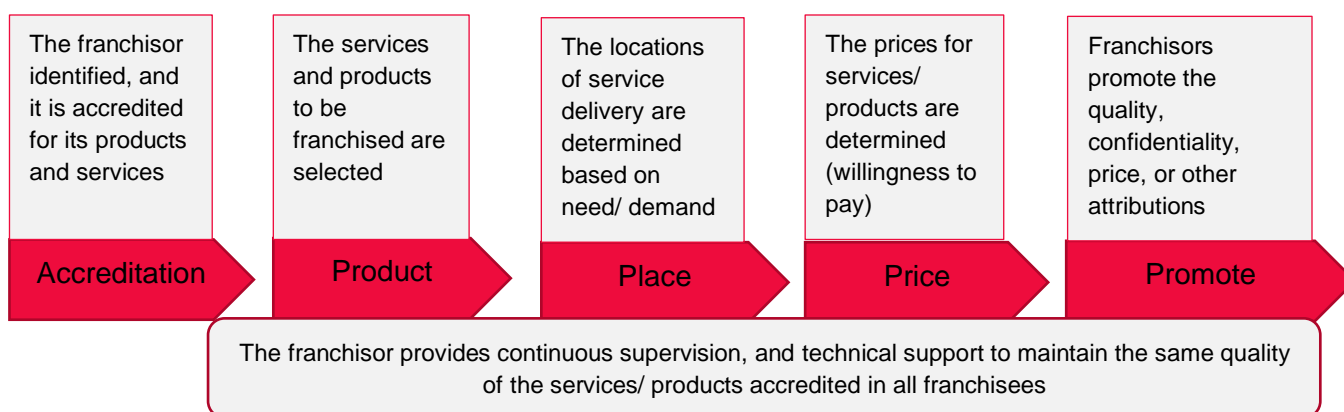
**Price:** The franchisor and franchisees agree on a standard price to be charged to the users, based on the demand level and willingness to pay. Pricing the services/products is especially important to ensure target groups afford to use, and that it can be subsidized by the government or donors. The franchisee is not authorized to change the price once it is agreed. They also agree on a fee for franchisor in return for the right to use its branding, standards, and technical support (this fee also can be subsidized or covered by the government or donors).

**Promotion:** The franchisor will promote its brand, which is used by all its franchisees, through different marketing and communication mechanisms. The purpose of the promotion is that people who need the services are assured of the quality, confidentiality, price, or any other aspect important to them, and are encouraged to utilize the product/service through whichever of the franchisees they prefer.

The government or the donor financing franchising should have clear systems to control for suppliers’ induced demands (to avoid unnecessary tests and treatments).

This process can be illustrated in the following diagram.

**Figure 3: Social Franchising process**





## **Annex 2: Other interventions under financing pathway**

### **2.1 Public-Private Partnership<sup>15</sup>**

PPP for health is an approach to addressing public health and social development problems through the combined efforts of public, private, and development organizations. Each partner contributes in its area of special competence, bringing in expertise (or resources, including in-kind) and sharing the risks. The partners in a PPP rally around a common cause, while at the same time pursuing their own organizational objectives. Public sector organizations—such as ministries of health—achieve their objectives in less time, with smaller investments. Private sector organizations—producers of health-related products, for example—can expand their markets, develop new marketing techniques, and contribute to the communities in which they do business. Development organizations achieve their strategic objectives in collaboration with others, leverage new resources for public health, and gain experience with a highly feasible and sustainable approach to public health promotion. Most important, the targeted communities and populations benefit from improved health.<sup>16</sup>

PPP is a complex and long-term approach, which may contain some contracting arrangements in it, and in this arrangement the partners bring resources together and share the risks/ benefits that makes it different from a simple contracting arrangement.

In this partnership either the public sector invests in a private facility (for example using a private hospital to deliver health services) or the private sector invests in a public facility (for example a private lab invests in the diagnostic services of a public hospital).

The Global Fund has supported several public-private partnership arrangements in different countries such as Myanmar, Pakistan, and Nigeria.

An example of a PPP could be the partnership that the government of India made with the private sector in case detection and treatment of TB. This program started in 2014, funded by Bill & Melinda Gates Foundation in three cities and was expanded by the contribution of the Global Fund and the government of India to 345 districts by 2019. The project (called PPSA) has been transitioned to domestic funding through a World Bank loan in 2020-2021 and government of India support.

In this partnership, the government recognized the economic interest and motivation of the private sector and instead of asking them to refer TB patients to public facilities, provided training, free diagnostic services for patients attending the private sector, free anti-TB medicine, free sample transportation, and follow-up of the patients to ensure the treatment was completed as per the standard protocols. Patients attending the private sector received all necessary diagnostic and treatment services without being referred to public facilities.

In this partnership the private sector providers retained their economic interest, while the government increased case detection and treatment of TB patients (social interest). The

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<sup>15</sup> It is also called public private mix in some literatures.

<sup>16</sup> Public-private partnerships: Mobilizing Resources to Achieve Public Health Goals, The Central American Handwashing Initiative Points the Way; USAID, BASICS II, Environmental Health Project, UNICEF, and the World Bank, 2001

government contracted an intermediary NGO to work closely with the private providers and represent the interests of the government, providing support to the private hospitals in sample referral, diagnosis, registration, free treatment and follow-up of patients.<sup>17</sup>

## 2.2 Strategic Purchasing

In many cases when public subsidies do not reach the poor, they may decide to purchase health care services. They may thus be exposed to some negative impacts, such as uncertainty of outcome and supplier-induced demand due to asymmetry of information, unregulated market and so on. That is why in many countries, government shifts from only focusing on provision of services through government facilities to more strategic purchasing of services, which can be done either by the government itself or any agency assigned (in the Global Fund context, PRs and SRs could play this role).

In designing a “strategic purchasing” initiative, there are five key issues: 1) governance, 2) information management system, 3) benefit package design, 4) mixed provider payment systems, 5) managing alignment, dynamics, and sequencing.<sup>18</sup> Another way to state this could be by answering the following questions: what services to buy, for whom to buy, from whom to buy, how to verify, how much to pay, and how to pay.<sup>19</sup>

Governance means that the purchaser and providers should both be governable and bound to some goals, rules, and regulations. The benefit package (what to buy and for whom to buy it), is the decision made by the government based on population need and priorities, as well as availability of resources (this can be included in the in the Global Fund grant application by the country stakeholders). Deliberations on population need and priorities can be part of the [policy dialogue](#), which is described in this technical brief.

The information management system requires that there be accountability on what is delivered and there is transparency in sharing information, as described in the [information exchange](#) section of this technical brief.

Managing alignment and from whom to buy means that services should be purchased from a credible source to ensure quality of services and to ensure the desired outcome. This requires strong regulation, oversight, certification or accreditation. Further details can be found under the [regulation](#) section of this technical brief. In addition to issues around managing alignment, dynamics sequencing and provider payment systems (how much to pay and how to pay), addresses the affordability and efficiency concerns, which are the core of the design of “strategic purchasing.”

A strategic purchasing is a clear example of holistic (systematic) engagement with the private sector, which requires all engagement pathways (policy dialogue, information exchange, regulation, and financing) to be considered, otherwise, it may not produce a desirable result.

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<sup>17</sup> JEET/ PPIA/ PPSA Report.

<sup>18</sup> Mathauer I, Dale E, Meessen B. Strategic purchasing for Universal Health Coverage: key policy issues and questions. A summary from expert and practitioners' discussions Geneva: World Health Organization; 2017.

<sup>19</sup> Adapted from: Public End, private means, strategic purchasing of Health Services, Alexander S. Preker et al. World Bank

### Annex 3: Quality measurement and quality improvement in private sector health care

Although it is perceived by many patients that quality of care in the private sector is higher than that provided by the public sector, studies that show this perception is not true for all<sup>20</sup>. The governance engagement pathway explained in this document will help countries to improve the quality of health care in the private sector. The following are some additional tips and resources to address this issue.

When speaking about quality of care, according to WHO, it should be<sup>21</sup>:

- **effective**, providing evidence-based health care services to those who need them;
- **safe**, avoiding harm to people for whom the care is intended;
- **people-centered**, providing care that responds to individual preferences, needs and values;
- **timely**, reducing waiting times and sometimes harmful delays for both those who receive and those who give care;
- **equitable**, providing care that does not vary in quality on account of age, sex, gender, race, ethnicity, geographic location, religion, socioeconomic status, linguistic or political affiliation;
- **integrated**, providing care that is coordinated across levels and providers and makes available the full range of health services throughout the life course; and
- **efficient**, maximizing the benefit of available resources and avoiding waste.

Quality of health care could be addressed either through **quality assurance** (assessment processes and mechanisms to ensure that services are fulfilling stated standards) or **quality improvement** (continuous actions to make health services more effective, safe, people-centered and satisfactory to clients).

The key to improving the quality of health care is to have regular and systematic measurement of the quality of care to ensure that any quality assurance or quality improvement actions result in improvements in the quality of care. One of the quality measurement methods is the **Donabedian's** three-components approach<sup>22</sup>. Donabedian believed that **structure** measures have an effect on **process** measures, which in turn affect **outcome** measures. Together these form the basis of what is required for an effective suite of measures.

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<sup>20</sup> See for example Comparative Performance of Private and Public Healthcare Systems in Low- and Middle-Income Countries: A Systematic Review: Sanjay Basu et al (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3378609/>) and Prohibit, constrain, encourage, or purchase: how should we engage with the private health-care sector?: Dominic Montagu and Catherine Goodman (<https://pubmed.ncbi.nlm.nih.gov/27358250/>)

<sup>21</sup> For more tools and materials on quality of health care please see WHO Quality toolkit at: <https://qualityhealthservices.who.int/quality-toolkit/qt-home>

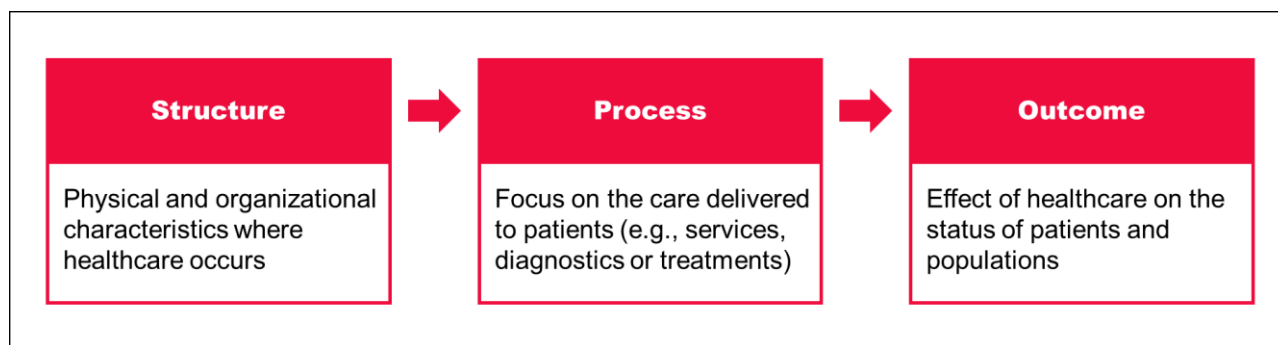
<sup>22</sup> See for example: Donabedian's structure-process-outcome quality of care model Validation in an integrated trauma system by Moore, Lynne et al ([https://journals.lww.com/jtrauma/Abstract/2015/06000/Donabedian\\_s\\_structure\\_process\\_outcome\\_quality\\_of.16.aspx](https://journals.lww.com/jtrauma/Abstract/2015/06000/Donabedian_s_structure_process_outcome_quality_of.16.aspx))

**Outcome measures:** these reflect the impact on the patient and demonstrate the end result of improvement work and whether it has ultimately achieved the aim(s) set. Examples of outcome measures are: reduced mortality, reduced length of stay, reduced hospital-acquired infections, fewer adverse incidents or harm, reduced emergency admissions and improved patient experience.

**Process measures:** these reflect the way systems and processes work to deliver the desired outcome. For example: the length of time a patient waits for a senior clinical review; if a patient receives certain standards of care or not; if staff wash their hands; if incidents are recorded and actions taken on the findings; and whether patients are kept informed of delays when waiting for an appointment.

**Structure measures:** these reflect the attributes of the service/provider, such as staff-to-patient ratios and operating times of the service. These are otherwise known as input measures. The model can be summarized in the following diagram:

Figure 4: The Donabedian model for quality of care



## **Annex 4: National Strategic plan for engaging with private sector**

It has been realized that in some countries, the ministries of health need to develop a national strategy for engaging with the non-state actors.

The strategy or strategic plan to engage with private sector must respond the following eight questions:

### **1. What problem do you solve? (Problem analysis)**

This is the first and the most important question to start with. While stating the main problem, it is equally important to analyze and find the root causes (*sufficient* and *necessary*) of the problem, until we reach to some root causes that can be addressed, by engaging with private sector. There are several methods of problem analysis such as problem tree, or fish bone analysis methods that can be used. Experts' advice and reviewing some reports in the context are critical for this stage.

### **2. What do you want to achieve? (Objective setting)**

Once the problems and root causes are identified, they can be turn into the strategy's objectives. Addressing the main problem at the population level could be the desired outcome, solving the first level causes could be the intermediate results, and solving the second level causes can be the objectives and even addressing more basic causes that can be addressed by a single intervention, could be the outputs. The strategy may not address all root causes, which is completely normal, so the focus would be only to those root causes of the problem that the strategy can address through public health interventions engaging with private sector.

### **3. What solutions are available? (Evidence based interventions)**

Once the objectives are formulated, there is need to search for possible interventions to design for achieving them. There are plenty of evidence-based interventions implemented in other countries of the world that can be adapted (*see for example table 1 in this document*) or there are interventions available in the country and need to be scaled up. This requires some research to decide about possible interventions to include in the strategy. Reviewing some peer reviewed documents or considering experts' advice, who were engaged in designing, implementing or evaluating those interventions, could be useful exercises.

### **4. What are your priority solutions, how do they relate to your objectives? (Theory of change)**

This step will differentiate the strategy from a wish-list document. In this step the possible interventions selected in the previous step, will be filtered by an analysis of the situation. Each proposed interventions could be scored from political, economic, social, and technical points of view; in each area the potential barriers, opportunities and stakeholders to engage with, their roles and interest to support, can be analyzed. At the end of this step, we would come up with a few interventions that can help us to develop a theory of change. The theory of change then simply could be: If we implement *{priority Interventions}* at scale *{explain}* we can achieve *{the x and y intermediate results}* that will lead us to the *{desired outcome}*.

## 5. How do you implement? (Implementation arrangement)

To make the strategy a practical and useful exercise, it is necessary to think about the basic design of implementation. The best way to do this, is to design the result chain for each priority intervention: Starting from the desired outcome, objectives, outputs, activities, and Inputs. A logical link should be established between each result chain and define who are the potential stakeholders (who could do what?)



## 6. Are you on the right track? (Monitoring framework)

To follow up during the implementation stage and ensure we are in the right track, for each of the above result chain stages we should come up with clear and well-defined indicators, source of data, baseline, targets, timelines for measurement and data quality assurance mechanisms.

## 7. How much it costs to implement your strategy?

If we follow the above-mentioned steps, pricing the strategy would be easy. For each intervention, going back to the result chain and looking at resources/ inputs need, activities and outputs, plus the monitoring and overseeing the strategy implementation could provide us with a good estimate of the strategy implementation.

## 8. Who is responsible for what? (Accountability framework)

Unfortunately, most strategies are prepared and shelved – not implemented – if there is not a clear accountability for its key functions – resource mobilization, financing, overseeing its implementations, and secretariate to coordinate these efforts. It is best practice to decide at least about responsible individuals or entities for each of these functions, their key roles and responsibilities, their reporting lines and timeline to report.

## Annex 5: List of Abbreviations

<b>ABC</b>	Activity-based contracting
<b>CBO</b>	Community-based organization
<b>CCM</b>	Country Coordinating Mechanisms
<b>CHW</b>	Community health worker
<b>CSO</b>	Civil society organization
<b>FBO</b>	Faith-based organization
<b>HMIS</b>	Health management information system
<b>HRH</b>	Human resources for health
<b>HTM</b>	HIV, tuberculosis and malaria
<b>IDSR</b>	integrated diseases surveillance and response
<b>LFA</b>	Local Fund Agent
<b>LLIN</b>	Long-lasting insecticidal nets
<b>MNH</b>	Maternal and newborn health
<b>MOH</b>	Ministry of Health
<b>NGO</b>	Non-governmental organization
<b>OST</b>	Oral substitution therapy
<b>PLHIV</b>	People living with HIV
<b>PPP</b>	Public-private partnership
<b>PR</b>	Principle Recipient
<b>PrEP</b>	Pre-Exposure Prophylaxis
<b>PSE</b>	Private sector engagement
<b>RSSH</b>	Resilience and Sustainable System for Health
<b>SOP</b>	Standard operating procedure
<b>SR</b>	Sub-recipient
<b>TA</b>	Technical assistance
<b>TOR</b>	Terms of reference
<b>UHC</b>	Universal health coverage
<b>WHO</b>	World Health Organization

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