INTRODUCTION

In most low- and middle-income countries (LMICs), key health-related products and services are delivered by a mix of public and private sector organizations. Large segments of the population, including the poor, receive the healthcare they need in the private sector, from a range of for-profit, not-for-profit, formal or informal entities.¹ As Figure 1 below shows, a majority of services for children with fever or diarrhoea are undertaken in such facilities in low- and lower-middle income countries.

In recent years, researchers have examined the main factors underlying the expansion of the private sector. On the demand side, these include: a perception that the public sector offers low quality care compared to the private sector;² a shortfall of public health facilities in some rural and semi-rural locations; and large-scale urban migration and the public sector’s inability to respond to changing demographics.³ On the supply side, and especially in countries where dual practice is common, the private sector represents a key source of income for many doctors and other health workers.³

As a result, a large private sector exists across many service areas, including primary care, hospitals, diagnostics, specialist therapeutic and curative services, and pharmaceutical supply chains, and several international agencies have adopted strategies to engage this sector in pursuit of their programmatic goals. These agencies include the World Health Organization (WHO) itself, which has sought to ensure that national treatment programs relating to TB and malaria have engaged sections of the local private health sector involved in delivering program-
related services and products. However, in the context of the 2030 Agenda for Sustainable Development, there is now a pressing need, as well as a promising opportunity, for the international community in general, and WHO-HGF in particular, to drive forward an agenda for strategically engaging the private sector to achieve health system strengthening objectives, including Universal Health Coverage (UHC) and the health-related SDGs. Therefore, our aim in this report is to assist the WHO’s Advisory Group on the Governance of the Private Sector for Universal Health Coverage by analyzing the nature and extent of current global health practice in this domain. We focus on three objectives in particular:

1. To map the current private sector engagement activities of key global health actors, with a focus on the goals, geographical foci, and programmatic approaches, of such activities;
2. To assess the strengths and limitations of these activities from the perspective of UHC; and
3. To analyze how WHO-HGF, as a new player in this area of activity, can deploy its distinctive strengths in order to accelerate progress towards UHC.

**METHODOLOGY**

We conducted an initial web search to identify the international actors that have been most active in private health sector engagement in LMICs (including bilateral and multilateral aid agencies, global health initiatives, UN agencies, and charitable foundations), and the evolution of their activities over time.

We conducted an initial document analysis, and a set of key informant interviews with key individuals with direct experience of private sector engagement in LMICs (see the
acknowledgments section), to describe the nature and extent of current programs being undertaken by international actors. Based on this analysis, we sought to identify the set of actors that have substantial and direct involvement (e.g. through direct financing or policy support) in private sector engagement. We then analyzed relevant documents produced by these organizations, and conducted further key informant interviews with senior staff members in these organizations to define for each of these:

1. its main goals in relation to the private health sector;
2. the key countries/regions and products/services targeted; and
3. its clients, operating frameworks, modes of engagement, and programmatic approaches. (These data are presented in tables 3, 4 and 5 below.)

Drawing on our findings, we analyzed the strengths, limitations and key gaps of current engagement approaches from the perspective of UHC – which we define here as a level of coverage in which everyone can access the health services they need, of sufficient quality to be effective, without incurring financial hardship. Accordingly, three broad themes were used to guide our interview questions and analyze our data, as follows:

A. the extent to which existing activities represent a strategic approach to private sector engagement for health systems strengthening;
B. the extent to which the goals and mechanisms of existing activities are consistent with the core UHC dimensions of equity in service use and financial protection; and
C. the ways in which WHO-HGF can optimize its contribution to this set of activities, given its leadership role in the health systems strengthening for UHC agenda.

A BRIEF HISTORY

Here we present a brief history of private sector engagement activities in global health. Our account highlights the origins of engagement in the large disease-specific ‘vertical programs’, and the evolution of engagement into broader-based private sector development strategies and (some) ‘horizontal’ approaches. The account provides context for the analysis of international agencies’ current activities, and the outline of recommendations for WHO-HGF.

First wave – the Social Marketing Experience

Social marketing (SM) is one of the first approaches to PSE in the health area. During the 1950s and 60s, several US government agencies successfully employed SM techniques to influence health-seeking behaviors. Key examples included the use of seat belts, breast cancer screening, and tobacco cessation. The first ever nation-wide SM program in an LMIC was launched in the 1960s by the government of India. Policymakers realized that consumer access to low-cost condoms through
public health facilities was inadequate. In response, they launched the Nirodh condom project for family planning (FP) and sexually transmitted infections (STIs). This project developed working relationships with mass-consumer goods companies to distribute subsidized condoms through commercial actors in the retail sector.

The success of the India SM experience led to the development of global SM programs, managed by international organizations and domestic entities with financial support from a select number of bilateral development partners. The three primary development partners supporting SM have been:

- **USAID**: In the 1970s, USAID funded the newly formed Population Services International (PSI) to expand the India experience throughout South Asia. In the 1980s USAID launched the SOMARC projects, managed by the Futures Group. USAID continues to support global and country-level SM projects that promote a wide variety of health products in FP/RH, HIV/AIDS, MCH and malaria.
- **KfW/BMW**: Although KfW SM programs have not had a specific geographic focus, they have concentrated mostly on family planning/reproductive health products (FP/RH), oral rehydration salts (ORS) and insecticide-treated bed nets (ITNs).
- **DfID**: The UK’s experience in SM programs dates to 1989 and a project in India managed by Marie Stopes. DfID’s SM programs accelerated in the 1990s; and by the beginning of the 2000s, DfID had supported more than 30 country SM programs. Today, DfID remains an active player – it’s SM projects concentrate on products for FP, STIs, and communicable diseases, especially malaria.

As other development partners – like UNICEF, UNAIDS and the World Bank – noticed the positive impact of SM programs, they began to adopt SM approaches in their health programs. As a result, the list of BCC and health products has continued to grow. Table 1 (overleaf) provides a brief overview of the breadth and scope of SM programs in LMICs. There is strong evidence of SM’s effectiveness and health impact. Multiple studies have demonstrated...

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Rationale for SM programs

- Public sector provision is often inefficient and ineffective.
- Guaranteeing access for particular ‘segments’ of consumers (e.g. unmarried youths in need of family planning products or services) is difficult to achieve through the public sector alone.
- Access through local shops is easier when compared to public health facilities.
- Subsidized prices reduce economic barriers.
- Purchases lead to a greater sense of “value”, more consistent use and appropriate use.


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the effectiveness of SM across a range of health areas – including HIV/AIDS, maternal and child health, and FP/RH. For malaria, research has linked behavior change resulting from SM interventions to changes in health status,\(^5\) as a result of which SM is considered a “high impact practice” in family planning (https://www.fphighimpactpractices.org/briefs/social-marketing/).

The success of SM programs had a major influence on donor thinking towards the private health sector. The first few clinical social franchising programs (i.e. networks of private sector facilities that are contracted by an NGO to provide standard services under a common brand) were created in south and southeast Asia in the 1990s. By 2015, more than 90 such programs existed in 40 low-income and middle-income countries. Most of these are in India and Kenya. Major donors - USAID, DfID, the Bill & Melinda Gates Foundation (BMGF), and the Norwegian Agency for Development Cooperation (NORAD)—have invested millions of dollars in these franchises. Social franchises offer a wide range of services in relation to: FP, SRH (not including FP), safe motherhood, TB, malaria, HIV/AIDS, abortion/PAC, paediatrics, NCDs, vision and dental care. However, FP continues to be the service that is offered by most franchises.

Second Wave – Global Public-Private Partnerships

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The latter half of the 1990s witnessed another form of private sector engagement – **global public-private partnerships for health development (GPPPs)**. Global health PPPs involve collaboration between the corporate and public sectors with the purpose of overcoming market “failures” in public health. In the succeeding decades, this type of partnership has attracted considerable resources into the international public health arena.

Most GPPPs focus on partnerships related to drugs and vaccine development. However, there are also other types of GPPPs (Table 2), i.e.:

- **Product based partnerships** consist primarily of drug donation programs but also allow for bulk purchase of products for public sector programs in low-income countries at a reduced price (e.g. female condoms or HIV/AIDS medications).
- **Product development partnerships** are designed to address a failure of the market to develop products with significant positive externalities (i.e. high social, but modest financial, returns).
- **System/topic partnerships** seek to harmonize approaches and coordinate public and private actors involved in a single disease as well as raise the profile of the disease’s on the global health agenda.

The entrance of BMGF into the global health arena played a catalytic role in the GPPP agenda. As one of its first investments in global health, the BMGF partnered with GAVI in 1998. The BMGF has also invested significant funds to accelerate discovery into new vaccines through its support to multiple product development partnerships.

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**Social Marketing Approaches**

- **NGO (Product) Model**: Works with existing NGOs or establishes a new NGO to develop a brand, and sell, distribute and promote the branded product through local infrastructure.
- **Behavioral Change Communications (BCC) Model**: Extensive use of BCC approaches has been made, often in combination with product distribution programs.
- **Manufacturers Model**: In which a commercial manufacturer provides marketing support to enter a new market, maintains control over the brand, and is responsible for sales and distribution.
- **Social Franchising Model**: A network of private healthcare providers linked through an MoU/agreement to provide socially beneficial health products under a common brand. A “franchiser” brands “franchisees: to signal to clients the quality and affordability of products at franchise clinics.
- **Total Market Approaches (TMA)**: In which different consumer segments are assessed to define the comparative advantage of public, SM, and commercial (private) delivery of products or services.

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the development of new pneumococcal vaccines, introducing effective pneumococcal vaccines for developing countries, and accelerating vaccine uptake by ensuring predictable vaccine pricing for countries. Subsequently, development partners facilitated other financial incentives in addition to AMC (e.g. tax breaks, purchase guarantees, reputation enhancements, etc.) to crowd in private investment.

In this same period, development banks such as the International Finance Corporation (IFC) began to accelerate direct investment (of both equity and debt finance) in commercial health sector businesses and, at the same time, lobby governments to reduce regulatory barriers to private sector development, and adopt new forms of public-private partnerships (PPPs), e.g. in relation to specific diagnostic (CVP, IAVI, MVI). As an example, BMGF has invested in one GPPP – BMGF Childhood Vaccine Program (CVP) – to develop more than two dozen vaccine projects that cut across 18 different diseases focusing on the world’s leading causes of childhood deaths: diarrheal disease, pneumonia, and malaria.

BMGF has also invested in piloting innovative financing mechanisms to crowd in private sector investment – mainly in pharma – as another strategy to develop vaccines and drugs for neglected diseases. For example, the Advance Market Commitment (AMC) pilot started in 2005 and was officially launched in 2007 with a collective US$1.5 billion commitment from BMGF, Canada, Italy, Norway, Russian Federation and the UK. The first AMC deal was for “Pneumococcal vaccines. The AMC deal succeeded in accelerating the development of new pneumococcal vaccines, introducing effective pneumococcal vaccines for developing countries, and accelerating vaccine uptake by ensuring predictable vaccine pricing for countries. Subsequently, development partners facilitated other financial incentives in addition to AMC (e.g. tax breaks, purchase guarantees, reputation enhancements, etc.) to crowd in private investment.

Table 2. Example of GPPPs

<table>
<thead>
<tr>
<th>TYPE</th>
<th>EXAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Product based partnerships</td>
<td>• Mectizan Donation Program</td>
</tr>
<tr>
<td></td>
<td>• Malarone Donation Program</td>
</tr>
<tr>
<td></td>
<td>• Albendazole Donation Program</td>
</tr>
<tr>
<td></td>
<td>• Zithromax Donation Program</td>
</tr>
<tr>
<td>Produce development partnership</td>
<td>• BMGF Childhood Vaccine Program (CVP)</td>
</tr>
<tr>
<td></td>
<td>• International Aids Vaccine (IAVI)</td>
</tr>
<tr>
<td></td>
<td>• Malaria Vaccine Initiative (MVI)</td>
</tr>
<tr>
<td></td>
<td>• Medicines for Malaria Venture (MMV)</td>
</tr>
<tr>
<td>Systems/issue partnership</td>
<td>• Children’s Vaccine Initiative (CVI)</td>
</tr>
<tr>
<td></td>
<td>• GAVI – Global Vaccine Initiative</td>
</tr>
<tr>
<td></td>
<td>• Roll Back Malaria Global Partnership</td>
</tr>
<tr>
<td></td>
<td>• Stop TB Initiative</td>
</tr>
</tbody>
</table>

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Third Wave – Market Systems in the Health Sector

Although by the early 2000s, social marketing programs were yielding some positive impacts, development partners began to grow concerned about long-term sustainability of such efforts. Over the last decade in particular, development partners like USAID started to push for greater self-reliance, and to graduate SM programs to local NGOs. In addition, development partners wanted to take to scale some of the private sector initiatives developed in response to HIV/AIDS in the late 1990s, such as contracting of NGOs to deliver key health services (e.g. South Africa’s ‘down-referral’ model) and outsourcing parts of the health system (e.g. in Kenya and Uganda, the contracting to faith-based organizations and treatment services, and even whole hospital systems. Until the 1990s, the IFC had not had a strong portfolio in the health sector. This changed dramatically during the first decade of this century. By 2016, the IFC had an active portfolio of $2 billion in private sector healthcare businesses located in LMICs.

International health was once dominated by the public sector through UN agencies and bilateral organizations with some NGO participation. However, with the introduction of GPPPs and the increasing emphasis on private sector development, there is, in global health, a far greater degree of involvement on behalf of private sector and commercial actors - and, in general, greater familiarity with and acceptance of market-based approaches.
to many supply chains to get drugs and health supplies to underserved regions).

Development partners turned to two different but complementary approaches – market-based approaches, and engagement of the private sector with a specific focus on health system strengthening.

Market-Based Approaches
USAID pioneered one of the first market-based approaches: the Total Market Approach (TMA). USAID’s implementing partners began experimenting with TMA as a strategy to assist SM programs to become more sustainable. The assumption is, with a TMA approach, the public and private sectors work together to increase the market for and the availability of FP products and services. The claimed advantages of the TMA are that it increases affordability and choice so that different socio-economic groups can utilize services. USAID has invested in standardizing the TMA approach and developed methodologies to conduct market analysis to determine a country’s readiness for TMA. USAID’s FP programs widely use TMA, and the UNFPA also supports this approach.

The TMA seeks to leverage the comparative advantages of different market sectors to enhance FP services across market segments with government coordination and support. It is based on an understanding that meeting the diverse needs of different population segments requires increased attention to coordination across sectors.

USAID has also driven the development of another market-based approach: Market Shaping. In 2014, the Centre for Innovation and Impact at USAID released the Healthy Markets for Global Health: A Market Shaping Primer. The primer was developed through a collaboration with several multi-lateral organizations involved in bringing vaccines, drugs and other health products to the global market - USAID, UNITAID, UNICEF, Gates Foundation, DFID, Norad, the Global Fund, and the Government of South Africa. The primer provides an overview of the basics of market shaping, an analytical approach for tracing market shortcomings to their underlying root causes, and guiding principles for designing, implementing, and evaluating interventions. In many ways, the market shaping primer brings together the collective experience in GPPP and presents a systematic approach to diversify “the supply base, increase shipment reliability, and ultimately increase product access for end users”. However, it is important to note that market shaping focuses almost exclusively on “life-saving commodities”
in the health sector.

During this period, DfID and the World Bank came together to develop a new market systems approach, called Managing Market for Health (MM4H). This builds on the Making Markets Work for the Poor (M4P) approach that seeks to change the way markets (primarily micro-finance and agricultural markets) work so that poor are included in the benefits of growth and economic development. The DfID and World Bank collaboration has sought to apply similar principles and experiences to the health sector. Unlike its predecessors, MM4H centers on the government’s role in shaping local health market sectors – e.g. primary care, hospital services, specialist services, product supply chains etc – through the use of a problem-based strategic framework and the use of ‘tools of government’ through which policymakers influence markets in support of core health policy objectives, such as equity of access, enhanced affordability, and higher quality services.

In common with these concepts, DfID supported a multi-year project to increase the use of private sector-provided health services by poor people in Kenya, Ghana and Nigeria using an MM4H approach. The project incorporated community engagement to encourage enrollment; advocacy to increase the range of preventative and primary care services in the National Health Insurance (NHI)-covered package; empanelment/accreditation of franchised providers; and technical assistance to private providers to improve business skills and access to credit. A similar three-year project in Kenya – PSP4H – sought to apply M4P principles in the country’s health sector, with the aim of reducing the cost of private health insurance and enhance access to private midwifes, private pharmacy networks, private eye care and surgery.

The brief history provides context for findings below concerning the global health community’s current approach to private sector engagement. As the trends in private sector engagement reveals, the approaches have been ad hoc and opportunistic, responding to country needs and global health crisis as well as the arrival of new actors into the global health community. However, the recent developments in private sector approaches relating to health systems strengthening and managing market systems are more promising. To consolidate the advances made to date in private sector engagement, it is important to move from ad hoc to strategic approaches embraced across agencies.

KEY FINDINGS

We drew on an initial online search to identify a ‘long-list’ of international organizations – including WHO divisions and regional offices – with a private sector component of their activities. We identified a large number of such entities, in various organizational categories (inter alia) bilaterals, multilaterals, development banks, charitable foundations, and
WHO departments/regional offices). In particular, we identified a large number of bilateral donors (the aid agencies of the US, the UK, France, Japan, Canada, the Netherlands, Norway and Sweden etc) that indirectly support private sector engagement activities by co-funding international agencies (e.g. UN agencies such as the UNFPA, UNITAID, UNICEF, UNAIDS and the WHO) and multi-lateral initiatives (e.g. GAVI, GATFM, Global Funds and the World Bank/GFF).

For example, GAVI has become an important player in private sector engagement at the global level - shaping international markets for health products and medicines through its GPPPs.

Similarly, GATFM is a major financier of disease-specific programs, in HIV/AIDS, TB and malaria, that include large-scale attempts to engage the private sector. However, our primary focus in this report is that subset of organizations which is directly engaged in private sector engagement at the country level.

Specifically, we focused our analysis on the 10 entities (see Table 3) that were identified by key informants as global leaders in the private sector engagement agenda on the grounds that:

1. they have programs and projects that directly engage with the private health sector in LMICs; and/or
2. they are active “in the trenches” of the private sector engagement agenda, using their expertise and influence to ensure that LMIC policy networks recognize the scale and importance of the private sector and, where possible, adjust their policies accordingly.

We focus on these 10 because, in our view, these are the main organizations that WHO-HGF will need to partner with, and learn from, in building an informed case and momentum behind the more strategic, UHC-focused, approach to private sector engagement that is called for by the 2030 Agenda for Sustainable Development and the WHO’s thirteenth

Table 3. Key international organizations directly involved in private health sector engagement in LMICs

<table>
<thead>
<tr>
<th>TYPE</th>
<th>ORGANIZATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bilaterals</td>
<td>• Department for International Development (DfID)</td>
</tr>
<tr>
<td></td>
<td>• KfW</td>
</tr>
<tr>
<td></td>
<td>• United States Agency for International Development (USAID)</td>
</tr>
<tr>
<td>Multilaterals</td>
<td>• World Bank (Health, Nutrition and Population)</td>
</tr>
<tr>
<td></td>
<td>• International Finance Corporation (IFC)</td>
</tr>
<tr>
<td></td>
<td>• Global Financing Facility (GFF)</td>
</tr>
<tr>
<td>Foundations</td>
<td>• Bill &amp; Melinda Gates Foundation (BMGF)</td>
</tr>
<tr>
<td>WHO divisions/regional offices</td>
<td>• Global TB Program</td>
</tr>
<tr>
<td></td>
<td>• Global Malaria Program</td>
</tr>
<tr>
<td></td>
<td>• Regional Office for the Eastern Mediterranean (EMRO)</td>
</tr>
</tbody>
</table>

11 We also examined the activities of the regional development banks – the European Bank for Reconstruction and Development (EBRD), the Asian Development Bank (ADB) and the African Development Bank (AfDB) – in the health sector. These banks are working with LMIC governments to implement infrastructure-related public-private partnerships (PPPs). However, with the exception of a small number of upper middle-income countries (e.g. Egypt, South Africa, Turkey), these efforts have so far had limited traction in the health sector.
As section 2 of this document makes clear, in the past, most donor-led private sector engagement approaches have been tied to ‘vertical programs’, i.e. programs that:

1. are focused on specific products and services (particularly, those related to certain health/disease areas such as FP/RH, MCH, HIV/AIDS, TB, and malaria);
2. engage a distinct set of funders and partners; and
3. involve a specific set of activities, priorities and evaluation approaches related exclusively to program-specific objectives.

Our data shows that this verticalized approach to engagement remains the norm. According to key informant interviews, the Public-Private Mix for TB Prevention and Care – led by the WHO Global TB Program – is perceived to be the most mature and sophisticated example of this approach. The PPM approach in TB involves the provision of free/heavily subsidized medicines and health products to clinical and diagnostic facilities in return for an agreement to notify cases and undertake training. In some cases, engagement includes financial incentives under formal contracts. In addition, to inform its programming, the Global TB Program has been involved in developing and applying new methods of private sector data collection and analysis, including patient pathway analysis, which has helped bring to light the considerable presence of the private sector in TB prevention and treatment.\(^1\)

Similar approaches have been used to serve program objectives in other disease areas. For example, between 2013 and 2016, the WHO was involved in a program to support the creation of markets for quality-assured rapid diagnostic tests for malaria (mRDTs) in five LMICs - Kenya, Madagascar, Nigeria, Tanzania and Uganda. Sustaining Health Outcomes through the Private Sector (SHOPS and its sequel, SHOPSPlus) – a USAID funded project – harnessed private sector capacity in multiple countries with the aim of improving health outcomes related to FP, HIV/AIDS, and MCH. Both projects provided financial resources, training and market information to inform suppliers along with technical assistance to reduce regulatory barriers and enable scale up of commercial markets.

In some cases, product-specific strategies have elements of a more ‘horizontal’ approach. For example, USAID’s PSP-ONE, SHOPS, SHOPSPlus and SM programs support activities to reduce regulatory barriers to private engagement. Examples of such activities include: (i) reforming regulations to allow private providers to diagnose and treat TB, HIV/AIDS and malaria patients; (ii) changing regulations related to the marketing of FP products; and (iii) bringing together

\(^1\)World Health Organization, Engaging Private Health Care Providers in TB Care and Prevention: A Landscape Analysis. WHO/CDS/TB/2018.33
public and private actors to dialogue on ways of addressing challenges to program implementation.

But, even here, the focus is on strengthening health systems so that they are better able to address program-specific objectives, as opposed to comprehensive health system objectives, such as UHC. While the technical work undertaken in these programs has been valuable, the focus on specific disease-areas, rather than on strengthening health systems more generally, has been limiting in terms of:

1. **Geographical coverage.** The primary factor determining the locus of engagement is the burden of the targeted disease. There appears to be no relation between the presence of engagement and the need for it – e.g. no evidence that activity is more likely to occur in settings in which there is a large, unregulated private sector relative to the public sector.

2. **Product/service coverage.** Current activity is concentrated on products (streamlined importation, efficient provision with geographic reach, and retailing and dispensing/testing within pharmacies and drug shops), and there is less emphasis on services, (and where services are captured, there is limited consideration of linkages between those targeted and other critical services delivered in hospitals, clinics, etc).

3. **The extent of health systems analysis.** In general, the dominant program-specific focus is unlikely to deliver – and may even undermine - the strategic framework for private sector engagement called for by the WHO thirteenth general program of work, 2019–2023, and reflected in the Advisory Group’s focus on Governance of the Private Sector for UHC.

Indeed, our documents and key informant interviews indicate that only a modest subset of the international agencies – DfID, the World Bank-HNP and the GFF – are routinely supporting/advising on market-based approaches and private sector purchasing strategies in a systems-focused way (Table 4).

(2) Some agencies’ approaches to engagement are not well-aligned with UHC objectives

Bilateral donors support a range of programs that focus on shaping or expanding specific commercial markets – e.g. markets for voluntary private insurance, or for health products and services. For example, the TMA approach, supported by USAID (see Table 5), seeks to segment the market according to consumer group. A core objective of the TMA is to take financial pressure off the public sector, allowing the public sector to focus its resources on those with the least ability to pay. The key informant interviews revealed that there is uncertainty about the extent to which this approach is consistent with UHC. The financial impact of out-of-pocket financing implied in TMA may not be consistent with financial protection. In addition, for reasons documented in the World Health Report 2010, neither voluntary nor out-of-pocket financing
are conducive to equitable access to care.

Similarly, the IFC has led the development of a number of funds for investment in commercial health businesses in Africa. These include the Africa Health Fund (US$105 million), the Investment Fund for Health in Africa (US$66 million) and the follow-up Investment Fund for Health in Africa II (US$137 million) – all part of the World Bank/IFC’s Health in Africa program, an investment program initially valued at $1bn, whose objective was to “catalyze sustained improvements in access to quality health-related goods and services in Africa, achieve financial protection against the impoverishing effects of illness...with an emphasis on the underserved.”\(^\text{14}\) However, an independent mid-term review of Health in Africa, conducted by Brad Herbert Associates in 2012,\(^\text{15}\) reported the program’s failure to reach poor people via the private sector, leading to a major re-scoping of the program.\(^\text{12}\)

However, there is some doubt among our informants as to whether investments focusing on expanding commercial markets in insurance, products and services can play a meaningful role in accelerating progress towards UHC. Where such goods are distributed on the basis of individuals’ willingness and ability to pay, there is likely to be inequities in their distribution to the population. It is possible that an expansion of such markets will lead to the establishment (or consolidation) of a ‘two-tier’ health system, one in the market is segmented into “high quality services for the affluent, and poor services for the poor”.

This is a particular concern for programs that aim to expand insurance markets (or individual insurance companies, or HMOs) as a means of enhancing coverage. While it can be argued that such markets can enable governments

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**Examples of IFC investments under the Health in Africa program**

**IFC Direct Investments**
- Hygiea (Nigeria/$2.2m) - Hospital & HMO
- Life Healthcare (South Africa/$100m) - Hospital
- Nakasero Hospital (Uganda/$3m) - Hospital
- IMG (Uganda/$2.2m) - Hospital & HMO

**Fund Investments - Investment Fund for Health in Africa (IFHA)s**
- Hygeia (Nigeria/€2m) – Hospital and HMO
- Pyramid Pharma (Tanzania/€1.4m) – Pharmaceutical distributor
- AAR (East Africa/€7m) – HMO
- Sourcelink (€2m) - Singaporean diversified medical holdings company active in Africa

**Fund investments - Equity Vehicle for Health in Africa (EVHA)**
- Nairobi Women’s Hospital (Kenya/$2.67m) – Hospital
- Revital (Kenya/$2.75m) – An early stage manufacturing company
- Avenue Group (Kenya/$2.5m) – Hospital & Managed Healthcare plan provider
- Bridge (Nigeria/$5) - specialized fertility treatment and medical laboratory services

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\(^{13}\)See USAID’s project website here: https://www.shopsplusproject.org


Table 4. Goals and foci of international organizations’ activities in private sector engagement (PSE)

<table>
<thead>
<tr>
<th>ORGANIZATION</th>
<th>GOAL(S) OF PSE</th>
<th>LMIC FOCUS FOR PSE</th>
<th>CLIENT(S) FOR PSE</th>
<th>PROGRAMMATIC/PRODUCT FOCUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>DFID</td>
<td>To enhance the value for money and quality of health-related products and services across private sector categories</td>
<td>Sub-Saharan Africa</td>
<td>Government, local private sector, (I)NGOs and CSOs</td>
<td>Horizontal and vertical dimensions, focused on specific services (relating to preventative, primary, maternity care); and products (for FP and SRH, nutrition, malaria, ARI, diarrhea, HIV, TB)</td>
</tr>
<tr>
<td>USAID</td>
<td>To create and/or support the growth of the commercial market for key health products, services, and private insurance</td>
<td>South- and south-east Asia, sub-Saharan Africa, Eastern and Southern Caribbean</td>
<td>Government, local private sector, (I)NGOs and CSOs</td>
<td>Mostly vertical and product-focused, in relation to prioritized disease/health areas: HIV, malaria, TB, MCNH, FP, nutrition</td>
</tr>
<tr>
<td>KfW</td>
<td>Create demand for high-quality FP/RH products, oral rehydration salts (ORS) and insecticide-treated bed nets (ITNs)</td>
<td>Global</td>
<td>Government, local private sector, (I)NGOs and CSOs</td>
<td>Mostly vertical and product-focused, in relation to prioritized FP/RH products, ORS and ITNs</td>
</tr>
<tr>
<td>World Bank (HNP)</td>
<td>To enhance government stewardship of private sector; and encourage private providers to improve the value for money and quality of their products</td>
<td>Global</td>
<td>Government (a loan to the government and policy support)</td>
<td>Mostly horizontal – e.g. focused on enhancing data (via funding for private sector assessments), and providing technical assistance for effective governance of the private sector, and strategic purchasing of private sector-provided services and products</td>
</tr>
<tr>
<td>IFC</td>
<td>To support the growth of the private health sector by increasing access to capital and advising governments on policies that engage businesses</td>
<td>Global</td>
<td>Government (policy support transactions advice); private sector (equity/debt financing)</td>
<td>Project- of firm-specific. The IFC’s focus differs by region, i.e. in sub-Saharan Africa, the focus is on secondary/tertiary hospitals and insurance; in south- and south-east Asia, it is integrated systems: outpatient care, diagnostics, e-health, and supply chains</td>
</tr>
<tr>
<td>GFF</td>
<td>To leverage, through policy support and funding, private sector capacity in countries to deliver on GFF objectives</td>
<td>Bangladesh, Ghana, Indonesia, Kenya, Myanmar, Mozambique, Nigeria, Uganda, Zambia</td>
<td>Government (a loan to the government and associated policy support)</td>
<td>Vertical in terms of disease/health area focus, but horizontal in delivery, due to range of services and products implicated in the RMCHN domain and the importance of primary care in particular</td>
</tr>
<tr>
<td>BMGF</td>
<td>Build government capacity to purchase both MCH-specific and general health products &amp; services from private actors</td>
<td>Sub-Saharan Africa</td>
<td>Government, academic institutions and NGOs</td>
<td>Can be vertical (SP4PHC); or horizontal in some cases (SPARCS)</td>
</tr>
<tr>
<td>WHO (TB)</td>
<td>To support improved engagement of private providers through PPM, contributing to universal access to quality, affordable prevention and care</td>
<td>Focused on high burden countries with dominant, poorly regulated markets: India, Pakistan, Indonesia, Philippines, Myanmar, Bangladesh, Nigeria</td>
<td>Government, National Treatment Programs (NTPs)</td>
<td>Vertical in health area focus (TB), focused on services (private facilities, physicians and laboratories) and products (medicines)</td>
</tr>
<tr>
<td>WHO (Malaria)</td>
<td>To support improved engagement of private providers through PPM, contributing to universal access to quality, affordable prevention and care</td>
<td>Focused on high burden countries where a high proportion care is privately provided: Chad, DRC Kenya, Ghana, Niger, Nigeria, Tanzania, Uganda</td>
<td>Government, National Treatment Programs (NTPs)</td>
<td>Vertical in health area focus (TB), focused on services (diagnostic) and products (diagnostic testing kits and malaria medicines)</td>
</tr>
<tr>
<td>EMRO</td>
<td>To assist member states in the EMRO region to strengthen their capacity to engage with the private health sector in a strategic way to advance UHC</td>
<td>EMRO countries</td>
<td>Government</td>
<td>Horizontal and UHC-focused (though agenda is currently at the development stage)</td>
</tr>
</tbody>
</table>
to refocus their resources towards the poor, experience suggests that this approach tends to result in a pro-rich distribution of health resources, leading to restricted access and coverage for poor people. In general, when engagement by international agencies leads to the development of commercialized (e.g. self-pay) markets, there is potential for a ‘two-tier’ system to emerge, one in which resources are concentrated in affluent areas and cater only for individuals who can pay. Such a health system is unlikely to deliver the levels of equity of access and financial protection required by UHC.

(3) There is an absence of engagement activities aiming at improved governance

Governments are in a unique position to leverage private sector capacities (e.g. its ability to respond to patient preferences, its ability to raise capital, its strong incentives to innovate etc) for the public health interest. Commercial incentives may compromise public health if they are not molded by effective government stewardship. The fact that in many low-income countries, the capacities needed to effectively steward the private sector are weak or non-existent implies major risks to public health.

The World Bank (HNP) has numerous bank loans supporting performance-based financing (PBF) and other health financing reform initiatives focused on social health insurance which, it is assumed, will result in stronger strategic purchasing of privately delivered health services. Similarly, USAID’s health financing projects provide technical assistance to help countries increase their domestic resources for health, manage government resources more effectively, and make more efficient purchasing decisions. Finally, BMGF’s Strengthening Strategic Purchasing in Africa (SPARCs) and Strategic Purchasing for Primary HealthCare (SP4PHC) assist Ministries of Health in LMICs to create the institutional arrangements and build capacity to buy health services that will use public health funds efficiently to deliver affordable, high-quality health services to more people in an equitable way. However, these projects do not systematically include the private sector – inclusion of private providers may happen, but is largely country driven. Indeed, most of the country’s request to include the private sector in their insurance and contracting reforms is driven by the imperatives of the UHC and not the development partners’ recognition of the reality of a mixed health delivery system.

There are a number of agencies involved in (a) reforming policies and regulations that present obstacles to private provision of specific services and products (USAID, WHO Global TB Program, WHO Global Malaria Program Malaria), and (b) conducting assessments on private sector activities (EMRO, USAID, World Bank, GFF and the WHO). Yet, as Table 5 shows, only two organizations – the World Bank (HNP) and GFF are routinely carrying out strategic governance-related activities with a focus on UHC. For example, under the Health in Africa

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<table>
<thead>
<tr>
<th>OPERATIONAL APPROACHES</th>
<th>DESCRIPTION</th>
<th>PROGRAM FOCUS</th>
<th>INTERNATIONAL ORGANIZATION</th>
<th>EXAMPLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance</td>
<td>Efforts to strengthen the capacity of governments to constructively engage the private sector in providing health services &amp; products.</td>
<td>Horizontal</td>
<td>World Bank (HNP)</td>
<td>Health in Africa: initiative to provide policy support, and to government in sub-Saharan Africa, and to enable public/private dialogue for service, product and insurance provision.</td>
</tr>
<tr>
<td>Strategic purchasing</td>
<td>The allocation of pooled funds (usually contingent on levels of performance), to providers of health products or services on behalf of a specified population.</td>
<td>Horizontal</td>
<td>BMGF</td>
<td>Strategic Purchasing Africa Resource Centre (SPARCS): Demand-driven resource platform for LMICs in sub-Saharan Africa implementing strategic purchasing.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Vertical - maternal health</td>
<td>BMGF</td>
<td>Strategic Purchasing for Primary Health Care (SP4PHC): Use strategic purchasing for delivery of FP and MCH services in primary care settings.</td>
</tr>
<tr>
<td>Market-shaping</td>
<td>Seeks to achieve health goals by changing the institutional environment in which market actors – manufacturers, distributors, buyers, regulators, and donors – choose how to produce, distribute and deliver global health products.</td>
<td>Vertical – disease-specific products</td>
<td>USAID, DFID</td>
<td>DFID-Clinton Health Access Initiative (CHAI): ‘Market-Shaping’ for Access to Safe, Effective and Affordable Health Commodities: accelerating access to new and improved health commodities across the areas of HIV, TB, malaria, hepatitis, family planning and vaccines.</td>
</tr>
<tr>
<td>Managing Markets for Health</td>
<td>Centering on the government’s role in shaping health markets to improve the range and quality of health products and services available to the population while insulating people against direct costs.</td>
<td>Horizontal</td>
<td>DFID, BMFG</td>
<td>African Health Markets for Equity (AHME): multi-year project to increase the use of private sector-provided health services by poor people in Kenya, Ghana and Nigeria using an MM4H approach.</td>
</tr>
<tr>
<td>Private sector development</td>
<td>Seeks to encourage the development of the commercial markets for health products, services, and insurance in LMICs by enhancing access to capital, market information and addressing regulatory barriers.</td>
<td>May be horizontal or vertical but tends to be firm-specific.</td>
<td>International Finance Corporation (IFC)</td>
<td>Health in Africa (HA): initiative, initially valued at $1bn, to enable engagement with and growth of the private sector in sub-Saharan Africa, underpinned by provision of capital financing (equity and debt) provided by IFC.</td>
</tr>
<tr>
<td>Total market approaches</td>
<td>Seeks to establish sustainable markets for needed health products by increasing demand for across consumer segments, enabling private actors to address demand.</td>
<td>Vertical – disease-specific products</td>
<td>USAID</td>
<td>Sustaining Health Outcomes through the Private Sector (SHOPS): harnessing private sector capacity to improve health outcomes in family planning, HIV/AIDS, and maternal and child health.</td>
</tr>
</tbody>
</table>
program, the Bank provided policy support to governments in sub-Saharan Africa to enable public/private dialogue to emerge for service areas related to the investment program. In addition, GFF’s country programs focus on public-private dialogue and the reform of policies to shape service markets of relevance to RMCNH. Although these organizations are in a good position to play a leading role in providing support to LMICs on governance, they are constrained by their mode of engagement (i.e. loans to government, and/or performance-based financing and contracting of private sector providers) - and, currently, limited numbers of specialist staff with experience in private sector engagement in health systems.

**Governance and policy framework to support private sector engagement and strategies to align private sector services and investment to national UHC goals and objectives are critical gaps in the collective activities of development partners.**

**RECOMMENDATIONS FOR WHO-HGF**

As highlighted above, parts of the WHO have already made substantial progress in recognizing and engaging the health sector. The Global TB Program has, for example, championed investment in data about the private sector, and has used this to demonstrate the scale of the private sector in target countries, and the need for engagement with the sector to optimize TB prevention, care and control. Outside of TB, progress on this agenda has been muted. Indeed, our key informants expressed skepticism that a “one disease at a time” approach is optimal.

It is encouraging, therefore, to observe EMRO’s approach. It is leading the calls for a new strategic approach to private sector engagement that has a clear ‘horizontal’ focus. A resolution of the Regional Committee for the Eastern Mediterranean endorsed its approach (EM/RC65/R.3), and called on member states in the region to (i) incorporate effective engagement with the private health sector into their national policy, strategies and plans for UHC and (ii) build capacity in ministries of health to design, manage, monitor and evaluate effective engagement strategies. EMRO’s initiative with its member states can inform, and move forward in synergy with, WHO-HGF’s own activities in this area. However, catalyzing action within LMICs will be challenging. Government officials may be reluctant to assume accountability for the private sector, over which they have limited influence.

In this context, our specific recommendations, organized by target audience, are as follows:

**For the Global Health Community**

Provide data on the private sector

A common theme among our key informant interviews is the lack of data and information on the private health sector, especially outside of those areas prioritized in the large disease-specific

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INTERNATIONAL ORGANIZATIONS AND ENGAGEMENT OF PRIVATE PROVIDERS

programs. For example, there are many LMICs where the scale of private expenditure as a proportion of total health expenditure is known to be large, but there is little knowledge of where this is going – and what the delivery system looks like. The key informant interviews revealed the difficulty for member states and global health practitioners to access data on the nature and extent of the private health sector at the country level to inform policy and planning, and to strengthen the case for recognizing the importance of engagement. As one informant commented: “It is time for the WHO and its member states collectively to develop some new sensory organs so that they become better at evaluating what’s actually happening on the ground.”

**WHO Headquarters (HQ) can play an instrumental role in centralizing and curating information on private health sector engagement in LMICs.** Other organizations, such as the USAID private sector projects (e.g. PSP-One, SHOPS and SHOPS+) have fulfilled this role for upwards of 15 years. However, this function may disappear due to the vagaries of donor funding; and, for reasons already considered, donor agencies are not best placed to provide technical leadership on cross-cutting areas such as UHC. WHO can provide the consistency and sustainability of this function for the global health community.

As a first step, WHO can create a “clearing house” on the WHO’s website that centralizes WHO’s documentation on current private health sector activities (e.g. Stop TB, EMRO policy analyses, etc.), tools and methodologies, publications and research. Other activities may include: (i) coordinating with Tier1 partners to find a way to link with their resources on private health sector activities, tools and methodologies and research, (ii) producing a series of WHOBulletins curating these technical resources from WHO and others, and (iii) “push out” new research, tools, and methodologies to subscribers as they are cataloged in the resource center.

In addition to creating a clearing house on private health sector engagement, WHO can also help shape and coordinate the research required to generate the evidence on private sector engagement. In its role as an “honest broker”, WHO can: (i) convene strategic development partners and research institutions to develop a common research agenda, (ii) advocate with other development partners to invest in building the evidence and documenting successful approaches in private sector engagement, (iii) encourage and

**WHO is in a unique position to play an honest broker and leadership role on private sector engagement.** WHO should constitute a standing Technical Working Group comprised of Tier 1 and 2 organizations as well as experts and practitioners in private sector engagement. The TWG can help build consensus among the global health community on a strategic approach to private sector engagement aligned to UHC.
assist member states to document and conduct operational research on private sector engagement, and (iv) partner with strategic development partners to sponsor dissemination events globally and regionally on the latest developments and evidence on private sector engagement.

**Frame private sector engagement**

There is a pressing need for WHO to facilitate a commonly shared framework with a UHC-oriented lens for private sector engagement that can be used by the global health community. Currently, WHO and other development partners (e.g. DFID, USAID, the World Bank (HNP)) are leading the way in private sector engagement with heavy emphasis on disease-specific programs. Progress towards a more systemic approach is variable and patchy as this report demonstrates. WHO can facilitate a consensus process similar to the one that created the Private Sector Governance Roadmap to develop a common framework for private sector engagement aligned with the UHC agenda. Through this process, WHO-HGF can co-develop a common language with clear definitions supporting the consensus framework, so that all stakeholders within the global health community can communicate effectively with one another.

**Coordinate approaches to private sector engagement**

WHO can also play a crucial coordinating and clarifying role on private sector engagement approaches. As our data sources have demonstrated, there is a large amount of activity in relation to private sector engagement but not all of it is well-aligned with UHC. Member states are struggling with multiple conflicting priorities driven by development partner agendas. Some donors (e.g. development banks) are focused on *private sector development* including commercial approaches (self-pay and private investment) while others (DFID, USAID, WB) are focused on enhancing government stewardship of the private health sector and ensuring private sector participation in national health insurance.

These priorities are different. At times, they may be in conflict (e.g. should countries view their private sectors as the delivery system for their national health insurance programs, or as a complementary source of provision for the better off?). WHO can help coordinate the approaches by:

1. sponsoring round-table meetings and regional symposia that disseminate the evidence and research on effective engagement approaches;
2. facilitating honest discussions among development partners on potential conflict and divergence in different private sector engagement approaches; and
3. creating clarity and a common understanding on the different private sector engagement approaches - particularly on the current generation of market-based approaches – their respective goals and applications.

**WHO HQ / Regional WHO Offices**
Four distinct groups emerge from the analysis of our interviews with WHO staff:

1. leaders in the private sector engagement agenda, such as the Global TB Program and WHO-EMRO, who have championed the importance of engagement, and are making (incremental) headway in reaching their objectives with respect to the private sector;

2. other regional and country offices, including those with high burdens of disease and PPM models at a less mature stage of development – who often field requests for technical support on the private sector, and are keen to learn more about how to provide this;

3. other WHO departments (e.g. relating to malaria, HIV/AIDS and MCH) that are well-positioned to integrate private sector approaches into their “toolkit” and methodologies, and are simply waiting for, and keen to see, new guidance and central direction; and

4. staff in Geneva and the Regions, who are suspicious of, and resistant to, working with the private health sector.

WHO-HGF can take a leadership role in setting central WHO policies/coordination that will help mainstream private sector engagement within WHO. It will be critical for WHO-HGF to form an internal “coalition of the willing” to widen the base of support, provide political cover, and create a shared understanding of the strong public health case for private sector engagement. The goals of the mainstreaming strategy on engagement would be:

1. to build WHO leadership support;

2. to broaden the base of support, in part by explaining and substantiating the nature of a UHC-oriented approach to engagement;

3. persuade regional offices to engage their member states; and

4. provide the tools and resources.

Below are a few activities that this “coalition of the willing” under HGF’s leadership can undertake together to build support for and normalize private sector engagement approaches within WHO.

Provide evidence-based advocacy to build support for private sector engagement

To date, there is still no clear vision or commitment from the WHO’s leadership on private sector engagement. As a result, some WHO departments and regional offices are reluctant to move ahead in this domain. Immediate steps to build political support include: (i) finalize the Private Sector Governance Roadmap; (ii) make a summary version of the Roadmap and disseminate this widely among WHO; (iii) bring WHO champions/leaders in private sector engagement together with WHO departments to share their experience and lessons learned; and (iv) assist these WHO champions/leaders to...
disseminate their messages and materials.

Provide international support among member states for private sector engagement
Another important strategy will be WHO/HGF’s initiative to pass another World Health Assembly resolution. This revised and more comprehensive WHA resolution should be focused on creating external pressure from member states supporting the resolution to provide political cover for WHO regional and country offices who want to increase their work on this theme.

Provide evidence and resources to assist WHO colleagues in private sector engagement
There are potential champions within WHO HQ departments and regional and country offices that need guidance to integrate private sector activities into their program and/or guidance to member states. Immediate steps to assist this small group of potential champions: (i) form an internal community of practice on private sector engagement; (ii) share information on current best practices and tools and methodologies on private sector engagement; (iii) share WHO’s best practices – for example, the patient pathway analyses undertaken within the Global TB Program (helping to ground private sector engagement within the frame of people-centered health systems), and the disciplined UHC focus of the emerging EMRO in this area; and (iv) create a roster of international experts and institutions with experience in private sector engagement and match them to COP members to adapt and integrate private sector approaches to COP members’ programs of work.

Member States
WHO can play a valuable evidence-informed advocacy role with LMIC Ministries of Health by leveraging its long standing relationships and close engagement with member states to introduce the concepts of private sector engagement and governance of mix health systems. Moreover, WHO is well positioned to directly assist and/or leverage resources needed to assist member states to tackle barriers to private sector engagement (e.g. government’s reluctance to extend its activities into the private sector, lack of data on private sector to inform policy and planning, absence of formal mechanisms to engage private health sector to name but a few). In the short- and medium-term, WHO/HFG can:

Provide evidence-based advocacy to build member state support
As an honest broker, WHO can assist country offices to address member state’s reluctance to engage the private health sector and/or to adopt best practices for governing a mixed health system. Extend the activities outlined in provide international support among member states for private sector engagement, but adapted to a country government audience: (i) identify the most promising countries who are open to private sector engagement and willing to implement aspects of the RoadMap; (ii) translate the RoadMap brief and develop a companion powerpoint; (iii) facilitate WHO champions/leaders
to engage these target countries in a regional workshop to share their experience and lessons learned; and (iv) facilitate opportunities to bring international experts and practitioners in private sector engagement together with these target countries through regional workshops or through other mechanisms (e.g., community of practice, routine webinars, etc.).

**Develop guidance and on evidence-based approaches**

As part of WHO’s mandate to provide the long-term support and guidance to LMIC governments, WHO – either directly or through strategic partnerships with other development partners – can: (i) develop policy frameworks, organizational systems and financing strategies for engaging private sector product and service providers in achieving public health objectives; (ii) develop strategic options for private sector engagement, including strategic purchasing, and facilitate and institutionalize private sector engagement; (iii) ensure that regulatory and quality assurance mechanisms include the entire health system and are enforced fairly in the private sector; and (iv) develop monitoring and reporting mechanisms that can hold both public and private health sector to account.

**CONCLUSION**

As one of our key informants noted, global and LMIC-based policymakers may be reluctant to devote serious attention to the private sector until it becomes a priority on their policy agenda: “They will wake up when there is a problem that they can’t ignore, and only then they’ll look for remedial action.” Considerable effort are required to draw global and local policymakers’ attention to problems related to the lack of engagement, especially when these problems have persisted for a long time since policymakers have routinely ignored or even accepted them as normal or unavoidable.

In this context, there is both an urgent need, and a notable opportunity, for WHO-HGF to play a pivotal role in addressing this challenge. Many of our key informants see WHO as being in a unique position, given its mandate as the steward and normative leader of global health, and its strong legitimacy, credibility and relationships with...
international organizations and LMIC Ministries of Health alike. As one of our key informants stated: “WHO should get out of their headquarters more - out into the field, into the countries. We need their help in bringing the public and private sectors into one room to agree on how to move forward on the UHC agenda.”
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<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
<th>Description</th>
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<tr>
<td>ADB</td>
<td>Asia Development Bank</td>
<td>LMICs, Low- and middle-income countries</td>
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<td>AfDB</td>
<td>Africa Development Bank</td>
<td>MOH, Ministry of Health</td>
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<td>AMC</td>
<td>Advance Market Commitment</td>
<td>M4P, Markets for the Poor</td>
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<td>ANC</td>
<td>Antenatal care</td>
<td>MM4H, Managing Markets for Health</td>
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<td>BCC</td>
<td>Behavior change communication</td>
<td>MMV, Medicines for Malaria Venture</td>
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<td>BMGF</td>
<td>Bill &amp; Melinda Gates Foundation</td>
<td>MVI, Malaria Vaccine Initiative</td>
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<td>CSO</td>
<td>Civil society organizations</td>
<td>NGO, Non-government organizations</td>
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<tr>
<td>CVI</td>
<td>Childhood Vaccine Initiative</td>
<td>NORAD, Norwegian Agency for Development Cooperation</td>
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<tr>
<td>CVP</td>
<td>Childhood Vaccine Program</td>
<td>NTP, National Treatment Programs</td>
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<tr>
<td>DFID</td>
<td>Department for International Development</td>
<td>ORS, Oral Rehydration Salts</td>
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<tr>
<td>EMRO</td>
<td>Regional Office for Eastern Mediterranean</td>
<td>RMCNH, Reproductive, maternal, child and nutrition health</td>
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<tr>
<td>GAFTM</td>
<td>Global Fund to Fight AIDS, TB and Malaria</td>
<td>SDG, Sustainable Development Goals</td>
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<tr>
<td>GFF</td>
<td>Global Financing Facility</td>
<td>TMA, Total Market Approach</td>
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<td>GPPP</td>
<td>Global Public-Private Partnerships</td>
<td>UHC, Universal Health Coverage</td>
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<td>HNP</td>
<td>Health, Population and Nutrition</td>
<td>UN, United Nations</td>
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<td>HSS</td>
<td>Health System Strengthening</td>
<td>UNFPA, United Nations Fund for Population Activities</td>
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<tr>
<td>HQ</td>
<td>Headquarters</td>
<td>UNICEF, United Nations Children’s Fund</td>
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<tr>
<td>IAVI</td>
<td>International Aids Vaccine Initiative</td>
<td>UNITAID</td>
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<td>IFC</td>
<td>International Finance Corporation</td>
<td>USAID, US Agency for International Development</td>
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<tr>
<td>iNGOs</td>
<td>International non-government organizations</td>
<td>WHO, World Health Organization</td>
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ABOUT THE PROJECT

For more information about the work, please contact Dave Clarke, clarked@who.int

This document was commissioned by the World Health Organization and recommended by the Advisory Group on the Governance of the Private Sector for UHC as part of its ongoing work to develop a strategy for the World Health Organization and member states to effectively engage the private sector for the governance of mixed health systems.

Additional documents in this series include the following:
- Private Sector Accountability for Service Delivery in the Context of Universal Health Coverage
- Measuring the Size of the Private Sector: Metrics and Recommendations
- Principles for Engaging the Private Sector in Universal Health Coverage
- Private Sector Utilization: Insights from Standard Survey Data
- Engaging the Private Health Sector to Advance Universal Health Coverage: WHO Eastern Mediterranean Region Case Study

The Advisory Group on the Governance of the Private Sector for UHC was convened in February of 2019 to act as an advisory body to the WHO about developing and implementing governance and regulatory arrangements for managing private sector service delivery for UHC. The group was formed with the primary goal of providing advice and recommendations on the regulation and engagement with the private sector in the context of the WHO GPW goal of 1 billion more people benefiting from Universal Health Coverage, and in particular outcome 1.1.4 of this goal – “Countries enabled to ensure effective health governance”. Members of the Advisory Group include: Dr. Gerald Bloom, Mr. Luke Boddam-Whetham, Ms. Nikki Charman, Dr. Mostafa Hunter, Mrs. Robinah Kaitritimba, Dr. Dominic Montagu, Dr. Samwel Ogillo, Ms. Barbara O’Hanlon, Dr. Madhukar Pai, Dr. Venkat Raman, and Dr. Tryphine Zulu.

The authors would like the thank the following people for sharing their invaluable insights as part of the underpinning research: David Clarke, Gerry Bloom, Luke Boddam-Wenham, Susan Rae Ross, Amit Thakker, David Elliot, Charles Dalton, Chris McCahan, Andrew Myburgh, Andreas Seiter, Benjamin Loevinsohn, Sneha Kanneganti, Caitlin Mazzili, Ben Light, Cicely Thomas, Nikki Charman, Andrea Bosman, Jane Cunningham, Hannah Monica Dias, Deirdre Dimanesco, Hassan Salah, Phyllida Travis and Julie Murugi. The authors would also like to thank David Clarke and Aurelie Paviza from WHO and Cynthia Eldridge and Samantha Horrocks from Impact for Health International.

WHO also thanks those who were involved in commenting on this document. Financial support for this work was provided by the European Union as part of its support for the UHC Partnership.


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