Share-Net
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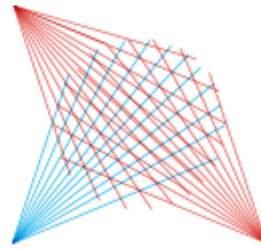

Getting to know each-other

Private sector engagement in improving Sexual and Reproductive Health and Rights in developing countries

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Foreword

Summary

Involvement of the private sector in the commitments of public and civil society sector organizations has become a major focus in development programs. However, little is known about the engagement of the private sector in improving sexual and reproductive health and rights (SRHR) in developing countries. This study aims to describe current private sector engagement and the experiences with such collaborations. This report brings a summary of the available literature. Additionally, key informants were interviewed about their experiences with private sector engagement. SRHR collaborations may have one or more of the following elements: (1) Advocacy toward governments, donors or the general public, in order to convince them of the importance of SRHR; (2) Strengthening the local private health sector, in order to reach populations that are difficult to reach through public health services alone; (3) Developing new products or service models, based on health needs of communities; and (4) Capacity building of professionals and health education of communities.

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1. Introduction

Involvement of the private sector in the commitments of civil society and public sector organizations has become a major focus in development programs. The sense of urgency to do so has been enhanced by reduced public funds for both development cooperation and the procurement of commodities, such as medicines or agricultural equipment. This has led to a greater reliance on the market for service provision, both in developed and developing countries (Capoor, 2005). For reaching the recently developed Sustainable Development Goals (SDGs), it is considered important that stakeholders from different sectors, including government authorities, businesses, civil society and non-governmental organizations, and research institutions cooperate (sustainabledevelopment.un.org). Such multisector partnerships bring together resources and skills that can help all partners to bring forward their missions, while also reducing risks for individual organizations (Urlings, Rook, Coppens, & Iver, 2015).

The 'market' is changing for the private sector. Until recently, "value was created by companies that had the power to invent, mass-produce, and deliver" (Brand & Rocchi, 2011). This situation is changing rapidly, now that the internet has enabled people to create and share content on an unprecedented scale, including opinions about products and the companies that produce them. Companies are required to listen to their consumers, rather than broadcast their own brand messages. Another development is that a higher level of stakeholder accountability is demanded. Social and environmental challenges are mounting, but these can also be construed as market opportunities. Moreover, the size and complexity of the problems in developing countries makes it evident that not one stakeholder can resolve them. Cross-sector collaboration is called for. Large corporations are increasingly involved in social causes (Brand & Rocchi, 2011). They do so for reputational benefit, competitive advantages such as opening new markets, and philanthropic health impact (Droppert & Bennett, 2015).

The Dutch Ministry of Foreign Affairs works with the private sector and encourages civil society organizations to do so as well. Private sector engagement is considered important for implementing Dutch development policy. The Ministry can contribute to such collaborations with funding, but also with sharing expertise, information, and contacts. Ministry funds for projects in which the private sector is involved are managed by the *Rijksdienst voor Ondernemend Nederland* (Netherlands Enterprise Agency, RVO), which comes under the Ministry of Economic Affairs, Agriculture and Innovation. Furthermore, the Ministry of Foreign Affairs supports the Partnerships Resource Centre at Erasmus University, where expertise on partnerships is concentrated (www.government.nl/topics/development-cooperation/contents/development-cooperation-partners-and-partnerships/public-private-partnerships).

Sexual and Reproductive Health and Rights (SRHR) is one of the four prioritized themes of Dutch development cooperation policy. The public sector, especially in the Netherlands, propagates a rights-based approach to sexual and reproductive health. A rights-based approach entails at least three characteristics: 1) the indivisibility of civil and political rights, and socio-economic rights; 2) active agency by those who are vulnerable to human rights violations; and 3) the powerful normative role of human rights in establishing accountability for protections and freedoms (London, 2013). The SRHR approach was firmly established in the 1994 International Conference on Population and Development (ICPD) in Cairo. However, SRHR was originally left out of the Millennium Development Goals (MDGs). Nevertheless, civil society and other advocates have ceaselessly stressed the importance of SRHR for development and wellbeing (Haslegrave, 2013).

So far, private sector engagement was primarily seen as bringing 'private sector efficiency' and focus to a world dominated by cumbersome public sector institutions (Chataway, Brusoni, Cacciatori, Hanlin, & Orsenigo, 2007; Roehrich, Lewis, & George, 2014). However, cooperation with the private sector is not without risk. The public and private sector have a different outlook on the world. Both public and private sector may be committed to improving the lives of people, but their missions do not necessarily converge. Characterized in short terms, the private sector is profit-oriented, while the public and civil society sectors are value-oriented. Of course, this distinction does not do justice to the variety within these sectors, and to the subtleties of the way they interact with each other and target populations. As a matter of fact, a trend has been observed that NGOs move toward more commercial models, such as social enterprises, while corporations are increasingly focusing on social objectives.

Some have warned that increased reliance on private investments may weaken a rights approach (McGovern, 2013). However, commercial interests do not necessarily conflict with human rights. The right to enjoy sexuality freely, for example, is substantially enhanced when women and men have access to contraceptives to protect themselves (and each other) from pregnancy and sexually transmitted infections (STIs). Even if sexual and reproductive rights are not the primary focus of companies, they may be able to contribute to their advancement. However, vigilance is needed, because the interests of partners (both government and business) can diverge from NGOs' commitment to sensitive issues, such as abortion and sexual diversity, leading to risk-avoidance in the themes and activities of multisector collaborations in this field (McGovern, 2013).

Share-Net International and its partners have decided to make public-private cooperation one of their eight priorities[1]. Even though cooperation between the public and private sectors is an important part of Dutch development policy, little is known about what is already being done and lessons learnt from joint programs. Therefore, this study sets out to draw up an inventory of existing initiatives in the field of SRHR. A literature review is conducted, supplemented with experiences of members and partners of Share-Net. The focus of this study is not on results and outcomes of partnerships, but on how the development of partnerships is experienced.

1.1. Research questions

The question that this study set out to answer was: How is the private sector engaged in improving SRHR in developing countries? This main research question is broken down in the following questions:

- What kinds of partnerships between public and private sector are there in general?
- On which SRHR themes do public and private partners collaborate, and what do they do?
- What are experiences of (particularly Dutch) organizations with these partnerships, including government?
- And what lessons can be learned from these experiences?

The aim of this research was to increase awareness among Share-Net members of the possibilities of private-sector involvement, what it takes to build a partnership, and to help them avoid common pitfalls in such cooperation.

[1] The other priorities are Sexual Diversity, Child Marriage and Teenage Pregnancy, Comprehensive Sexuality Education, Youth Friendly Health Services, Gender Based Violence, Integration of HIV and SRHR, and Contraception and Abortion.

2. Methods

This study consists of two parts: a literature review and telephone interviews. For the literature review both systematic and unstructured searches have been carried out. For the systematic searches, the following databases were searched in November 2015: EBSCO (Academic Search Premier), Medline (Ovid), and Sociological Abstracts. The search string was: (“private sector” or “public-private partnerships”) AND (“sexual*” or “srhr” or “contracepti*” or “hiv” or “reproductive rights” or “reproductive health”). If articles had terms in their titles or abstracts for both private sector involvement as well as sexuality-related terms, they were selected. If articles had HIV as the only sexuality-related term, HIV needed to be in the title for the article to be selected. Articles needed to be from 2003 or later.

This resulted in exactly 150 unique articles for consideration. Based on the abstracts, a further selection was made. Fourteen of the articles were not about SRHR, but about for example hormone replacement therapy or specific diseases, such as ovarian cancer or malaria. The majority of the other articles (118) were not about multisector cooperation. They were mostly about the local private sector, without public or civil society sector involvement. Some merely called for cooperation with the private sector in their conclusions. The remaining 18 articles were selected for closer inspection.

Further documents were found in unstructured searches. These searches were done with Google and Google Scholar with varying search terms. Also, experts and interview participants did some suggestions for essential reading. The documents that were found in this way included scientific articles, but also grey literature, such as online information, reports and policy papers. Most of these documents were not specifically about SRHR, but about multisector cooperation in general. All in all, 20 papers were found that described collaborations between public, private, and civil society partners.

Telephone interviews were done with participants of the Round Table meeting about engagement with the private sector in the field of SRHR and HIV at the Dutch Royal Tropical Institute in Amsterdam on 19 November 2015. A few other interviewees were suggested by participants. The list of the 16 participants can be found in the annex. The interviews were about experiences with projects in which the private sector was involved, experiences in working together with public, nonprofit and private sector parties, and lessons that can be learned from previous experiences. The interviews each took around 30 minutes. They were recorded (after the interviewee consented) and the researcher made a summary of what was said during the interviews. These were not validated with the participants.

For the analyses, the information of the documents that have been selected and the summaries of the interviews were studied for answers to the research questions. They were not formally coded, but the content of all sources was investigated for both convergent and conflicting points of view. These were synthesized into a narrative review of the data.

3. Multi-sector cooperation

The first research question of this paper is about the kinds of partnerships that exist between the public, private and nonprofit sectors in general (not specifically in the field of SRHR). None of the sectors are uniform entities with single purposes. Possibilities for cooperation differ between different organizations. There is not one blueprint for the collaboration between public and private sectors. In this chapter, the first research question is addressed with reference to literature about partnership modalities, position papers, and interview responses. Several possible configurations of partnerships are described. First, a description will be given of the public, private and civil society sector players that may be involved.

3.1. The public sector

The public sector provides government services. It includes both government authorities and providers of public services, such as public education and healthcare. Government authorities on all levels may be relevant for public-private cooperation. Local and regional authorities may be involved for grounding activities locally and to make them more sustainable. National authorities are often needed for supportive policies and resources. Transnational authorities, such as UN organizations (like UNFPA or UNAID) are important as well. They may stimulate innovation, procure commodities and supplies, or provide guarantees for procurement. Providers of public services, such as public schools and health providers, may be involved in collaborations with the private sector as well.

3.2. The private (for-profit) sector

The private sector comprises multinationals, which may set up foundations for their more socially involved work. Increasingly, businesses position themselves as ‘social entrepreneurs’, creating business solutions for social problems. Funders, particularly large private foundations are important too. These include the Bill & Melinda Gates Foundation, the Hewlett Foundation, and the Clinton Foundation. They fund innovations in development. On a national level, the *Postcode Loterij* plays a similar role. The private sector does not only consist of large companies and foundations. All small and medium-sized enterprises (SMEs) together employ more people than corporations and may be willing to contribute to public goals as well (Madden, Scaife, & Crissman, 2006).

Developing countries also have their own private sectors. A substantial part of health care services are provided by the private sector. In financial terms, the private sector is bigger than the public sector in most countries with the largest unmet needs (England, 2004). However, there often is little quality control of private sector health care providers, which leads to concerns about the quality of the services they deliver (Mills, Brugha, Hanson, & McPake, 2002). These misgivings seem to be misplaced. There is no support for claims that the private sector is usually more efficient, accountable, or medically effective than the public sector. The public sector often does lack timeliness and hospitality toward patients (Basu, Andrews, Kishore, Panjabi, & Stuckler, 2012). Local private health care providers should not be disregarded. They may provide services that complement those from public and social marketing sectors (Nguyen, Snider, Ravishankar, & Magvanjav, 2011). Private providers may deliver services which are more accessible and responsive to the needs and preferences of users. They can sometimes reach communities where public services are unavailable. They may even be more affordable, particularly where public providers charge official or unofficial user fees (Patouillard, Goodman, Hanson, & Mills, 2007).

3.3. Civil society (nonprofit)

Civil society is a third sector that is often involved in public-private collaborations. The civil society consists of different players as well. NGOs are generally funded with public money in order to attain public goals. Nevertheless, in some cases, they may also be active in commercial activities, such as service delivery. In these cases, they may be similar to the private sector, but they remain not-for-profit organizations. In addition to NGOs, academia is involved in many cross-sector partnerships.

Civil society organizations may have diverse roles within partnerships. Collaborations with a broad macro orientation on development almost always include NGOs. Civil society organizations may be important because of their 'boots on the ground'. They have workers in the field, who know about local circumstances and who are involved with local communities (Capoor, 2005). Therefore, they may play a role in reaching target populations, as well as community leaders and other stakeholders. They may also have a good knowledge of what is feasible in certain populations, and what is not. Finally, they may provide technical assistance, based on their knowledge and experience.

3.4. Partnership models

Several different configurations for cooperation are possible. There can be public-private partnerships, but also partnerships of private and nonprofit sectors, and tripartite collaborations. Models of collaboration that were mentioned during the interviews were the following:

From their corporate social responsibility (CSR), companies may be prompted to donate funds, commodities, or time to NGOs for specific projects. This can be viewed as private sector philanthropy. There is no true partnership, other than a donor relationship. For example, the implementation of a sexuality education program could be funded by a company. For companies, these programs focus mostly on reputation and have only a limited connection to the business, making them hard to justify and maintain over the long run (Porter & Kramer, 2011). Philanthropy is not the focus of the current review.

This review focuses on partnerships in which shared value is pursued. Shared value is the integration of enhancing the competitiveness of a company, while simultaneously advancing the social and economic conditions in the communities in which it operates (Porter & Kramer, 2011). In order to make this work, companies need to work together with partners from other sectors. These partnerships can have different aims. In product-development or *innovation partnerships*, new products or services are developed in cooperation. For example, innovative reproductive health services or products in a region may be developed by an international NGO, a corporation, and local public and private health care providers. In *go-to-market partnerships*, NGOs are fitted in the business model of the company. NGOs may be hired by a corporation to do specific tasks within the marketing of a product or service. For example, an NGO may be responsible for an educational campaign accompanying the introduction of a new product.

A distinction that can be made, is between activities on different levels on which partnerships operate (Kolk, van Tulder, & Kostwinder, 2008). Micro-level activities are usually project-oriënted and focus on a particular country or specific activity. Meso-partnerships aim to improve the sustainability of a certain sector or supply-chain. Macro-partnerships have broad objectives, define issues widely, address multiple interests, and therefore also cover several countries or global activities (Kolk et al., 2008).

3.5. Management and funding

Organizationally, new entities – usually not-for-profit – may be formed for the implementation of public-private partnerships (PPPs). For some, only such novel 'hybrid' organizations are 'proper' PPPs. In this report, the term private sector involvement is used more generally for all partnerships in which public, nonprofit and private sectors cooperate to attain public goals. When one of the partners is clearly in the lead, the collaboration can be organized as an activity within that organization. In the case of corporate philanthropy, the NGO is the leading partner. In shared value partnerships, either private or civil society partners can be primarily responsible for the project. True shared responsibility is complex and requires high levels of mutual trust and understanding. One way to do this, is to have rotating chairs (Milward & Provan, n.d.).

Private sector engagement is sometimes seen as a way of filling the financial gap, left by decreased public funding. However, merely funding an NGO's project is not typically what companies want to do anymore. Instead, they aim to actively participate in these programs (Ramiah & Reich, 2005). In some cases, they do not fund the projects in which they participate at all, but provide their knowledge and skills, or they may provide commodities, such as contraceptive supplies, for free or for a reduced fee. In many cases, governments or supranational organizations finance such partnerships, either directly or by guaranteeing a certain turnover.

Increasingly, business cases are being developed in which customers/clients of products or services pay for these themselves. This is believed to be a more sustainable model than philanthropy. However, the expenses need to be kept to a minimum in order for customers/clients to be able to afford the products or services. Fee paying patients look for affordable short courses of treatment, creating an economic incentive for providers to satisfy these demands even if the treatment offered is incomplete, especially when faced with competition from other providers. This is insufficient for treatment of the individual patient, but may also be detrimental to public health, for example because of increased resistance to antibiotics (Brugha & Zwi, 1999). Despite the need to pay for private sector services, they are widely used, also by the poorest people in developing countries (Patouillard et al., 2007).

4. Elements of SRHR collaborations

When reviewing the literature, not many collaborations between public, private, and civil society sectors with regard to SRHR surfaced. Although collaborations have been described in other sectors, such as health systems improvement and infrastructure, such partnerships seem to be rather new within the SRHR field. In the literature and the interviews, some programs have been identified, some of which were already well-implemented. However, even in the interviews, not many initiatives were mentioned. Of 820 projects funded by the Dutch Ministry of Foreign Affairs through RVO, only two were explicitly about SRHR. Both couple a focus on SRHR with poverty-related diseases. One of these, 'Healthy Business, Health Lives', is described in further detail later. The second, 'Mobile Solutions for Scaling up Access to Quality Healthcare in Nigeria', is a partnership between PharmAccess, Kwara State government, and Hygeia. It aims to strengthen the health system and its capacity with regard to sexual and reproductive health, linking primary care centers with district hospitals, using mobile health solutions (aiddata.rvo.nl/projects).

In this chapter, an overview is presented of possible components of multisector projects, as found in the literature and as mentioned in the interviews. The findings are illustrated with several 'case stories' of collaborations between private and public sector partners. These have been written in collaboration with at least one of the partners. They are examples of various ways to set up partnerships, rather than best practices which should be followed by other organizations.

SRHR programs with private sector partners may contain different elements. Programs may aim to create awareness in Western countries and advocate for new policies. They may also strengthen the local private sector in hard-to-reach communities or develop new service models. Lastly, health education is often a component of SRHR programs.

4.1. Advocacy

Advocacy is an important element of many multisector collaborations and an essential part of the work of NGOs. The public endorsement of products or programs is required for sustainable change, not in the least because governments have the financial means to support programs. In some cases, national or local governments do support SRHR, but in many cases they need to be persuaded to make it a priority. Sometimes, NGOs or donors are inclined to bypass governments because of inefficiency, misdirection of funds, or slowness to act. However, without governmental support, it is almost impossible to accomplish sustainable change. Moreover, as one of the interview participants said, there is a moral dimension as well. Governments are responsible for their people, it is offensive to start acting in a country without government approval. On the other hand, it may be frustrating if a government does not endorse a program. Advocacy efforts may also be directed at Western governments and supranational organizations for (particularly financial) support. Activities may also target communities in Western countries, for fundraising or raising awareness.

Advocacy is not only relevant with regard to governments, but also toward companies. There is a correlation between a publically expressed commitment of pharmaceutical companies to improve reproductive health and actually taking action (Urlings et al., 2015). Part of a larger advocacy approach may be to increase access to medication or other supplies through reduced prices. Price reduction is a strategy which is commonly used in the area of contraceptives, by all major players in this field (Merck & Co, Bayer, & Pfizer). The companies do this work in many (up to 70) of the world's poorest countries, based on priorities set by FP2020 (Urlings et al., 2015).

Case 1

Female condom partnership

Female Health Company (FHC) manufactures, markets and sells the FC2 Female Condom. Female Health Company is the largest manufacturer in the world of female condoms. The FC2 provides protection against unintended pregnancies and sexually transmitted infections (STI's), including HIV/AIDS.

dance4life is a nonprofit organization that works in 20 countries to build a healthier world by empowering and educating young people. dance4life provides young people with knowledge, skills and confidence to protect their health and promote sexual safe choices.

The partnership

The defined objective of our partnership is to empower and educate young people to make safe sexual choices.

In 2015, we started our partnership in Ghana, the Netherlands, South-Africa and Tanzania by training peer-educators, by running an awareness campaign~~,~~ and by advocating for women's empowerment. In 2016, we will expand our partnership into Kenya, Zambia and Uganda.

Female Health Company has provided funding which enabled dance4life to train peer-educators about women empowerment and the use of female condoms. The topic has been incorporated in the dance4life sexuality education program in schools and communities with the aim to inspire young people to explore this additional mean of protection. In collaboration with the local Ministries of Health and UNFPA in the countries, FHC distributed female condoms in order to make sure that young people, and women in particular, not only have the information, but also the access to protect themselves from STI's, HIV/AIDS and unplanned pregnancies.

Marketing-wise both partners developed a fun guerilla activation to create awareness and social media attention via a blog and video.

Also, as a joint activity, both partners shared a booth and gave workshops about public-private partnerships at two conferences.

With this complementary partnership dance4life brought in her network of young people and nonprofit partners, her marketing communications expertise and her positive brand. FHC brought in FC2s, her network of institutional and corporate partners and funding.

The growth vision

By 2018, both partners aim to have engaged young people in seven African countries, the Netherlands and Asia. And they aim to have engaged UNFPA and the Ministries of Health in their activities. It is of great importance that young people are equipped to have a better quality of life, therefore the partnership needs to be visible to the government and the decision makers.

4.2. Strengthening the local private health sector

The services for which people go to private or public sector providers differ. For example, according to a comparison of both sectors in six Sub-Saharan African countries, "[p]ublic providers played a predominant role in antenatal and delivery care for institutional births, but home deliveries with unqualified attendants dominated. The private sector was a major supplier of condoms, oral pills and IUDs. Private clinics, pharmacies and drug vendors were important sources of STI treatment." (Nguyen et al., 2011). Women chose to use private sector facilities because of fewer stock-outs, more

convenience (closer location, shorter waiting time, more flexible hours), and because services were perceived to be more confidential and less stigmatizing (Akol et al., 2014; Brugha & Zwi, 1999).

Originally, NGOs and especially governments were apprehensive of directing money to the private sector (England, 2004). However, it was soon acknowledged that this was a necessary strategy to direct care to the people who needed it most. A lot of research has been done with regard to strengthening the local private health sector. Several strategies have been tested, including market-based, administrative and public empowerment approaches (Patouillard et al., 2007; Peters, Mirchandani, & Hansen, 2004). Some of these strategies include the cooperation between the local private and public sectors, also known as a 'total market approach' (Drake et al., 2011) or 'sector-wide approach' (SWAp) (Mugisha, Birungi, & Askew, 2005).

Market-based strategies include direct or indirect financing, for example by contracting providers to purchase their services, often accompanied with applying benchmarks with regard to amount or quality of these services. This may also take the form of franchising, by which networks of service providers (franchises) are created, sharing resources and activities. Alliances can be between private sector service providers, but they can also collaborate with public sector partners. In recent years, voucher systems have been used as a new market strategy to improve access to reproductive health services, for both public and private health care (Bellows, Bellows, & Warren, 2011). Examples of administrative strategies are regulating the private health sector, accreditation of providers, and training private providers. Training is by far the most studied strategy. Public empowerment encompasses educating the public about health-promoting behavior, health service use, and information on private providers. This way, demand is created for quality services.

Although provider training was the most commonly used method to strengthen the private sector, a combination of strategies appears to work best (Peters et al, 2004). Voucher systems are capable of increasing the utilization of reproductive health services, improving the quality of care, and improving public health outcomes (Bellows et al., 2011). With regard to franchising, the results are more mixed. They may improve certain aspects of care, but they have poorer outcomes on cost-effectiveness and equity (Beyeler, York de la Cruz, & Montagu, 2013). There is a need for stronger evidence that interventions to strengthen the private health sector lead to improved health among poor people (Patouillard et al., 2007). Also, stronger research designs are needed (Bellows et al., 2011).

Case 2

Healthy Business, Healthy Lives

In the 'Healthy Business, Healthy Lives' project Simavi (NGO), Healthy Entrepreneurs (private sector), Emesco Development Foundation (NGO) and Kibaale District Health Office (government) join forces to improve access to SRH services and medicines, and combat poverty related diseases in the Kibaale District in Uganda (755,000 population). Although health infrastructure has improved, the population still suffers from ill health due to a lack of good quality medication and inadequate services and information on both reproductive health as well as poverty related diseases. Poor information on SRH topics hampers healthy behaviour and service utilisation. This is reflected in the high maternal mortality rate of 438.

Activities

In order to increase the number of people with access to contraceptives and drugs to combat poverty related diseases, this demonstration project aims at establishing a self-sustaining business case. This outcome is envisaged through implementing a continuous supply of contraceptives, high-quality affordable generic medicines and livelihood products via a social entrepreneurship model. The products

will be sold by selected entrepreneurs who generate their own income. A selection of local Community Health Workers (CHWs) and Accredited Drug Shop (ADS) owners will be trained as entrepreneurs and receive, after an investment of US$100, an integrated package of contraceptives, medication, and livelihood products worth US$300.

The model is combined with an e-health tool; a solar powered electronic 'tablet' device with a broad range of health education content. This device will be used as a tool to support local health promotion, including provider capacities. The trained CHW and ADS people in the selected project area will provide interactive health information on various topics like contraceptives, HIV/AIDS, safe motherhood, sexuality and malaria. The project will come up with a whole range of e-health applications in local language with information, counselling and referral options to raise awareness about health services, and create demand for uptake of services and health behavior. The tablet can also be used to manage stocks and the supply chain. The use of e-health tools for supply chain management is expected to ensure greater responsiveness and transparency.

Continuous monitoring and evaluation with multiple stakeholders, on both program and financial level, will feed adaptive programming to ensure local needs are met in order to create a self-sustaining business case. The e-health app allows to collect data of all users such as the number of viewers of one health topic. Sustainability of the project is ensured because entrepreneurs are able to generate income that feeds into the establishment of a business case.

Partnership

The partnership is complementary: Simavi brings in SRH knowledge and has experience in project management, advocacy and, behavioral change and demand creation. Emesco Development Foundation is the main nonprofit health provider with local network and understanding. They will manage the central warehouse. Healthy Entrepreneurs is experienced in 'bottom of the pyramid' health supply chain management and will ensure continuous stock supply to Kibaale. The District Health Office of Kibaale is committed to increase health access and will look into quality control and regulatory aspects and advise on the overall project.

4.3. Developing new products or service models

PPPs are very important in the development of new contraceptive methods, because pharmaceutical companies rarely do this independently anymore. In a review of pharmaceutical companies' engagements with regard to maternal health and family planning, only one of the companies (Merck & Co) had contraceptive methods in the pipeline (Urlings et al., 2015). The Population Council has a track record of developing innovative methods in collaboration with pharmaceutical partners. For example, levonorgestrel (LNG)-releasing implants and IUDs have been developed with the Population Council (Harper, 2008). Currently, a one-year contraceptive vaginal ring, a dual-action ring (combining contraceptive and microbicides that prevent HIV infection), and microbicide gels are in different stages of development (www.popcouncil.org). In an overview of the contribution of pharmaceutical companies to advancing maternal health and family planning, Urlings, Rook, Coppens, and Iver (2015) mention non-hormonal contraceptives, new long-acting methods, and methods that can be used on demand (only before or after sexual intercourse), and thermo-stable products (e.g. contraceptive rings) as the most pressing R&D needs in this area.

Surprisingly, Urlings et al. (2015) do not mention the development of male contraception as an R&D need. Studies aiming at contraceptive methods for men have also been conducted since the nineteen seventies. Until now, no products have been admitted to the market. However, some promising methods are still in the pipeline. Examples of hormonal methods include transdermal gels and

subdermal implants, both developed with the involvement of the Population Council. Non-hormonal methods are in early stages of development as well (www.mailcontraceptive.org).

Other products that have been developed by PPPs include HIV vaccines. The International Aids Vaccine Initiative (IAVI) has been created as a Product-Developing Partnership (PDP) of academic, industry and government organizations. It is a large not-for-profit organization that positions itself as both a knowledge broker and knowledge integrator (Chataway et al., 2007). HIV vaccine trials have also been conducted in Brazil through a collaboration between government, the R&D system, the manufacturing sector, and broader society. NGOs were involved, particularly for prevention (Velho & de Souza, 2007).

An example of a new service model is the creation of a new condom brand for young Indonesians by the Indonesian branch of DKT. This was a social marketing strategy, involving key commercial and NGO partners. Fiesta condoms were made available in a range of flavors, shapes, colors, and pricing, specifically designed to appeal to young people. During this project, several activities were done to educate young people about sexual and reproductive health issues. Media that were used included TV (with MTV), radio talk shows, print media, and mobile text messages. After three years, fiesta condoms held a 10% market share. Furthermore, the brand was well known and appreciated (Purdy, 2006). According to a review of several female condom programs, the introduction of female condoms went differently. Not the media, but face-to-face communication with potential users was sought, for example by trained peer educators. Female condom programs require the sanction, leadership and funding of governments and donors. However, the non-governmental and private sectors have also played a major role in program implementation (Warren & Philpott, 2003).

There are also examples of new models of care. For example, in Botswana, a public-private partnership was created to deliver antiretroviral (ARV) drugs to HIV patients. Merck and its foundation, the Bill & Melinda Gates Foundation, and the government of Botswana worked together under the name African Comprehensive HIV/AIDS Partnership (ACHAP). This was originally a five-year program for comprehensive support, including HIV prevention, care, and treatment of HIV/AIDS patients. By now, it has extended its health scope, for example including safe male circumcision, and it is opening up for other donors than just the Merck Foundation (Ramiah & Reich, 2005; 2006; www.achap.org).

Case 3

North Star Alliance

North Star Alliance is a non-profit PPP that maintains a network of roadside health clinics at major truck stops in Sub-Saharan Africa. The organization was founded through the public-private partnership of the World Food Program and TNT. They found that they were losing so many of their truck drivers to AIDS, that they were struggling to deliver food to people in need. The experience not only highlighted the vulnerability of truck drivers and other people on the move to HIV and other diseases like tuberculosis, malaria, but also the critical role they play in spreading the diseases as they move between cities and countries. Although the services of North Star Alliance extend beyond sexual health, HIV and STIs remain an important aspect of their work.

Activities

Working with government, corporate and civil society partners, North Star Alliance uses converted shipping containers ('Blue Boxes') to house their Roadside Wellness Centers (RWCs). The organization places its clinics at hotspots of disease that are identified along major transport routes, such as border posts, transit towns, or ports. The clinics provide health services to otherwise hard-to-reach populations,

mainly mobile workers such as truck drivers and sex workers. They also provide primary care to local community members, who make up half of the clinics' patients.

North Star teams of local community health workers provide essential health services and public health information, while an electronic health passport system enables patients to continue their treatment at any of the 37 North Star clinics along their route. North Star Alliance's Blue Boxes are not only used for direct health services, but also for educational purposes. Of all 329,552 sessions that took place in blue boxes in 2014, 43% were educational sessions. Group educational sessions provide hard-to-reach populations and community members with information and tools ranging from driver safety tips to STI and general health information.

Partnership

Both public and private sector participation is essential for the North Star Alliance. The organization has worked with more than 70 different partners, from multinational companies to locally-based non-governmental organizations and family foundations. In each country, North Star Alliance works closely with the government to support and strengthen national health systems. Locations for new clinics are determined, based on local needs. They need to strengthen local capacity, not duplicate it. Finally, North Star teams partner with local and international civil society at the regional, national and community levels to get their clinics up and running.

North Star partnerships have helped to open clinics, deliver anti-retroviral drugs for HIV patients, conduct valuable research on the spread of disease via mobile populations, and create durable relationships with stakeholders on community, national and global levels.

4.4. Capacity building and health education

Although health education is rarely the sole focus of projects that are being done in cooperation with the private sector, it is often a component of such collaborations. This may be directed at the target communities, but may also take the form of training professionals. The majority of projects that are supported by pharmaceutical companies include capacity building as part of their approach. This means that health care workers are trained to improve their services. If the public sector is involved in these activities, the training programs will always be broader than about specific pharmaceutical products. With regard to strengthening the local private sector, training private sector providers is by far the most commonly evaluated intervention (Patouilard et al., 2007; Peters et al., 2004)

Educational efforts may also be directed to target populations. For example, comprehensive sexuality education, integrating HIV and STI prevention with family planning, may be organized or supported by multisector collaborations. For NGOs, this is common practice. For private companies, these educational initiatives may be part of a broader marketing campaign to create demand for their products. However, this sort of health education may only be profitable in the long run for companies. More product-specific marketing efforts are possible as well within a multisector collaborative context, for example in the female condom partnership, as described in Case 1.

Case 4

World Contraception Day

Bayer, one of the largest pharmaceutical companies in the world, has started World Contraception Day every year on September 26th. It was launched in 2007 as a campaign to raise awareness of contraception and to enable young people to make informed choices on their sexual and reproductive

health. In spite of progress in recent years, contraceptives remain out of reach for many young people worldwide, resulting in millions of unplanned pregnancies and abortions each year. From the outset, World Contraception Day was a joint effort from Bayer with NGOs, governmental organizations, and scientific and medical societies.

Activities

Many activities take place under the umbrella of World Contraception Day. Together with twelve partner organizations, comprehensive sexuality-education campaigns are organized in schools, universities and shopping streets in over 70 countries on this day. Leaflets and free condoms are distributed and health checks offered. This project is done in collaboration with DSW (Deutsche Stiftung Weltbevölkerung), a German NGO.

An example of a larger project with DSW started in 2009 to increase the knowledge of both boys and girls in Uganda and Kenya by peer education at youth clubs. The peer educators receive a training that includes leadership, cooperation, and financial skills. Whole communities are being involved, including parents, teachers, local politicians, and health care workers. This approach works, leading for example to a higher proportion of girls who finish school. Schools increasingly take up this program and incorporate it in their curriculum.

Another example is a youth ambassador advocacy project with the NGO Women Deliver. Six young people from all continents are equipped with the skills to collect and share digital stories about young people's SRHR and access to contraception in their home countries. They receive a storytelling and digital media training and a seed grant of 5,000 US dollars. Furthermore, they are given advocacy opportunities to showcase their work at the international level.

Partnership

Access, availability and affordability are crucial for family planning. But, in addition, we also need education, counselling and training for health care providers and advocacy work. Bayer cannot do this alone. For this reason Bayer initiates targeted dialogs with stakeholders in politics, industry, and healthcare at a local, national, and an international level. All partners have their own particular expertise, network, and resources, which they contribute to the partnership. When there is a shared interest, and achievable expectations, these partnerships can be mutually rewarding. However, there must be a willingness among all partners to make the partnership happen. Mutual respect is required. The challenge of addressing contraception issues worldwide is a task that no company, aid organization, government, or research institute can manage alone. However, as part of a network of strong partners it is possible to make a real difference.

5. Conditions for success

There are lessons we can learn from the (albeit limited) experiences with existing projects in which public, nonprofit, and private sectors collaborate. Although the field is relatively new and still developing, some common themes come up regularly. Based on experiences of the people that were interviewed and as described in the literature, the following elements seem to be important in the process of creating and implementing a partnership.

5.1. Build trust

Trust, openness and fairness are basic foundational underpinnings of successful PPPs (Jamali, 2004). Samii, van Wassenhove, and Bhattacharya (2002) highlight the key formation requirements of effective PPPs, including resource dependency, commitment symmetry, common goal symmetry, intensive communication, alignment of cooperation learning capability, and converging working cultures. The first requirement for developing a partnership must be joint goals or objectives. It must be recognized that what can be achieved together cannot be achieved alone. Furthermore, there should not be large differences in commitment to the partnership in terms of allocation of time and resources. And there should be a common understanding of mutual benefits. If these basic requirements are fulfilled, building a trusting relationship is possible (Drost & Pfisterer, 2013; Samii et al., 2002).

Mutual trust is not self-evident. However, experiences differ between different organizations. Where one interview participant from an NGO warns to be watchful when you negotiate with commercial partners, and mindful of your own interests, another says it is easier to deal with private than with public partners. This participant experiences private partners as more straightforward and honest, while public partners always have their own agenda. NGOs may be suspicious, not only about involvement of commercial partners, but about each other as well, as they are often competing for funds. What helps, is to have people in the organizations who have experience in both the public sector and in business. These can act as a bridge between partners from both sectors. It is also advisable to do a risk assessment of a possible partnership, including financial stability and track record of partners. Furthermore, an internal policy with regard to partnerships, specifying ground rules and selection criteria for whether or not to engage in a partnership is useful.

5.2. Clarity of partners' values, roles and responsibilities

It is important to know your partner's value framework and room to operate. As Ramiah and Reich (2006) formulate it, it is important "to understand the key values that motivate other partners". Such values go beyond what is written in strategic policies or mission statements. The organizational culture is relevant as well. Private corporations do not always understand the complex social realities and value systems public-sector organizations have to work with (Ramiah & Reich, 2006). The business philosophy of the private partner needs to be clear as well. Is it philanthropy or a business model? The latter case is more sustainable. However, in this case, it is also necessary to be open about costs and benefits for all partners.

Just knowing the values of partners is not enough. It must be possible to align the goals and values of all partners. Otherwise it is very difficult to allocate the necessary resources. However, the terminology that is used in the public sector differs substantially from the terms that are generally used in companies, as several interview participants have noticed. A strong link to international commitments, like the Sustainable Development Goals (SDGs) may help to find connections between public, nonprofit and private partners. Defining terminology and goals of the partnership will help alleviate challenges

or communication errors, as well as hone in on the assets that each partner has in relation to the end goal.

The next step is to define the roles and responsibilities of the partners within the partnership. These should be based on the core complementary competences of the partners (Drost & Pfisterer, 2013). All partners are in a partnership for a specific reason, based on what they are good at. Such competences may include access to resources, technical knowledge, production facilities, distribution, etc. A clear description of roles and responsibilities allows for accountability between partners and towards external stakeholders (Drost & Pfisterer, 2013).

5.3. A firm commitment

The value of cross-sector partnerships lies in the potential to create win-win situations. Mutual benefit entails that it is accepted that each partner organization has the right to gain positive outcomes from the partnership. A certain level of mutual generosity is required (Drost & Pfisterer, 2013). The benefits for each partner motivate them to cooperate. When organizations have something to gain from a partnership, they will be more committed to it. On the other hand, mutual expectations can be exaggerated as well, which may lead to disappointment and friction within the partnership. Expectations need to be managed in order to be clear and realistic.

In effective partnerships, partners define and agree on partnership objectives and develop a strategy on how to reach these objectives. Once the objectives have been successfully negotiated, they have to be made measurable in defined and agreed upon indicators (Drost & Pfisterer, 2013). This implies that all partners must be able to specify and quantify their added value. Several interview participants said that when partners agree on a course of action, it is wise to capture the agreement in a contract, including information about managing the partnership and decision-making. Contracts can play a vital role in managing long-term PPP relationships. However, it may be impossible to foresee future contingencies. Therefore, in some cases the contract may become too rigid and hamper, rather than facilitate progress (Roehrich et al., 2014).

5.4. Create opportunities for success experiences

Success of collaborations is very important, not just for reaching the goals that were set for individual activities, but also to establish trust among partners, donors, and governments, which may help to set up new projects. The most important condition for success is to keep communication open. Formal or informal mechanisms that promote regular information-sharing within each partner organization as well as between partner organizations are critical. It is better to have weekly telephone conversations and regular meetings with partners and implementers than to send out a quarterly update. It is important to build relationships at all organizational levels, not just at the management level, but also among technical and operational staff members (Ramiah & Reich, 2006). Another suggestion of Ramiah and Reich (2006) is to build a portfolio of diverse activities. This may increase the chances of success. Even if some of the activities fail, others are likely to work. Moreover, these are learning experiences that can help to improve new initiatives.

5.5. Flexibility and conflict management

There are substantial differences between values and practices of the public and private sector. In addition, there may be sudden changes within partner organizations and working environments. An example is the takeover of Organon by Schering Plough. This development has put a stop to partnerships that were in the making at the time. It is important to be able to change one’s strategies and activities, adapting to surprising developments (Ramiah & Reich, 2006). These developments may

include strains on the partnership, because of cross-sector differences. Organizations that are able to anticipate, manage, and channel conflicts are more successful. Such situations require flexibility of both partners, as well as good leadership. According to Drost and Pfisterer (2013), good leadership in the context of a collaboration is based on guiding, rather than directing. Leaders can create hope and optimism when processes stagnate. A leader may help partners to understand collaboration as a learning process, rather than an organizational structure (Ramiah & Reich, 2006).

6. Conclusion

Multisector collaborations are possible on different levels. On micro-level, new products and services can be developed or marketed. An examples of this approach is the introduction of a new brand of condoms for young people in Indonesia (Purdy, 2006). Sexuality education projects may be micro-level activities as well. Most projects that were found in this review were meso-level projects. These are aimed at improving the sustainability of a sector or supply-chain, such as the projects that support the local private health sector. Macro-level activities go beyond single projects. They include broader objectives in a wider array of countries. Advocacy is usually a part of macro-level initiatives. The inclusion of governments is indispensable at this level.

Not all SRHR issues seem to be appropriate for private sector involvement. Multisector collaboration is biased toward technical and pharmaceutical aspects of SRHR. Contraception, condom use and ARV medication for HIV patients are usually the main themes of partnerships. As mentioned in the introduction, sensitive issues may be avoided when working with the private sector (McGovern, 2013). No activities with regard to sexual violence, safe abortion or sexual diversity were found in this review. Commercial sex work was a part of the North Star Alliance's program, but mainly from the perspective that commercial sex workers brought risk of HIV transmission to truck drivers. NGOs might well adopt the opposite perspective that the sex workers are at risk themselves. Nevertheless, the North Star Alliance does provide medical services to the commercial sex workers as well. Multisector SRHR partnerships are mainly active in the health sector. The term SRHR positions sexuality and reproduction in the health sphere. However, other sectors could be important for issues surrounding sexuality and reproduction as well. For example, the legal system is relevant in the context of sexual violence and abuse.

Experiences with SRHR cross-sector partnerships are mixed. Cross-sector cooperation can be difficult. As several of the interview participants said, there are cultural barriers between public, civil society, and private sector organizations. The languages they speak are not the same, corporate values differ, and there may be mutual mistrust. These issues need to be solved before the start of partnerships. This does not mean that organizations in both sectors ought to think and act alike, but they should be aware of the differences, and have a plan on how to deal with issues as they arise. The stakes may be high, both financially and organizationally, but in order for partnerships to be successful, partners need to give each other space to pursue their own interests, as long as they do not conflict with common goals.

Organizations may feel reluctant toward working with other sectors. This is understandable, being aware of the limitations and difficulties of cooperation, but there are advantages as well. Working with large commercial partners can offer scale, focus, and a financial scope, that is difficult to acquire otherwise. As Roehrich et al. (2014) conclude, "[P]ublic-private partnerships can combine the strengths of private actors, such as innovation, technical knowledge and skills, managerial efficiency and entrepreneurial spirit, and the role of public actors, including social responsibility, social justice, public accountability and local knowledge, to create an enabling environment for delivering high quality health infrastructure and services." All in all, most people who were interviewed were positive about the possibilities of cross-sector cooperation.

This review has some limitations. It was not meant to give a complete overview of private sector involvement in SRHR projects. Instead, it presents examples of projects that are being done and a synthesis of the information that was collected from the literature and interviews. As the interviews were mainly done with people who work in the Netherlands, there is a bias toward projects of Dutch

organizations. The literature review began as a systematic review, but found few examples of relevant partnerships. Therefore, unstructured searches for published and grey literature were done as well. The quality of the literature that was found was not very strong, but the review was not supposed to document outcomes and effects of partnerships, only experiences with them. Strong research designs are less important for such studies. However, the completeness and accuracy of the analyses that were used were difficult to determine. A final limitation of this review is that there may be a bias to more successful experiences with cross-sector cooperation. These are more likely to be published, and most (although not all) interview participants were generally positive about this sort of cooperation. The ones who were most critical about the possibilities of cross-sector cooperation did not have personal experiences with such projects in the field of SRHR, because of which their views may be underrepresented in this report.

A conclusion of this review must be that there is little information about partnerships between the public and private sectors in the field of SRHR. Only a limited number of published articles (20) on multisector collaborations that targeted SRHR were found. Most of these were about strengthening the local private health sector. Although other initiatives have been mentioned during the interviews, the overall impression remains that not very much is being done in this field, and progress is made slowly. One of the reasons may be scarcity of public funding for initiatives in this field. The focus of SRHR funding of the Ministry of Foreign Affairs has been on developing alliances between civil society partners, not on involving the private sector. The Netherlands Enterprise Agency (RVO) does manage funds for private sector engagement, but it does not have an SRHR program.

There is much more experience with private sector engagement in other areas of development cooperation than SRHR. Therefore, a follow-up to this review could investigate what the SRHR community can learn from partnerships in other sectors. However, it would be particularly relevant if partnerships that address sensitive issues in developing countries could be found. More importantly, evaluations of existing initiatives are needed. This is the only way to learn from experiences, so other organizations do not make the same mistakes, and that they can build on the strengths of earlier programs. This review is a first step for Share-Net International to operationalize its commitment to private sector engagement. The next step must be to stimulate actual cooperation with private sector partners.

6.1. Recommendations

Share-Net International may decide to follow up this study with the following activities:

- The Netherlands Enterprise Agency (RVO) should be stimulated to start an SRHR program, in order to support this main theme of Ministry of Foreign Affairs policy.
- Share-Net International may act as a facilitator or broker for possible partners to get acquainted, including NGOs in developed and developing countries, corporations, academia, and last but not least, the government and supranational institutes.
- Furthermore, Share-Net can continue to be a platform for sharing experiences.
- It is advisable for members of Share-Net who want to start working with (new) private partners to formulate a short plan (for themselves), specifying what they have to offer in a partnership, what they are looking for in a partner, for what sort of program(s). When approaching a company for a possible partnership, it is essential to have a clear idea about why a partnership is sought with this specific company.
- Furthermore, these members may wish to hire a professional with a background in business, in order to facilitate contacts with private sector partners.

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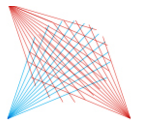

- If Dutch organizations do not address sensitive issues with regard to sexuality, it is questionable whether anybody else will. Projects on these themes are crucial, so they must continue and be upscaled, regardless of whether this can be done with private partners or not.
- Share-Net members who partake in multisector collaborations ought to involve research institutes to document the results and outcomes of these collaborations, but also the process that leads to these results.

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