Mechanisms for engaging the private sector in planning, delivering and demonstrating accountability for quality maternal and newborn health services

DATA ANALYSIS WORKSHOP:

Key Informant Interviews

Workshop aims

1. To develop a shared understanding of the project's methodology for qualitative data analysis

   - *Share some insights to interviewers of areas of interview guide to focus on and probe further [using NG-003 transcript example]*

2. To provide an opportunity to practice skills extracting and coding data

   - *using NG-003 as an example and practicing extraction of major themes and quotes*

Review of NG-003 transcript and areas for probing

Interviewer insights on areas for probing during interviews

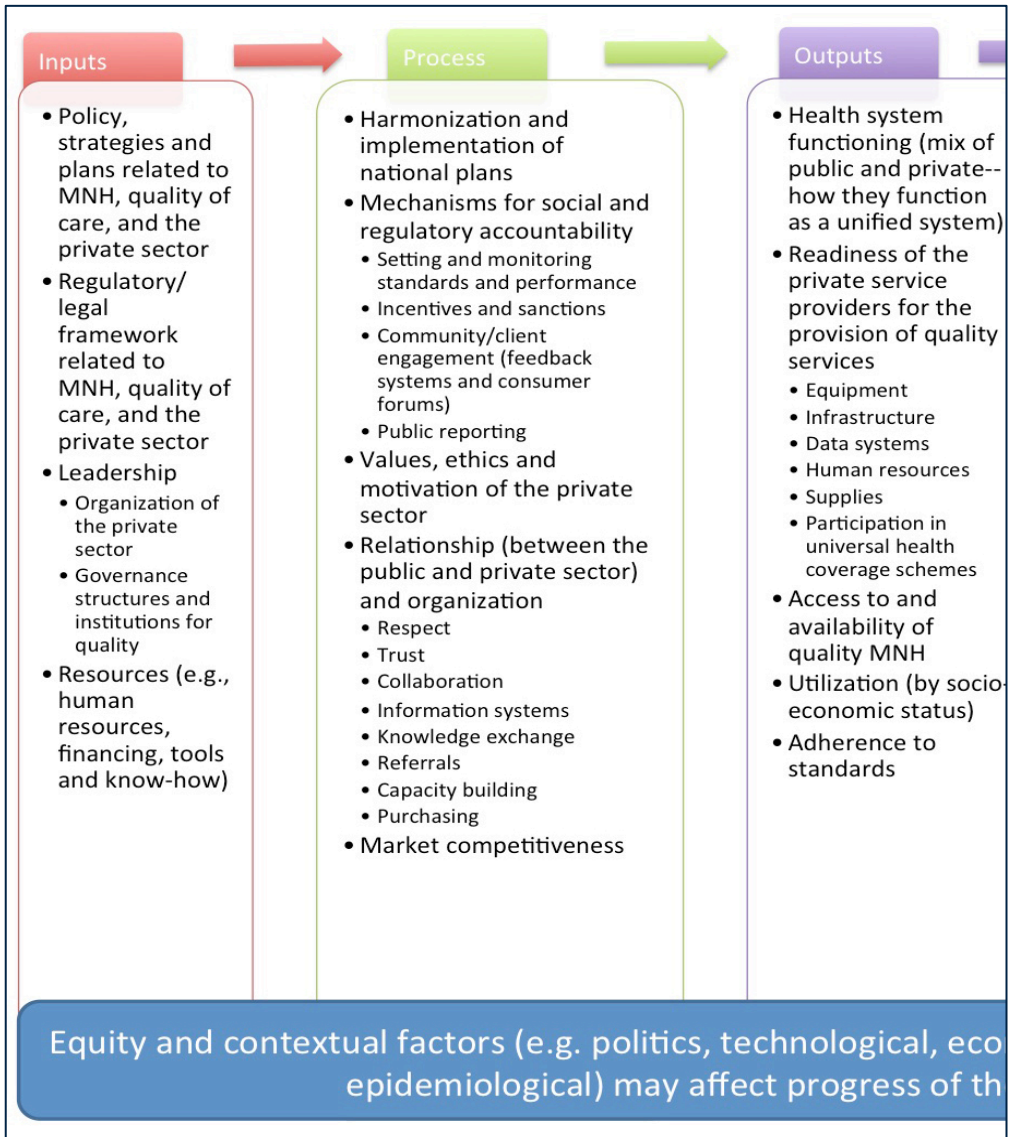
Some preliminary preparations that could help…

1. Doing some background research on the respondent ahead of the interview

2. Understanding the private sector landscape from the literature review and reports (when possible)

3. Understanding the aims of the transcript/interview and thematic areas

Quick recap: Study aims and thematic areas



Ghana Report: Findings Structure (as a guide)

Findings.....

Overview of the private health sector in Ghana .....

Landscape of Ghana health sector actors .....

Private sector engagement in maternal and newborn health services .....

Type, size, and scope of private sector maternal and newborn health service

Maternal and newborn health market demand, supply and segmentation.....

Available inputs: Enabling environment, organization, and resources .....

Key quality policies and strategies for the private sector .....

Market conditions (resources) as reported by the private sector .....

Market conditions (resources) as reported by the public sector.....

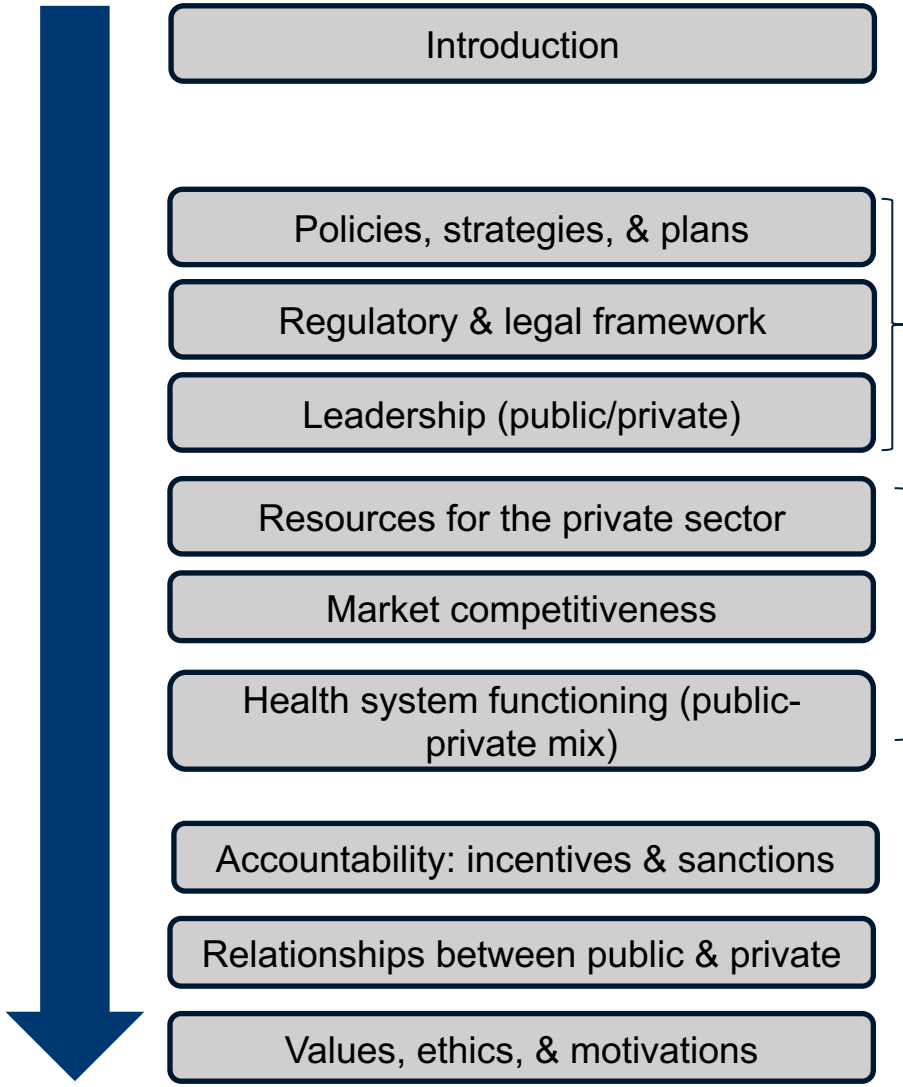
Private sector accountability with reporting.....

Available mechanisms to encourage private sector engagement .....

Regulatory mechanisms .....

Values, ethics and motivation of the private sector .....

Interviewer insights on areas for probing



Overall private sector landscape:
Definition (perceptions), size, type => gain better understanding of role, size, and type of private sector in maternal and newborn health

INPUTS: Enabling environment & available structures => *have an idea of available legislation and policies; focus on understanding if they are evenly applied across the public and private sectors – licensing, credentialing, quality of care, etc.*

INPUTS: Current market conditions and examples of public-private mix/private sector engagement => *Focus on better understanding of finance, equipment, human resources, and if they are applied evenly across and within the public and private sectors*

MECHANISMS: Available incentives/sanctions; relationships => *focus on understanding whether all private sector stakeholders are involved in planning, data reporting, dialogue, urban/rural, etc.*

Example: N003 Transcript

We will go (very quickly) through N003 as an example of areas interviewers could probe further and along the thematic areas identified…

Data analysis overview

Data Analysis Overview

1. Key informant sampling matrix (Excel)

2. Interview data sheet (Excel)

3. Transcript extraction and development of thematic codes (Excel)

4. Aggregation of findings (PPT)

Steps for Data Analysis

1. Key informant sampling matrix (Excel)

- Information on key informants: organization, level of seniority, remarks, etc.

2. Interview data sheet (Excel)

- Information on interview: date, format, length, location
- Information on key informant: sex, urban/rural, level of seniority, etc.

Steps for Data Analysis

3. Data extraction and development of thematic codes (Excel)

- Template with major themes from the semi-structured guide (one main theme from the interview guide per worksheet tab)
- 3-step extraction process (for INTERVIEW DATA columns):
  1. Summarize and extract interview data by themes
  2. Note missing data/reports that can add to private sector analysis landscape
  3. Identify new potential key informants for value-add
- Aggregate all interviews
- Develop thematic codes and track them across the interviews

4. Aggregation of findings for report (PPT)

- Use the logic model, table of contents from the Ghana report, and thematic codes to document key findings
- Identify key findings, opportunities, and recommendations
- Enhance the findings with the literature review, other literature searches/reports, and secondary data analyses to make initial recommendations

1. Key informant sampling matrix (Excel)

Health Sector	Role	Level	Participant's Name (Title, Organization)	ID	Remarks	Transcribed
Public Sector	Policy / administration	National	NAME (Head, Policy Coordination Unit, Ministry of Health)	Pub-01	Done	Transcribed, yet to be shared
			NAME (Head, Resource Mobilization-Domestic, Bilateral & Multilateral, Ministry of Health)	Pub-03	This interview is still yet to be completed - second half has yet to be completed.	Transcribed and shared (first half)
			NAME (Dep. Director, Family Health, Ministry of Health)	Pub-04	Two interviews. After the interview with the Director, she recommended I also speak with this staff member who was responsible for the maternal health program of the national health service and had also been neck-deep in the national QoC efforts. I thought it was necessary I make the contact to see what she adds to the discussion!	Transcribed and shared
			NAME (Program Manager (MNH), Ministry of Health)	Pub-05		Transcribed and shared
			NAME (Deputy Director of Operations, National Ambulance Service)	Pub-18	Interview scheduled for 8 October 2020	Not yet transcribed
		Sub-National	NAME (Regional Health Director, National Health Service)	Pub-12	Interviewed this district director because of xxx; also because the region has virtually failed to answer calls or be forthright with their availability. The districts could be substitutes if we are OK	Transcribed and shared
				Pub-15	Interviewed this district director because of xxx; also because the region has virtually failed to answer calls or be forthright with their availability. The districts could be substitutes if we are OK	Transcribed and shared
			NAME (Regional Director, National Health Service	Pub-10	Done	Transcribed and shared
	Service Delivery	National	NAME (Director, xxx Teaching Hospital)	Pub-16	Done	Transcribed and shared
			NAME (Administrator, xxx Teaching Hospital)	Pub-07	Interviewed the administrator of the department of child health	Transcribed and shared
		Sub-National	NAME (Doctor, xxx Regional Hospital)	Pub-11	Done	Transcribed and shared

1. Key informant sampling matrix (cont.)

- Regular review (weekly call) of the sampling matrix to better understand interview quality, usefulness, and challenges
- Use and update legend for quick next steps
- Discuss adding new interviews suggested by informants
- Plan transcription of interviews, when transcriptions will be shared for data extraction, etc.
- Store interview sampling matrix, recordings, transcripts, and data extraction forms in a shared folder (e.g., Dropbox, Google Drive)

2. Interview data sheet (Excel)

No	Date	Time	Duration	Participant ID	Participant Demographics					Interview Method	Language of interview	Transcript Shared?	Translator	Quality	Notes
					Gender	Rural/Urban	Name of Organ	Level of Resp	Type of Organ						
1	13-Feb-20	9:10:00 AM	2hrs:45mins	Pub-01	Male	Urban	MoH	Policy	Public	Face-to-Face	English	Yes	N/A	the quality was excellent. Provided indepth understanding of the public-private health sector issues	Interview was intermittently interrupted by visitors and meetings until at a point when interviewee locked us up in his office to get it completed. Interviewee was also visibly tired with intermittent standing and pacing about in his office. Interviewee was generally receptive and willing to share more. There were portions of the interview the interviewee wanted off the record
2	24-Feb-20	3:00:00 PM	1hr:23mins	Pub-02	Male	Urban	MoH	Regulator	Public	Face-to-Face	English	Yes	N/A	the quality of this interview was equally great and very revealing about HeFRA and what they have been up to. It was interesting to know HeFRA from an immediate past registrar	the interviewee was the immediate past registrar of the health facilities regulatory agency. He spoke in his capacity as a former registrar. He is currently the registrar of the Mortuaries and Funeral's Homes Agency-a relatively new agency. He's been sent there by the Minister to start that outfit. the respondent pointed out the section on market competitiveness that it was not applicable to him (and by extension HeFRA). He looked visibly tired at some points of the interview

- **Discuss quality and challenges of interviews conducted during the week**
  - Participant information: ID, gender, organization, position, rural/urban, etc.
  - Interview information: date, quality, length, format, language, etc.
- **Discuss adding other interviews suggested by informants and recommend next steps**

3. Data extraction and development of codes

BACKGROUND INFORMATION						
Respondent ID	Public or Private Sector	Interview Guide	Level	Organization	Respondent's Title	Thematic Area
NG-003	Private	Policy/admin	National	Chemonics	Director of RMNCH	Introduction and role of the private sector
NG-005	Public	Regulation	National	Medical and Dental Council of Nigeria (MDCN)	Head of Inspectorate Department	Introduction and role of the private sector

INTERVIEW DATA		
Thematic Summary and Comments from Interview Transcript	Potential Quotation(s)	Interview Data Notes (e.g., missing data/reports to check, potential new key informants for value-add, points to clarify)

THEMATIC CODES							
Existing national policies, strategies and plans for the private health sector	*Faith-based organizations not considered private sector*	*Facilitating public-private collaboration*	*Implementation challenges*	*Uneven government support for private sector*	*Quality of private sector services*	*Public-private relationship*	*Fragmentation of private sector*

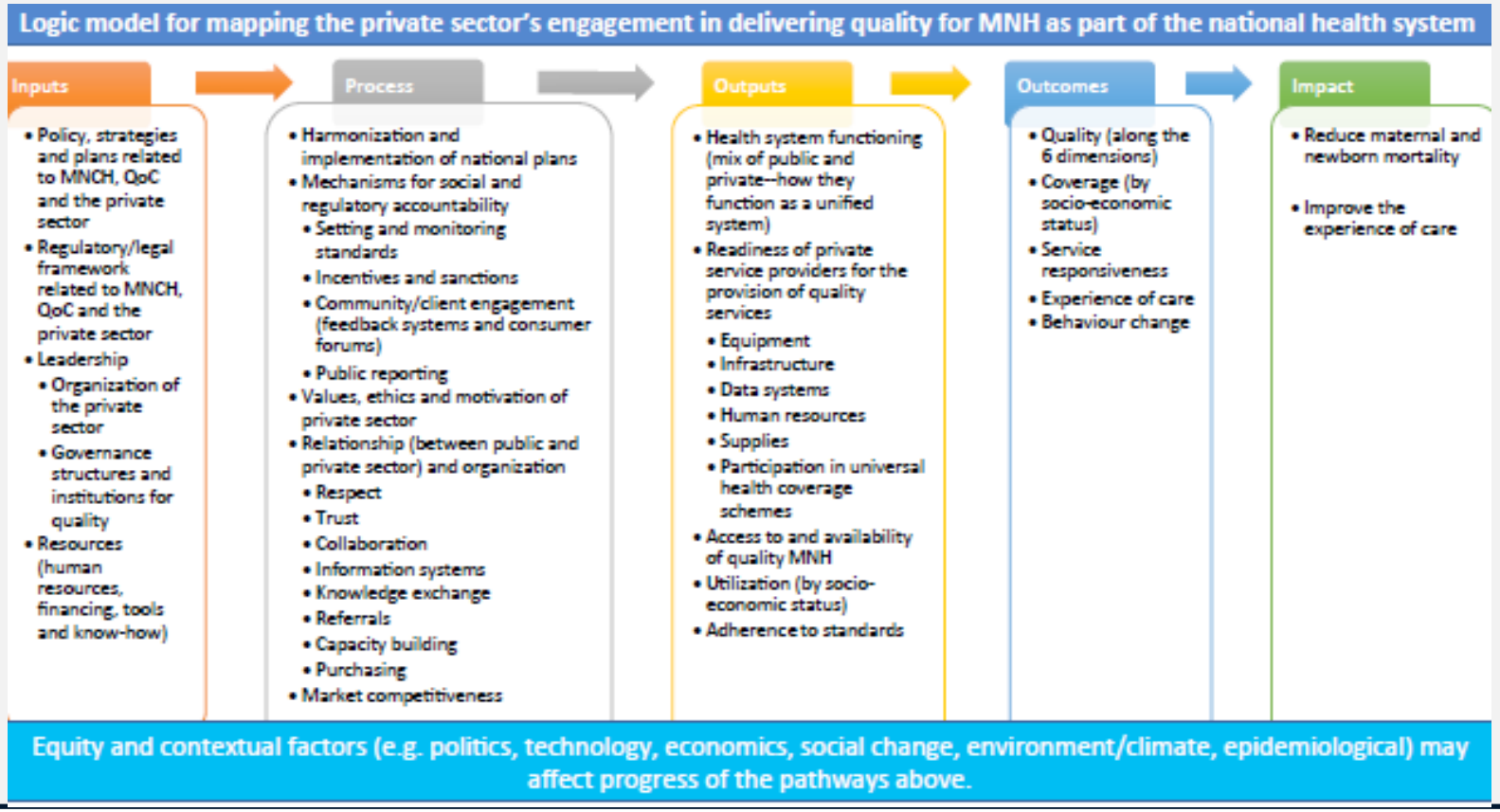
- In Excel, extract two types of data directly from the interview transcript:
  1. Background information
  2. Interview data (i.e. a summary of findings related to the theme on that tab, any interviewer comments on the theme, potential quotations, and notes)
- Use one tab in the Excel workbook for each of the main themes in the interview guides.
- Develop and add thematic codes (to Row 2, columns K+) as they appear in the text, and use a '1' to indicate that the interview contained the code. '1' will be used later to sort by thematic code when pulling findings for the report.

3. Development of thematic codes

- How does one create a thematic code?
  - Think about the index in a book. Codes should provide a basic description of the content in a passage/quotation.
  - Codes should also link back to the main theme on that page in the Excel workbook (e.g., policies/strategies/plans, accountability).
  - Codes should be a word or short phrases
- If multiple people are coding, create a codebook where you document the meaning of the codes. Include:
  - The label/name of the code
  - Who created the code
  - The code definition or description
  - Information about how the code relates to other codes

4. Aggregate findings (PPT)

- Review the project logic model to identify key themes of interest
- Review the Ghana report structure to better understand aggregation themes
- Based on thematic codes, aggregate data across the three categories: regulation, service delivery, and policy/administration
- Start identifying opportunities and initial recommendations



Individual data extraction and thematic coding practice – NG-003

Steps

1. Using the NG-003 transcript, populate the transcript extraction template with data. In the interest of time, focus on one thematic area.

2. Once you finish extracting a thematic area in the transcript extraction template (e.g., policies/strategies/plans, accountability), move to the thematic code workbook in Excel. Populate the row for NG-003 with your comments/quotations, and develop thematic codes.

3. Repeat steps 1-2 for additional thematic areas in NG-003.

Presentations: Data extraction and thematic codes for NG-003

Any questions?

DATA AGGREGATION:
Ghana Example

Public and Private Sector Interviews

Public Sector (n=17)

Policy and Administration

- National (n=4)
- Sub-national (n=3)

Service Delivery

- National (n=2)
- Sub-National (n=1)
- Facility (n=2)

Regulation

- National (n=2)
- Sub-national (n=3)

Private Sector (n=18)

Policy and Administration

- National (n=4)
- Sub-national (n=1)

Service Delivery

- National (2 pending)
- Sub-national (n=6)
- Facility manager/director (n=4)
- Facility service provider (n=2)

Regulation

- National/sub-national (n=1)

#1: Private Sector Type, Scope, Size

Large but fragmented stakeholder in service delivery

Size: > 51% of services currently being delivered by PS

- **FBOs**: largest PS service provider, following MOH decentralization - in rural areas and urban-poor to service the lower income groups
  - *CHAG: 326 facilities and 33 church denominations* *Ahmadiyya: 7 hospitals linked to MOH*
- **SF:** 20% hospital care while many in pharma and import. Select urban large chains (tertiary level), mainly small, physician led clinics, maternity homes - serving all SES, Sex but mainly middle-high income groups willing to pay for shorter waits, customer service
  - *PHFAG: started in 2018 with 400 members* *SPMDP – oldest, >300 facility members*

Type: FBOs dominant in hospital care with CHAG a significant player

- **FBOs:** CHAG, Ahmadiyya, Pentecostal and others – few NGOs
- **SF:** Fragmented with SPMDP, oldest umbrella organization, mainly hospital facilities and PHFAG (newer) but also a few other associations of pharmacists, labs etc.

- **Scope – While FBOs offer the full range of MNH services, SF focus on antenatal care mainly due to financial barriers to expand to tertiary NICU care…**
- **FBOs:** Offer full scope of MNCH services similar to GHS (sometimes instead of GHS in select districts) – GHS & CHAG get referrals from SF small facilities in rural for more resource intensive cases such as NICU, maternal complications and sometimes even delivery (due to lack of NHIS incentives for SF to cater to deliveries)
- **SF:** Very rarely present outside of urban for service delivery save for some maternity homes run by midwives and MNH scope limited to antenatal care services

#2: Market segment: where and why

Users across all SES, geography, and sex choose private providers half of the time - behavior varies by type of private sector

Main points

- Private sector are chosen for **easy, convenient, good customer services** and reasonably good quality
- **PS quality** perceived to be generally good but differ by specialties/diseases – ok for common diseases but less so for tertiary, resource-intensive services such as surgeries, NICU, cancers etc. Private maternity homes are usually lower quality because of inability to retain skilled personnel
- Middle to low income group switch to public for almost all deliveries (normal and complicated); High income stay with urban private provider (the bigger tertiary such as Nyaho)
- CHAG and GHS providers used for quality, lower price ,courteous services & availability of doctors
- SF focused on urban while CHAG & chemical sellers are in rural and urban-poor.

Market segmentation

- **Middle to low –Mainly CHAG/GHS providers (rural and urban-poor) and some SF that refer out**
  - SF can't expand to this income group because NHIS reimbursement to low, reimbursement for specialists too low), also not paid timely (2 years); cash flow problems….Cant get bank loans……Not interested …
- **High income groups– SF in urban as well as most times in rural for available services (will switch for specialists or services not available in SF)**
  - Many have private/employer insurance, or co-pay with NHIS, or willing to pay OOP – despite NHIS, OOP is high even across GHS, CHAG and SF

#3a: Private sector market conditions (*as perceived by the private sector*)

Not enough financial incentives to delivery quality MNH and expand scope beyond ANC to critical care – several referrals

- **National Health Insurance Scheme –** big delays in claims management and low reimbursement for services like deliveries, neonatal care, hard to expand in rural etc.
- **Financing/poor investment climate**: Limited access to local/foreign Loans; no "knowledge capital" and available interest rates are as high as 35%; Limited access to credit/taxes for major equipment
- **Pharma procurement:** Unregulated medicine prices and not reimbursed by NHIA – Affects Quality delivery
- **MOH policy there but not well implemented:** Policies/strategies there (esp. that National Quality strategy) but no capacity for implementation and inclusive dissemination
- **Uneven support from MOH**: Personnel/equip support only to CHAG; no ability to leverage on grant donations; support mainly on awareness of new drug or disease specific such as malaria (good working example for PSE)
- **Perception of private sector:** Negative; a competitor, not represented by SF across major platforms and no dialogue platform that is objective
- **Human Resources** – Very competitive to retain specialists in PS as not recognized when go back to Public sector and public sector pays high; Brain drain and retention challenges; PS mainly have PT workers (dual practice) but that poses QA challenges

#3b: Private sector market conditions (*as perceived by the public sector*)

Have high caseloads of maternal cases and limited capacity and financial challenges…

- **Human Resources**: Quality (skill-level is low, lack of ethics, soft skills and attitude); retention (very low attrition and brain drain); low leadership abilities; high turnover
- **Infrastructure:** Insufficient and poor/old infrastructure, space and maintenance of facilities and equipment is a challenge
- **Bureaucracy** and **duplication of services** across departments and high turnover impedes policy implementation, especially at district levels
- **Shortages/procurement constraints** of supplies, medical equipment, reagents and drugs within government facilities and across the country
- **High financial burden** on patients and need to scale up financing schemes – NHIS there but very high OOP remains…
- **Insufficient funds** allocated to health, limited budget to implement and lack of financial management skills and business process management and information systems
- **PS Fragmentation and large informal sector at lower levels –**making it difficult for MOH to engage and understand scope and size to make meaningful planning
- **Lack of data and analytics** – Private sector scope, size, cost of care and other unknown, thus limiting better policy making and even NHIS cost structures
- **Efficiency/management of operations** – substandard usually in public facilities as compared to private as harder to regulate gov facilities in general (cannot close)
- **Case referral gaps** affect quality – The ambulance NAS sector and the inefficient referral systems between private to public and also within public-public affects

#4: Key Policies/Strategies that guide Quality

MOH develops key policies and implements within decentralized regional -> district levels (DHMT) but lack capacity and resources

Key MNH Policies/Strategies – for both public and private

- The National Health Policy
- The Ghana Newborn Policy and Action Plan
- The free Maternal and Newborn Care National Policy
- The Reproductive Health Policy (and standards)
- The National Healthcare Strategy **–***Limited power and no quality inspection capacity*
- The National Health Care Quality Strategy TWG **–***Only CHAG a part of it but limited participation from the Self-financing ones. Sets Quality KPIs including Hospital scorecards*
- Several Quality committees and TWG – Quality steering committees; MAF; National Newborn Sub committee; Child Health Steering Committee

Key Issues Identified for Implementation

- Development of policies did **not engage all PS** and execution plan not well done
- MOH **lack capacity and expertise** in Quality Processes and in execution
- **Lack financial resources** to engage fragmented PS actors
- District level capacity varies in understanding policy
- No **comprehensive data** to monitor as not all PS report to DHMIS

#5: Regulatory Structures that Drive Quality

Regulatory structures new, not well-implemented, more stringently applied in PS, no clear roles and responsibilities across the agencies

- **Multiple agencies responsible for MCH quality assurance**
  - HeFRA licensing: Inspects and licenses all facilities; key KPIs, standards and scoring mechanisms
  - JCI/COHSASA through safe care program–for private sector and self-regulation is common
  - NHIA: has QA guidelines and QA teams for accreditation but not always effective
  - GHS – QA department & monitors DHMIS data at district level but no accountability
  - MOH – PPME QMU Quality Management Unit sets Qoc policy and sets DHMIS data requirements but not will implemented at district level; the DHMT of MOH does regular site inspections of PS facilities
  - Ghana MDC, Pharma, Nursing councils – license/credential health professionals but can also license (pharma) creating confusion in roles..
- **have different quality standards and KPIs**
  - Each agency asks for different data; Monitoring extent depends on relationship with district
- **duplication between agencies**
  - Pharm councils and HeFRA – both can license pharmacies
  - MOH & HeFRA – MOH can "self-regulate" and monitor their own facilities making it difficult for HeFRA

#5: Regulatory Structures that Drive Quality

No common regulatory framework and legislative framework not complete and clear – creates confusion of roles & resp.

Challenges

- **Double standards** in implementation – more stringent with PS & difficult to regulate public
- **Lack of capacity/Resources** – many public facilities remain unlicensed (<10% licensed)
- Role, standards are many and confusion across regulatory structures and need streamlining
- **PS reluctant** as extra work & added cost to comply with data
- Main bottlenecks are district level – no capacity/funding
- NHIA both regulatory and purchaser – potential conflict

Opportunities

- Strengthen HeFRA – classification of facilities is weak and affects NHIS
- Harmonize tools for credentialing and establish transparent governance (e.g Pharmacy Council)
- Drug authority also under-resourced and QA through post-market surveillance non-existent

#6a: Leadership & Governance (*according to the private sector*)

Private sector is highly fragmented with different governance structure for QOC and QA by type/level of facility

FBOs – CHAG well-structured with effective QA governance

- CHAG very influential; receive staff subsidies and supplies….perceived as an arm of MOH with an official MOU (but that took long to get to);
- CHAG - Effective QA and decision making under a decentralized structure with secretariat, board of trustees – active stakeholder in implementation of MOH KPIs & all 326 CHAG facilities self-report across the 9 pillars of Safecare program
- Fragmentation - within FBOs (CHAG – well established, well governed, and Ahmadiyya trying to get their foot in the door… CHAG and Ahmadiyya competing)

SF – fragmented with weaker governance for the smaller one and self-regulated

- Fragmentation between self financing associations – not organized - SDMPD – longest established but very facility focused vs. PHFAG – newly and several other "federation" like association
- SF not as engaged in QA policy development at MOH level and thus not fully compliant for data or other – the larger tertiary urban tend to do much better than the smaller SF facilities (no resource for QA)
- SF tend to "self-regulate" to uphold reputation as quality is important
- Big high level PS facilities like Nyaho have a strong Quality assurance governance structure with an ethics committee and clinical governance that looks at patient safety etc.

KEY POINTS:

- **Fragmentation between FBOs and private sector – own governance**
- **SF key QA process is case complaint reporting**
- **FBO have KPIs across several aspects of QA including Safety, efficiency etc.**

#6b: Leadership & Governance (*according to the public sector*)

QA structures not well consolidated, new institutions such as HeFRA and roles not well defined and confusion

- **Generally well-structured but gaps at district and sometimes regional levels –** some facilities report directly to national and skip regional; overall weak financial management and reporting is a barrier; weak information systems
- **Several levels of QA; disease-focused; undefined roles for available structures**
  - MOH level – Quality Management Unit (In PPME division) – develops key protocols to disseminate to district level
  - GHS has a QA department;
  - Several TWG with other key divisions but new structures and not well-defined roles
  - QA strategy well implemented for certain disease such as Malaria and HIV

. CHAG is embedded to MOH Qoc and QA structures but not others like SF

- SF fragmented making it difficult for MOH to Qoc Monitoring – no capacity to engage all
- Inaccurate data on PS size and scope by district to better monitor so monitoring boils down to complain cases brought to national level (reactive not proactive)

KEY POINTS:

- **Lack of capacity to execute QA policy developed at national level**
- **Role duplicity and confusion – Different KPIs, Standards for NHIA etc.**
- **Issues of definition private sector – do not consider CHAG as PS and**
- **More resources available for CHAG for QA training and diseases (Malaria, etc.)**

#7: Quality Accountability Structure

Quality accountability structures not harmonized across sectors/ agencies and implemented at varying levels (no clear sanctions/ incentives)

Private Sector

- **CHAG has a strong QoC governance**
  - Strong community engagement
  - Have their own QoC KPIs and patient feedback process that follows Gov decentralized process
- **Most PS have patient satisfaction & complaints reporting systems**
  - Some but most reported QA department
  - Identified challenges in QA expertise and skills and need to enforce that
- **SF vary in their QoC by level of facility**
  - Tertiary level urban have very good structures both for MOH KPIs but also for self-reporting and accreditation
  - Less so for the smaller clinics and maternal homes (no resource)

Public Sector

- **HeFRA main accountability structure but new, not well-functioning/harmonized**
  - University hospitals have their own QoC governing bodies
  - Monitoring PS uneven due to low capacity
  - Today if PS fails inspection they pay money
  - Although act for yearly data submission, it is not enacted as such (district-level)
- **Accreditation through NHIS**
  - holds PS accountable and can help guide where to set up but needs better guidance and integration
- **HMIS/DHMIS data submission –**incomplete
- **No sanctions per say** if PS not meeting quality standards – key cases are brought up to MOH
- **MOH staff seconded in FBOs such as CHAG –**They support KPI and data reporting and somewhat render these PS facilities more accountable to quality standards than others

#8: Data Reporting

PS is engaged through the districts for DHMIS and HMIS data but accountability structure not well defined (role of GHS/NHIA) and minimal PS engagement in other areas results in reluctance to report data…

- **No good reporting to MOH – overall thought about 50% reporting**
  - Reasons unclear but mainly due to lack of trust, transparency/suspicion and cost for small facilities
  - MOH does not share data back to PS and not organized to share knowledge and learning
  - Reporting a bit better for FBOs – CHAG 216/326 facilities report and training the others
  - Confusion of role for data reporting – GHS? MOH? (competitiveness and lack of trust)
- **MOH does not have accurate, timely data**
  - Centre for Health Information Management (CHIM) with HMIS can monitor
  - Overall no proper analytics and weak systems
- **MOH collects quality KPIs on private sector**
  - Collect but do not report to private sector
  - PS does not know data gaps nor can they access their own data for better market understanding
  - PS regularly reports maternal data that are included in performance review meetings
- **Private sector has lots of data on consumer**
  - Collects lots of consumer satisfaction
  - Only complaints to HEFRA
  - Consumer perception – private sector has better quality (customer services, facility)

#9: Relationship between Public and Private

Level of engagement varies by type of PS -ineffective existing platforms but strong willingness to engage on both sides; open for improvements

- **Govt does not evenly involve all segments of private sector**
  - Cherry picking; almost all CHAG (with MOU) and a few of the self financing
  - Gov funds HRH and major equipment in CHAG but few preventive material (e.g. malaria nets) for SF
- **Existing platforms ineffective, boil down to regulatory and resource mobilization**
  - MOH: PS desk (ineffective), Uneven engagement for policy planning (more CHAG, less SF); DHMT more effective in one district than other, National TWG (not repress.)
  - NHIA: several TWG but does not engage all at all times;
  - Hefra – at least 1 PS on board and regular meetings but not as active as need be;
- **Intent to engage**
  - Have a private sector engagement plan and policy (PSDP) but no implementation (turn over in MOH staff and no resources to implement but do have political will)
  - No data on who, where
  - Insufficient staff – a desk but one person with no resource
- **Disorganized and fragmented PS is a barrier to engagement**
  - Difference between Central and District; Too many, not organized, MOH overwhelmed

Public sector's individual level of PS perception and available funding could mean PS is not always engaged where they should be

#10a: Identified Opportunities

OVERALL: PS needs to better organized; public sector develops strategy and commits clear resources and capacity for implementation; Strong PPD

1) Private sector, especially SF, need to be better organized and advocate

- Ensure community level engagement and identify key barriers common to all groups (hospital care, pharma, etc. such as the NHIA); PS have certain HRH expertise and skills that Gov can "contract" and use thus advocate for those **"quick win"** collaborations

2) MOH needs to build PS engagement strategy, capacity, clear roles/governance

- MOH to dedicate a **focal department** with clear effective mandate – although there is a PS desk, awareness not there and person has to understand/come from PS
- Regular meetings calling all and **data sharing information platform**
- Ensure all relevant Gov stakeholders such as the NHIA, Ministry of finance are organized for improved private sector engagement
- Strengthen **HeFRA mandate** to include DHMIS reporting and as part of scoring for licensing as currently under and harmonize with NHIA accreditation

3) Revamp current PPD platforms across several topics in addition to regulation

- Need to better engage and joint delivery systems and Initiatives such as Outsourcing labs, emergency services, encourage rural area coverage etc.
- Ensure capacity and resource at district level for uniform PS engagement process and reporting process
- Seek PS feedback on engagement and develop PPD platforms across key areas such as Financing, referrals etc.

#10b: Identified Opportunities

Harmonizing quality structures, case referrals, data sharing & analytics could be immediate opportunities for improved quality of MNH services

- **Strengthen PS Qoc governance/accountability structure** for meaningful contribution to meeting national goals – strengthen engagement PPD and ensure relevant incentives and sanctions implemented to "guide" PS QoC structure
- **Improve current care referrals to improve quality:** Develop effective referrals for MCH (PS ambulance can be used?); PS should be encouraged to engage in the full delivery of MNCH services through better cost sharing, referrals and also for PS to support in more rural areas –financing mechanisms should account for the different SES levels and ability to pay
- **Sharing of Quality improving experiences:** PS can teach Public facilities on patient experience and better QoC through self-regulation; Can we leverage on PS self-assessment to be part of overall QoC? explore franchising and networks of practice
- **PS can support HRH shortage:** PS is more efficient and can support HRH shortages (production) and complement government services
- **Increase opportunities for mechanisms of financing/more resources for private sector while setting up the relevant quality accountability framework**
  - Cost-sharing mechanisms to encourage PS to engage in the full spectrum of MNH services, especially delivery cases

#11: New Initiatives for Quality Improvement

There are ongoing initiatives at gov and private sector level to improve engagement and quality of MNH services

- **Government initiative to improve PS engagement, data reporting etc.**
  - New initiative to do PS mapping of size and scope by district – analytics
  - Trying to gather Patient Health ID at MOH to assess quality
  - Created a private sector desk but not efficient beyond trying to mobilize resources
- **HeFRA as independent body out of MOH rather than the perception of MOH regulating is a big PLUS but needs to be strengthened**
  - Similar restructuring of NHIA as payor and accreditor should be separate
  - NHIS Fund management and disbursement is a big topic of disagreement and needs to be looked at objectives
- **New initiative trying to build quality incentives through NHIA**
  - Give rewards for zero death rate
  - Review costing structure with available data (ongoing)
  - NHIA accreditation to allow PS to locate in certain "gap" areas and confirm level of health facility licensing (classification by HeFRA is not adequate sometimes

#12: Some existing examples of private sector engagement/public-private partnerships

Not many examples and although a successful PPP policy framework, the infrastructure PPP models have not been successful….

- **Some select PS Facilities allow GHS to do some immunization on site**
- **Pharmacy council and the district pharmacy program to incentivize pharmacies to open in rural areas –**allow 1 pharmacists to attend to 2 adjoining pharmacies and limited dual practice etc.
- **PPP for pharmaceuticals importers and NGOS** with a revolving fund set up - mainly but not much with public sector
- **Malaria program collaboration** – prevention, testing, training has been successful
- **Public-CHAG is a good PPP example** – e.g in Madina enclave no district hospital and a Pentecostal facility is serving instead
- There are **child welfare clinics** within private facilities in some area
- Current collaboration is mainly for prompt **referrals for cases** such as neonatal cases from maternal homes to higher level facilities -There are referral policies from FBOs to public mainly for specialized skills access
- High level facilities like Nyaho work together with gov facilities for **blood donation, transport** of nurses in between referral facilities; share more data and referral cases with district level facilities etc.