RESEARCH PROTOCOL

General Information

Protocol title

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

Date

2 March 2020

Name and address of the sponsor/funder

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Protocol Summary

Rationale

The Quality of Care Network, a consortium of 11 countries and their technical partners, aims to halve maternal and newborn deaths and stillbirths in health facilities in five years' time. Whilst the Network's efforts to achieve this goal have largely focused on strengthening the public health sector, members recognize that private providers are an important source of health care and have a role to play in improving quality care. However, little is known about how to effectively engage and sustain private sector involvement in delivering quality care in low- and middle-income countries. This gap must be addressed, if the Network is to achieve its aims. The purpose of this project is to explore mechanisms for engaging the private sector in delivering quality maternal and newborn health services (MNH) in Bangladesh, Ghana, and Nigeria. This protocol focuses on the work in Ghana.

Methods

In Ghana, the exploratory research involves conducting a situational analysis on the private sector's involvement in delivering quality of care for MNH. Three components will comprise this analysis: (1) a literature review, (2) a stakeholder assessment, and (3) key informant interviews. Qualitative interview data will be analyzed thematically using NVivo. Key findings from this situational analysis will then be discussed at a multi-stakeholder dialogue, where participants will review the initial findings and prioritize key actionable issues to take forward. Findings from the situational analysis and multi-stakeholder dialogue will be combined to develop a country case study.

Expected Outcomes

Based on the findings, models will be proposed for effective engagement of the private sector in collaborating with the national government for delivering and demonstrating accountability for quality of care for MNH. The implementation experiences and lessons learned will be turned into a package of guidance and tools to be shared with other countries looking to replicate this process.

Table of Contents

List of Acronyms and Abbreviations

CHAG	Christian Health Association of Ghana
CHPS	Community-Based Health Planning and Services
FBOs	faith-based organizations
GHS	Ghana Health Service
HeFRA	Health Facilities Regulatory Authority
HSMTDPF	Health Sector Medium-Term Development Framework
LMIC	low- and middle-income countries
MDC	Medical and Dental Council
MNCH	maternal, newborn and child health
MNH	maternal and newborn health
MoH	Ministry of Health
N&MC	Nursing and Midwifery Council
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
NHQSC	National Healthcare Quality Steering Committee
NMTDPF	National Medium-Term Development Framework
NQMU	National Quality Management Unit
OOP	out-of-pocket payment
OPD	outpatient department
PPP	public-private partnership
QoC	quality of care
STI	sexually transmitted infections
UHC	universal health coverage

WHO World Health Organization

List of Tables

List of Figures

1.0 Introduction

1.1 Background and rationale

The Network for Improving Quality of Care for Maternal, Newborn and Child Health (the Network), a consortium of Ministries of Health in 11 countries and their technical partners, works to improve the quality of care for maternal and newborn health (MNH). To achieve the Network's goal of halving maternal and newborn deaths and stillbirths in health facilities in five years' time, countries and partners in the Network are improving quality of care in health facilities through four strategic objectives: leadership, action, learning and accountability (Adeniran, Likaka et al. 2018, World Health Organization 2018).

Whilst the Network's efforts to achieve this ambitious goal have largely focused on strengthening the public health sector, members of the Network recognize that private providers (i.e., non-government providers, for-profit businesses) are an important source of health care and have a role to play in improving quality care. The private sector addresses an increasing volume of MNH care needs amongst countries in the Network. However, little is known about how to effectively engage and sustain private sector involvement in delivering quality care in low- and middle-income countries (LMIC). This gap must be addressed, if the Network is to achieve its aims of reducing maternal and newborn deaths and stillbirths.

The engagement and contribution of the private sector in implementing quality care standards, developing and identifying best practices for delivering quality MNH care and strengthening health systems for delivering with quality is an area with great potential that requires immediate attention. There is a need to understand what can be done to create, nurture and encourage a vibrant private sector that is fully engaged in improving and sustaining quality of care for mothers and newborns. Through an effective collaboration with private sector, we have the potential for reaching more women and newborns with quality health services in accordance with their needs.

1.2 Study purpose and aims

The purpose of this study is to: (1) explore mechanisms for engaging the private sector in planning, delivering and demonstrating accountability for quality MNH services in Bangladesh, Ghana, and

Nigeria; and (2) establish the evidence base on mechanisms that ensure an active and meaningful engagement of the private sector in Network countries for delivering on national plans for quality of care with a focus on MNH. While this study is global, this application for ethical review focuses on the work to be conducted in Ghana. (The research methodology and work to be conducted in Nigeria and Bangladesh are identical.)

Specifically, over eight months, the project in Ghana aims to:

1. Analyze the drivers and determinants of the current engagement of the private sector to deliver quality MNH services;
2. Identify opportunities for involving the private sector in working within the national health system to deliver quality MNH services; and
3. Propose models for effective engagement of the private sector within the national health system for implementing quality MNH services.

1.3 Expected outcomes of the study

The expected outcomes of this study in Ghana include:

1. Establishment of an evidence base on mechanisms that ensure an active and meaningful engagement of the private sector for delivering on national plans for quality of care with a focus on MNH;
2. Initial guidance for implementing private sector engagement for delivering improved quality of MNH;
3. Recommendations for private sector engagement; and
4. Identification of opportunities for involving the private sector in working with the public sector to deliver quality MNH services.

The findings and evidence will be shared with other Network countries so they can adapt both the process and the recommendations for private sector engagement to improve MNH care outcomes.

2.0 Literature Review

2.1 Introduction

In most countries, the private health sector serves more than half of the population representing a major segment of the health sector and plays significant role in the delivering health services including sexual and reproductive health services (National Academies of Sciences, Engineering, 2018). Among women aged 15-49 years, the private health sector contributes substantially towards the provision of family planning services in countries such as Asia (45%), the Caribbean and Latin America (44%) while sub-Saharan Africa contributes less than a third (28%) (Ugaz, Chatterji et al. 2015). However, the market share of family planning is more than 60% in Nigeria and the Democratic Republic of Congo (Dennis, Benova et al. 2018). One in five births in LMIC occurred with care provided by the private sector (Benova, Macleod et al. 2015).

Despite the private sector's expanding role in many countries, the quality of services varies. To accelerate progress to reach the Sustainable Development Goals for ending preventable maternal and newborn deaths, it is critical that both the public and private health service delivery systems invest in increasing coverage of interventions to sustainably deliver quality care at scale. The private sector presents enormous opportunities in ensuring that coverage of and access to services are improved to meet national and international standards. The engagement and contribution of the private sector in implementing quality care standards, developing and identifying best practices for delivering quality MNH care and strengthening health systems for delivering with quality is an area with great potential that requires immediate attention and investigation.

2.2 Ghana's health system

Ghana operates a pluralistic health system. In 2003, the Ministry of Health (MoH) developed a Private Health Sector Policy that sought to properly appreciate the significance and worth of the private sector for improved quality of care (QoC). The Health Sector Medium Term Development Policy Framework (HSMTDPF) (2014-2017) was developed two years after the revision of the Private Health Sector Policy in 2012, based on the National Medium-Term Development Policy

Framework (NMTDPF) that defined the medium-term vision and development for Ghana. The NMTDPF policy identified seven priority areas of which one was "to enhance competitiveness of Ghana's Private Sector" (MOH, 2014, pg. i). In response to the NMTDPF (2014-2017), the health sector developed HSMTDPF to provide a basis for planning and a framework to guide the implementation of priority programs by public and private sector providers.

The MoH followed the process with the creation of a private sector health unit and facilitated the recognition of the private sector by regularly inviting members of the private sector to annual health summits and other national health sector events (Ministry of Health, 2014). The MoH has noted modest institutional successes over the implementation period, particularly in the area of ensuring that mechanisms are available to engage public and private healthcare providers. For instance, public and private facilities have demonstrated respect for and adherence to the standards and requirements for opening health facilities. A Private Sector Unit was also established with the responsibility of ensuring the coordination of all private sector related activities of the ministry and the implementation of the Private Health Sector Policy. The Unit is tasked with the responsibility of providing the needed "support to facilitate the effective and efficient implementation of the policies, programs and projects of the health sector" (Ministry of Health Ghana, n.d.).

Furthermore, the MoH's public-private partnership arrangement with the Christian Health Association of Ghana (CHAG) is working well with the latter invariably becoming an extension of the Ghana Health Service (GHS) in underserved communities. The National Healthcare Quality Steering Committee (NHQSC) tasked to support the National Quality Management Unit (NQMU) to accelerate the implementation of the National Healthcare Quality Strategy, and it has a representative from the private sector. Private associations also represent health professions and providers, and private schools have contributed significantly to the supply of various categories of healthcare workers such as doctors, nurses, pharmacists, physician assistants and allied health professionals. There is also the credentialing program of the National Health Insurance Authority (NHIA) that systematically ensures that aspects of quality and patient safety are addressed in both the public and private sectors (Ministry of Health, 2014).

Insufficient involvement of the private sector affects policy formulation, planning and program implementation in spite of the increase in collaboration since the development of the policy. Though the MoH has a private sector desk to facilitate policy coordination and dialogue between the public and private sectors, the desk has inadequate staff and resources. There are also duplication of efforts and inadequate opportunities to leverage on the experiences and expertise of the private sector, including to share best practices and to use resources efficiently. Above all, there is a lack of trust and mutual suspicion between the public and private sectors. Successful public-private partnerships are possible only when there are clearly defined roles for the private sector to play in helping to achieve universal health coverage (UHC) within a strong and transparent regulatory setting (Wadge, H., Roy, R., Sripathy, A., Prime, M., Carter, A., Fontana, G., Marti, J., & Chalkidou, 2017).

2.3 Definition of the private health sector in Ghana

In Ghana, the private health sector is defined as any non-governmental health actor including private self-financed (also referred to as for-profit), not-for-profit, and mission-or faith-based facilities involved in delivering health services directly, the supply of inputs (e.g., pharmaceuticals, equipment), health training institutions and research, informal and traditional providers, education and promotion of health and financing (Makinen, Sealy, Bitrán, Adjei, & Muñoz, 2011; MoH, 2013). The private sector can thus be classified into two broad groupings: for-profit and not-for profit. The not-for-profit group includes charities, social enterprises, foundations and organizations that are non-governmental or faith-based. Social motives and profit often inform the operations of for-private organizations. The private sector can either be national or multinational; individuals, clinics or hospitals; and they can be involved as providers (hospitals or clinics), associated industries (pharmaceutical provision) or payers (insurers) (Wadge, H., Roy, R., Sripathy, A., Prime, M., Carter, A., Fontana, G., Marti, J., & Chalkidou, 2017).

In Ghana, a public-private partnership (PPP) is defined as "a contractual arrangement between a public entity and private sector party, with clear agreement on shared objectives for the provision of public infrastructure and services traditionally provided by the public sector," (Ministry of Finance (MoFEP), 2011, pg. 2). The private sector is complementing the efforts of government in the provision of public services such as healthcare and infrastructure with its expertise and finance. Mindful of this, the government of Ghana has introduced and is implementing varied mechanisms

and reforms with respect to the laws, finance, incentives and other institutional support to encourage the private sector to provide these public goods in order *"to improve the quality, cost-effectiveness and timely provision of public infrastructure and services in Ghana"* (Ministry of Finance (MoFEP), 2011, pg. 1 italics added).

The public and private health sectors are inseparable and pursuing PPP remains a viable option to take by governments. In Ghana for instance, there is no policy yet against dual practice. Hence, members of staff are able to work in both the public and the private sectors simultaneously. The downside is that the public sector often suffers whenever providers have coinciding shifts. This situation is similar in other LMIC such as India (National Academies of Sciences, Engineering, 2018).

2.4 Size and scope of the private health sector in Ghana

In Ghana, private health care is one of the fastest growing segments of the healthcare system, and private providers (i.e., non-government providers for profit individuals, facilities and businesses) are an important source of healthcare. They are the second largest providers of outpatient department (OPD) services after government providers, contributing about 42% of services (Ministry of Health (MoH) Ghana, 2014; MoH, 2013). Interestingly, the private sector's services and share keep growing, contributing significantly to improved geographical and financial accessibility to quality and safety. Out of the 7,089 total hospital beds in 2016, 20.5% is owned by the private sector. This figure is about a 2% increase from that of 2012 (Ghana Health Service, 2018; WHO, 2013).

A large number of informal providers also practice in Ghana, and the scarcity of accurate and reliable data makes it difficult to give its true size and scope of these providers. Globally, the size of the informal private sector varies from "55% in Uganda, 70% in rural India and as high as 87% in Bangladesh" (National Academies of Sciences, Engineering, 2018, pg. 170-172). The impact of the private health sector in the delivery of safe and quality care cannot be overemphasized, particularly because of its diversity and size. There is a need to bring more members of the private sector on board and to encourage the sector to grow to its full potential, if countries are to attain UHC.

2.4.1 Place of delivery

About 80% of pregnant women who delivered in Ghana did so in health facilities, and about 11.2% of these facility-based deliveries occurred in private sector facilities (Ghana Statistical Service, Ministry of Health, 2017, pg. 115). According to the Maternal Health Survey (2017), deliveries in private facilities saw a 3.1% increase in 2017 over that of 2014 (from 8.1% to 11.2%) (Ghana Statistcal Service, Ministry of Health, 2014, pg.115; Survey & Indicators, 2017), and institutional deliveries increased from 54% in 2007 to 79% in 2017 (Ghana Statistcal Service, Ministry of Health, 2017, pg. 57). About 67.5% of women who delivered during the Maternal Health Survey in 2017 did so in public sector facilities, while home deliveries accounted for 20.1% of births (Ghana Statistcal Service, Ministry of Health, 2017, pg. 72). Doctors assisted with 23.6% of deliveries in private facilities, while nurses/midwives assisted with 74.8% of deliveries in private facilities, according to the Ghana Maternal Health Survey (2017) (pg. 75). Similarly, deliveries in public sector facilities were conducted by 19.4% of doctors and 78.5% of nurses/midwives (Ghana Statistcal Service, Ministry of Health, 2017, pg. 75). Comparatively, more doctors assisted with deliveries in private facilities than in public facilities in Ghana. In private facilities, cesarean section is the main mode of delivery (17.2%, 1230 births) unlike in the public facilities (15.8%, 7384 births) (Ghana Statistcal Service, Ministry of Health, 2017, pg. 76). Furthermore, 99.6% and 99.1% of deliveries in the public and private facilities were assisted by a skilled provider (Ghana Statistical Service, Ministry of Health, 2017, pg. 75).

2.4.2 Deceased women and healthcare

Ghana's Maternal Health Survey (2017) shows that 84% and 16% of deceased women sought care in public and private health facilities respectively (Ghana Statistcal Service, Ministry of Health, 2017, pg. 142). More women in urban areas (21%) sought care in private healthcare facilities than women who resided in rural areas (13%), largely because more the half of private providers are located in urban areas (Ghana Statistcal Service, Ministry of Health, 2017, pg. 134).

24.3 Abortion, miscarriage and sexually-transmitted infections

The proportion of abortion in public (19.9%) and private (19.8%) facilities is similar, according to the 2017 Maternal Health Survey (Ghana Statistcal Service, Ministry of Health, 2017, p. 100). The percentage of women who sought help after a miscarriage from private facilities was 21.8%, while 77.2% of women seeking help after a miscarriage went to public facilities (Ghana Statistcal

Service, Ministry of Health, 2017, p. 106). For sexually transmitted infections (STI), most women (61%) and men (58%) sought care from the private sector by attending to a clinic, hospital, doctor or other health professional for advice or treatment of STI or symptoms related to STI (Ghana Statistical Service, Ministry of Health, 2017).

2.4.4 Malaria

The private sector provides significant support to the malaria prevention and control efforts in Ghana. Some of these efforts include: an indoor residual program whose implementation is supported by the USAID-President's Malaria Initiative and AngloGold Ashanti, a private mining company in Ghana; intermittent preventive treatment of malaria and free administration of sulphadoxine-pyrimethamine to pregnant women as a directly observed therapy; and malaria diagnosis via microscopy (Ministry of Health (MoH) Ghana, 2014; Ministry of Health, 2014). All of these initiatives and efforts occur in both public and private health facilities across the country.

More children with fever resulting from malaria visit public health facilities (60%) than private health facilities (38%) for advice and treatment (Ghana Statistcal Service, Ministry of Health, 2014, pg. 199). The main public sector sources for malaria-related care include health centers (30%) and government hospitals (24%), while individuals seeking care from the private sector most frequently attend pharmacy/chemical/drug stores (27%) (Ghana Statistcal Service, Ministry of Health, 2014; Ghana Statistical Service, Ministry of Health, 2017).

2.4.5 Family planning

Findings from the Ghana Demographic and Health Survey (2014) show that a third of contraceptive users obtained their methods from private providers, particularly from drugs or chemical shops (22%) and pharmacies (7%) (Ghana Statistical Service, Ministry of Health, 2017). Most modern contraception is delivered by the public sector (64% of current users). The findings further indicate that the private sector is a major supplier for users of pills (82%) and male condoms (89%). Public providers (77%) are likelier than private providers (33%) to share information on the side effects and what is to be done when one experiences them (Ghana Statistcal Service,

Ministry of Health, 2014, pg. 89). It is evident that if the private providers are given the requisite support, they can complement the efforts of the government to increase accessibility to family planning commodities and products, even in rural and underserved areas (Ghana Statistcal Service, Ministry of Health, 2014).

2.5 Policies, strategies and plans

Since 2004, Ghana has developed specific policies to strengthen the partnership between the public and private sectors, to improve the investment climate and to develop the private sector generally. Some of these policies include: The Private Sector Development Strategy I&II (2004; 2009), the National Public-Private-Partnership Policy Framework (2011) and the Private Health Sector Development Policy (2003; 2013). The National Health Policy (2007; 2018) is one of the health sector specific policies that strongly articulates and advocates for a partnership between the private and public sectors. The document further emphasizes the need to attain the desired health outcomes including those for maternal, newborn and child health (MNCH). One of the key features of the policy is to "build a pluralistic health service that recognizes allopathic, traditional and alternative providers, both private and public," (MoH, 2013, pg. 7).

The Private Health Sector Development Policy (2003, 2013) specifically looks at what role the private sector can play in the delivery of quality healthcare and how it can better influence the private sector's development to ensure that Ghana's health sector goals and objectives are met. It is guided by national and health sector procedure, policies and legislation (MoH, 2013). Unfortunately, much of the agenda of this policy is yet to be fully implemented seven years after its adoption.

2.6 Legislation and regulation

Regulatory activities in Ghana's health sector focus on protecting the client/consumer by ensuring that the required and appropriate human resource are available in adequate numbers to provide care at the point of service in a conducive environment. Regulation also ensures that agencies that deliver healthcare services meet the minimum prescribed standards (Makinen et al., 2011; MoH, 2013). The regulatory agencies in Ghana include the Health Institutions and Facilities Regulatory Authority (HeFRA) whose object is to "license and monitor facilities for the provision of public and private health care services" (Parliament of the Republic of Ghana, 2011); and the Traditional

Medicine Practice Council that is tasked to ensure that the marketing, use of products and the practice of traditional medicine in Ghana are regulated and controlled (Ministry of Health Ghana, 2018). Other regulatory agencies include the Centre for Research into Plant Medicine that seeks "to make herbal medicine a natural choice for all." Its mandate includes conducting and promoting scientific research into herbal medicine and providing quality control and technical support to institutions and individual herbalists (Centre for Plant Medicine Research, n.d.). The Food and Drugs Authority (FDA) is tasked with responsibility "for the regulation of food, drugs, food supplements, herbal and homeopathic medicines, veterinary medicines, cosmetics, medical devices, household chemical substances, tobacco and tobacco products and the conduct of clinical trials," (Food and Drugs Authority, n.d.). The Pharmacy Council is mandated "to secure in the public interest the highest standards in the practice of pharmacy in Ghana," (Pharmacy Council, 2017). The Nursing and Midwifery Council (N&MC) seeks to "secure in the public interest the highest standards of training and practice of nursing and midwifery," (Nursing and Midwifery Council, 2020). The Medical and Dental Council (MDC) is the statutory body tasked by law "to secure in the public interest the highest standards in the training and practice of medicine and dentistry," (Medical and Dental Council, n.d.). The Allied Health Professions Council (AHPC) is tasked to "regulate the training and practice of Allied Health Professions in Ghana and to grant professional accreditation for all Allied Health Programs," (Allied Health Professions Council, 2018).

What is the right oversight for countries like Ghana with weak regulatory mechanisms to protect populations and to ensure that quality of care and safety standards are met or strictly adhered to while at the same time encouraging innovation and involvement from the private sector? The paucity of regulations and inconsistency among the existing regulations presents significant barriers and risks to quality of care and patient safety. Strong leadership and management are required when using regulatory mechanisms and systems to establish accountability and to improve quality of care (Kruk et al., 2018). In Ghana however, there are capacity and resource-related limitations of regulatory bodies to accredit, license, renew, monitor, supervise, enforce and provide technical support. Similarly, partnerships between and among some of the regulatory agencies (such as NHIA and HeFRA) and private providers are weak, although there have been

great strides at addressing many gaps that exist to provide quality and safe care in both public and private healthcare facilities.

A mechanism is needed to unite all the regulatory domains, such as human resources, facilities, service delivery, supplies and products, so that this mechanism covers different institutions (Akhtar, 2011; Makinen et al., 2011; Ministry of Health, 2014). This mechanism should also have the ability to monitor how healthcare providers shuttle between public and private practices. Professional associations should be able to institute mechanisms to sanction their errant members whenever they fail to meet minimum standards (Kruk et al., 2018). This approach will be one of the many ways of ensuring improved performance of their members (Akhtar, 2011; Rochefort, Adams, Calhoun, & Shaw, 2017). In Ghana, like many LMIC, self-regulation is often underutilized. Professional organizations in high-income countries often advocate for their members, and their self-regulation promotes a "sense of accountability among professionals to people, and reduces transaction costs for governments," (Kruk et al., 2018, pg. e1233). A typical example from Canada shows that "physicians successfully self-govern all aspects of the profession, from setting nationally uniform entrance exams to monitoring and remediating substandard clinical practice among practising physicians," (Kruk et al., 2018, pg. e1233)

The role of regulation in the provision of quality and safe care in any healthcare delivery system cannot be overemphasized. Regulatory oversight is crucial. These roles could be in areas such as competence, professionalism, and numbers of the health workforce required for particular types of facilities; education and training of health workers; medicines, technology and health infrastructure (National Academies of Sciences, Engineering, 2018). Relevant "safeguards and transparent oversight can enable self-regulation of prices, quality, and numbers," (National Academies of Sciences, Engineering, 2018, p. 214). Regulatory bodies should also start addressing how multiple approaches can be used to contain costs and ensure improvement in quality of care outcomes.

2.7 Financing and infrastructure

Self-financing private providers are saddled with numerous challenges in rural areas, mostly as a result of the high poverty rate in rural populations. Unfortunately, unlike the private not-for-profit

providers who receive some levels of support from government, there is little or no support and/or any partnership arrangement existing between the government and the self-financing private sector. The operational cost of the private sector is mainly financed by out-of-pocket payments (OOP) and claims reimbursement from the National Health Insurance Scheme (NHIS). There is, however, the need to discourage OOP as Ghana strives to attain UHC.

Other challenges confronting the private sector include: inadequate infrastructure including infrastructure of poor quality; inefficient water and electricity supply; and poor road networks and transportation services that greatly influence the location and type of services to be offered. Other financing limitations include the high cost of credit, including prohibitive interest rates from the banks; the time frame in which one is expected to pay back principals and interest on bank loans; unavailability of start-up and investment capital; and high transaction costs. Often times, the banks and financial institutions do not understand the needs of the private health sector and how they can design appropriate products to help (Makinen et al., 2011; Ministry of Health, 2014; MoH, 2013).

The private sector may need to be encouraged to invest its own resources to improve quality of care outcomes for clients. Some financing options that can be considered by the private sector include strategic purchasing that involves deciding on what service to purchase, from who to purchase and at how much as against passive purchasing; and input and output incentive contracting that was found to reduce post-partum hemorrhage by 20% in India (National Academies of Sciences, Engineering, 2018, pg. 237).

CHAG is one of few—and probably the only—private sector players that are supported financially by the government. The organization also receives donations and support in other forms from other development partners and donors. This support from the government comes in the form of paying the salary for staff and other associated costs, training, equipment supplies and subventions. The Government of Ghana through the MoH has also developed and signed a performance contract with CHAG and by extension other agencies of the ministry (Makinen et al., 2011; MoH, 2013).

The NHIS is a social intervention program that seeks to ensure financial access to quality and safe care. It is a contributory scheme that has currently enrolled a significant number of the population

than private health insurance scheme that are mostly commercial and have enrolled a very small group. Subscribers renew their membership annually via the payment of a processing or renewal fee (except exempt categories such as pregnant women and elderly people above 70 years) that enables them to access both public and private healthcare facilities credentialed by the NHIA. However, there could be instances in Ghana where even though someone has registered or subscribed for health insurance, the person will still not be covered or be able to access care in any of the credentialed facilities. This issue is likely to happen in the following instances: 1) the individual has a card that is expired and has not yet renewed it; 2) the individual is waiting to complete the paperwork of her/his registration so that he/she can receive his/her card. The NHIS is also fraught with delayed "reimbursement, leading to cash flow constraints and loan defaults, particularly on the pharmaceutical supply chain," (Makinen et al., 2011, pg. 7). Some self-financing private sector players end up charging insured clients additional fees (Makinen et al., 2011, pg. 59) (Makinen et al., 2011; Ministry of Finance (MoFEP), 2011; MoH, 2013).

In Ghana, findings from the Demographic and Health Survey show that four-fifths of women aged 15-49 years are registered with any insurance, but only 46.2% are able to access the benefits of health insurance (Ghana Statistcal Service, Ministry of Health, 2017, pg. 15). When it comes to privately purchased commercial insurance, even fewer individuals are registered (0.2%) (Ghana Statistcal Service, Ministry of Health, 2017, pg. 7). The Maternal Health Survey (2017) further revealed that men aged 25-29 years were less likely to be covered by NHIS. The national health insurance uptake in Ghana is further influenced by socioeconomic and educational status. For instance, men and women who are in the wealthiest quintile and/or with secondary or higher education are more likely to be covered by the NHIS compared to other subgroups (Ghana Statistical Service, Ministry of Health, 2017).

Increasing numbers of consumers continue to pay nothing at public and private health facilities in order to access healthcare services. Unfortunately, however, this trend has yet to affect OOP when such payments are required in facilities. The irony is that private health service providers are mostly in favor of the NHIS because it allows people to access private healthcare services for the first time. However, private providers continue to express frustrations with the NHIS because of delayed reimbursements, incomplete credentialing and lower tariff rates among other reasons (Makinen et al., 2011). It is noteworthy that in spite of the decline in private and OOP expenditures since the introduction of the NHIS in 2004 and the Free Maternal Healthcare Policy in 2008,

financial risk protection remains inadequate. There have been instances where pregnant and lactating mothers and their newborns have had to pay various sums of money at antenatal care clinics, for caesarean sections, and for delivery at the point of service (Adua, Frimpong, Li, & Wang, 2017; Wang, Temsah, & Mallick, 2017).

Insurance "fraud can be committed by multiple actors within the health care system, including health care providers, government inspectors or regulators, payers (whether public or private), and even suppliers of equipment and medicines," (National Academies of Sciences, Engineering, 2018, p. 209). There have been instances of insurance fraud when health facilities submit false claims for reimbursement to insurance companies. In 2018, one medical superintendent of a district hospital was convicted and sentenced to 10 years in prison for defrauding the NHIS by GHS 415,000 (Nyabor, 2018). An audit by the NHIS revealed how he had submitted same names of users for his private clinic and the government facility where he was the medical superintendent. Interestingly, none of the names he submitted had ever attended his private clinic (Nyabor, 2018). There have also been instances where patients have had to made informal payments to access care that have in many instances resulted in bad outcomes (National Academies of Sciences, Engineering, 2018).

Innovation and digital health technology are changing healthcare quality and safety, but the public health sector seems to lag behind the private sector in these innovations. The private health sector is making significant investments in this area. Public sector efforts are ongoing in Ghana with the government's digitization agenda working to digitize public hospitals' current paper-based systems. The largest teaching hospital in Ghana, Korle Bu Teaching Hospital (KBTH), is currently in the process of complying with digitization and its Family Medicine Department is going completely paperless (Korle Bu Teaching Hospital, 2019).

2.8 Market competitiveness

Ghana, like many other countries, has introduced various policies and reforms aimed at advancing competition among healthcare providers and increasing the choices of the patient. Some of these policies have been directed at creating a conducive environment and incentives to attract private sector players into a sector that has traditionally been government owned and directed.

Historically, healthcare provision in Ghana has been centralized and non-market oriented. Through the establishment of the NHIS for instance, the choice of the patient has significantly improved, and patients are in a unique position to drive quality of care among health facilities in the country. Until the NHIS, patients had very little choice over where they could go and receive healthcare. The NHIS began credentialing private health facilities as part of the process of creating an environment that would foster competitiveness.

A competitive healthcare market will be defined as one in which providers (i.e. sellers) and patients (i.e. buyers) engage in a relationship where there is some kind of an exchange between the actors such as providers and patients, among providers, or providers and insurers (Goddard, 2015; Lábaj, Silanič, Weiss, & Yontcheva, 2018). Market competitiveness could be based on price and quality (or non-price competitiveness such as quality of service, quality of care, convenience, timeliness, etc.). Results of studies that demonstrate an association between market competitiveness and quality of care outcomes are mixed. Gaynor (2004), cited in Cooper 2011, showed that where prices of health services are fixed it results in improvement in the performance of hospitals (Cooper, Gibbons, Jones, & Mcguire, 2011) while Gowrisankaran and Town (2003), cited in Cooper 2011, also revealed that an increase in competition in any fixed price market will lead to an increase in mortality for acute myocardial infarction (AMI) patients.

Similarly, the type of ownership (private versus public) could also be a basis to instigate competition (Goddard, 2015). Type of ownership could be driven by numerous factors such as: economies of scale, scope and level of spare capacity that can be tolerated; the amount of quality and unbiased information that is available and its ease of access and the willingness of patients to travel to access services (Goddard, 2015). Health sector markets are complex, large-sized and "complicated by the presence of public-private mixed services," (National Academies of Sciences, Engineering, 2018 pg. 209). The health sector, like many others, is prone to corruption and decreased quality of governance (National Academies of Sciences, Engineering, 2018). Even though there have not been significant studies on the impact of market competitiveness in healthcare, the benefits if market competitiveness cannot be overemphasized. Studies by Cooper (2011) and Gaynor, Moreno-Serra, & Propper (2013) have shown instances where market

competitiveness has resulted in reduced mortality among myocardial infarction patients in the National Health Service in the United Kingdom.

Competition also helps improve efficiency and timeliness in the provision of care (Bevan & Skellern, 2011). Patients are in a position to drive quality of care in market competitive environments because of their purchasing power and choice of providers. However, in healthcare markets where providers are better informed than patients, it is likely that health providers may underprovide quality. Partnerships between public and private providers and adequate investments are often needed to accelerate improvement in the quality of care in market-competitive environments such in Ghana (National Academies of Sciences, Engineering, 2018).

In systems where health care is mixed and funded both publicly and privately, these "systems tend to suffer from poor performance, such as a failure to achieve fairness in financing and equity in outcomes. This has been hypothesized to result from an interplay among three determinants: insufficient state funding for health, insufficient regulatory oversight, and a lack of transparency in governance," (National Academies of Sciences, Engineering, 2018, p. 213). It is necessary therefore to develop effective stewardship mechanisms to ensure that the services of both the public and private sectors are used for the general good of the populace (National Academies of Sciences, Engineering, 2018). There is a need to urgently increase funding for healthcare or risk commercialization of both healthcare and hospitals. One cannot assume that market forces alone can and are able to drive the desired quality and safety in healthcare, especially the in the private sector.

2.9 Accountability

Accountability in the health sector is weak and limited by the reporting of health service indicators, such as quality of care and user profiles in both public and private sectors. The private sector, however, offers little information about quality and quantity of care delivered. There is an urgent need to integrate and incentivize the private sector in reporting, planning and monitoring; and to also ensure the private sector's timely and reliable reporting of data (Saleh, 2013). In order to ensure that accountability and action is present in healthcare, the quality of the data must be ensured at all times. Ghana, like many countries in the Network, has adopted a national electronic

health records system (DHIMS2) that seeks to facilitate "aggregate reporting from paper-based" registers in health facilities (Kruk et al., 2018). Even though the private health facilities are also expected to submit reports and feedback their data to the MoH, this rarely happens. The reason for this failure is sometimes due to the MoH's inadequate enforcement of its rules. Private providers have also suggested that often times, the requirements for reporting are not clear. Their participation and data completion in national health management information system is often very low. However, a true "national view of health system quality requires measurement from the private sector. The exclusion of private providers restricts health system assessments" (Kruk et al., 2018, pg. e1228). Occasionally there is reluctance on the part of the private sector to share its data with the government; however, there is also a willingness to share data once strong mechanisms and incentives exist to do so (Bhattacharyya S, Berhanu D, Taddesse N, 2016; Kruk et al., 2018).

Informal payments are a common phenomenon, ranging from 3% in Peru to 96% in Pakistan with variations across other regions of the world (National Academies of Sciences, Engineering, 2018, pg. 208). These payments have negative impacts on quality, efficiency and equity of healthcare provision. The practice is more prevalent in public facilities than in private not-for-profit facilities, but it is highest in private for-profit facilities in Cameroon (Kruk et al., 2018). A global need exists for a sector-wide and sector-specific approach to solving it (Kruk et al., 2018).

2.8 Service delivery

In Ghana, health service delivery is the responsibility of the GHS, faith-based organizations (FBOs) (including CHAG and Ahmadiyya Mission) and the five teaching hospitals. Ghana has designated another level of care, the Community-Based Health Planning and Service programme (CHPS), as part of its efforts to improve geographical access to quality and safe care. The activities of private and FBOs are overseen by the GHS in regions and districts through the Regional/District Health Directorates. All FBOs, particularly CHAG, have facilities based primarily in rural and underserved areas of Ghana to facilitate the provision of primary health care. Tertiary and specialists' services are provided at the teaching hospitals and also act as main referral facilities.

Private health facilities contribute significantly to the provision of health services even though often times their contributions are deliberately or inadvertently ignored. Quality of care is

fragmented and inequitably distributed between the public and private facilities. Across the six dimensions of healthcare quality (i.e. safety, timeliness, equity, efficiency, effectiveness and person centeredness), poor quality has been identified in both public and private health facilities (Basu S, Andrews J, Kishore S, Panjabi R, 2012). Public and private facilities performed similarly in the provision of quality antenatal care according to a household survey in 46 countries (Powell-Jackson T, Macleod D, Benova L, Lynch C, 2015). Evidence suggests that private health facilities in Democratic Republic of Congo, Kenya, Rwanda and Uganda adhered more closely to the World Health Organization (WHO) guidelines for sick children than public facilities (Kruk et al., 2018). Similarly in India, private facilities adhered more closely to the use of checklists than public facilities in a standardized patient study (Das, Das, & Tabak, 2012).

Yet, private facilities have been cited as strong violators of medical standards and have also ranked lower in efficiency than public facilities (National Academies of Sciences, Engineering, 2018). Nonetheless, private facilities continue to be known for their hospitality and timeliness in service delivery more than their public counterparts (National Academies of Sciences, Engineering, 2018). A systematic review in LMIC also revealed that public providers had better outcomes, were likelier to follow and adhere to the standards of medical practice, had less incentives for needless testing and treatments, and were more efficient than private providers including unlicensed and uncertified providers (Basu S, Andrews J, Kishore S, Panjabi R, 2012). PPPs offer an important opportunity for quality improvement in healthcare generally and for MNCH in particular.

2.9 Treatment seeking and perceived quality of care

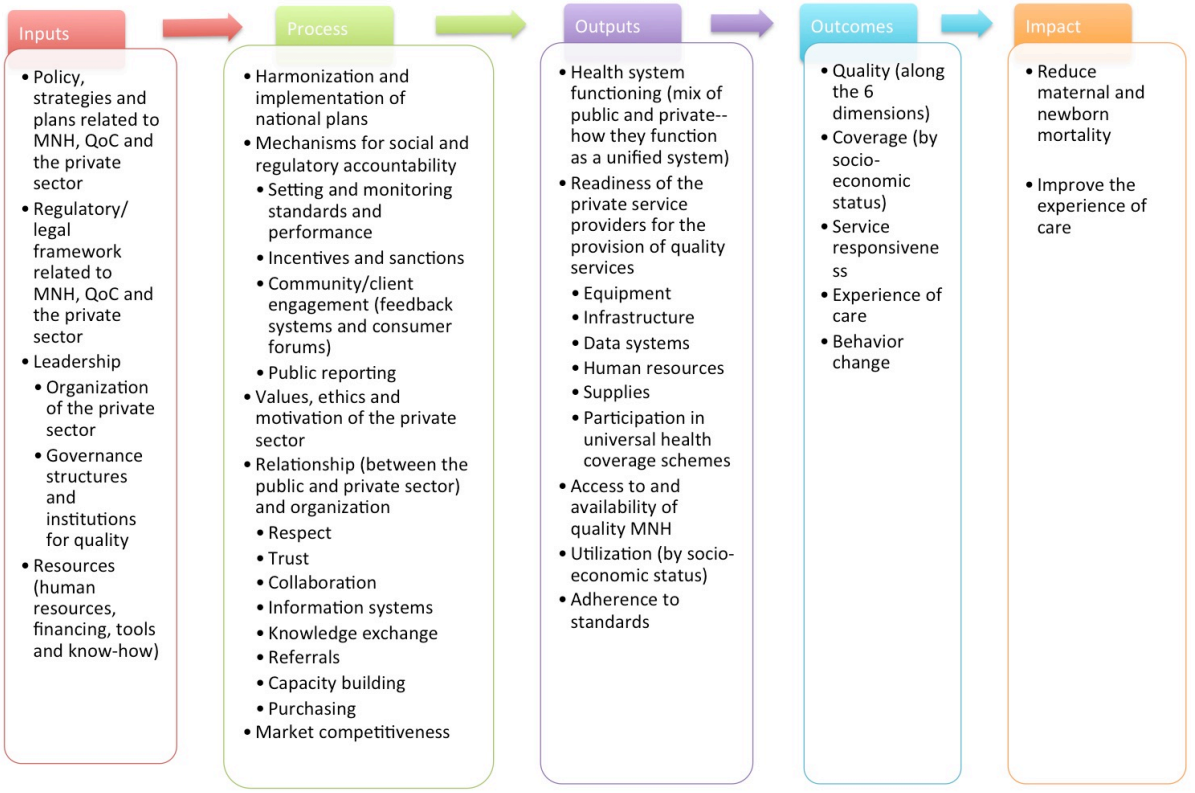
There is little referral between private and public facilities even when the relevant specialty is available in the former. Similarly, with the exception of medical diagnostics, referral between private facilities is infrequent (Ghana Statistcal Service, Ministry of Health, 2014; Ghana Statistical Service, Ministry of Health, 2017). Studies in high-income countries have revealed that the quality of care in private facilities is better and of higher quality than in public facilities (National Academies of Sciences, Engineering, 2018). However, this finding seems to be different in LMIC such as Ghana.

Improving quality of care outcomes requires an integrated system of care and productive interactions between the public and private sectors. Delivering person-centered care requires "the provision of care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that these values guides all clinical decisions" (National Academies of Sciences, Engineering, 2018, pg. 143). Poor experience with the health system is believed to significantly impact the healthcare seeking behavior of the patient, loss to follow-up and unnecessary spread of disease. The levels of dissatisfaction ranges from 2.2% (UK) to 54.3% (Vietnam) (National Academies of Sciences, Engineering, 2018, pg. 145).

2.10 Project logic model

Based on the relevant literature reviewed above as well as input from colleagues at WHO and a global advisory working group, we developed a logic model (Figure 1) to guide the project.

Figure 1: Logic model for mapping the private sector's engagement in delivering quality for maternal and newborn health as part of the national health system



Equity and contextual factors (e.g. politics, technological, economic, social, environmental/climate, epidemiological) may affect progress of the pathways above.

3.0 Methodology

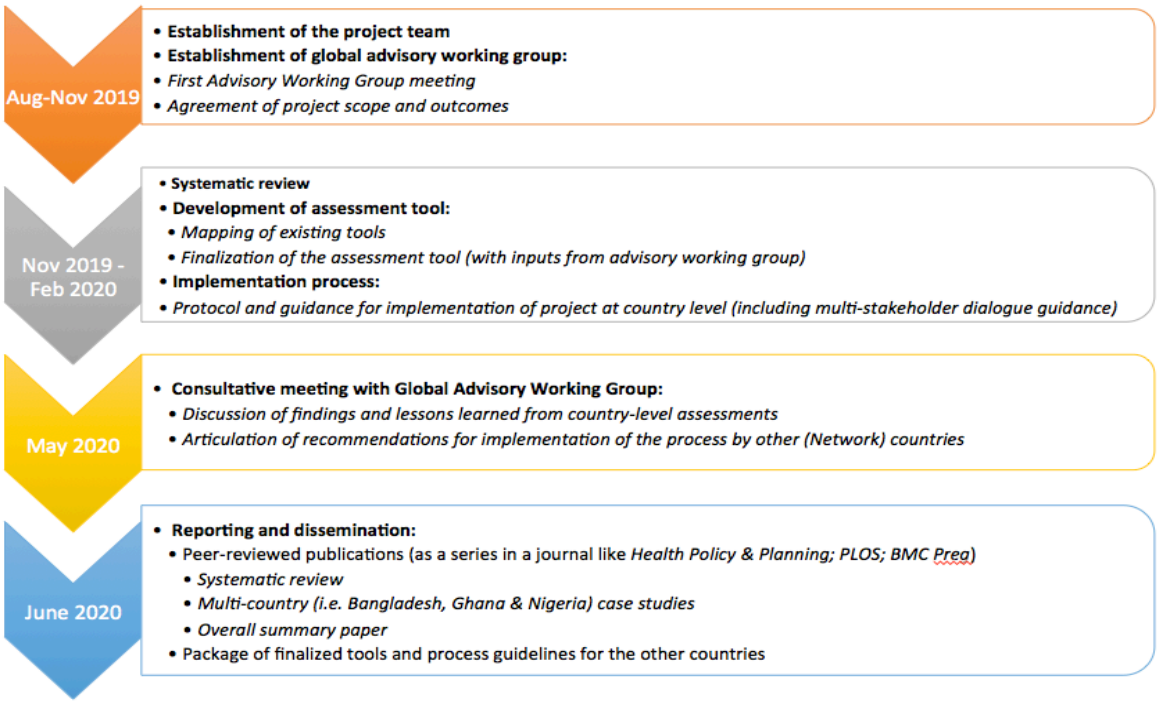
This exploratory project seeks to establish the evidence base on mechanisms that ensure an active and meaningful engagement of the private sector for delivering on national plans for quality of care with a focus on MNH. The study seeks to document the implementation experiences and lessons learned from the private sector and its interaction with the public sector for delivering quality health services in Ghana. The findings from the key informant interviews will serve as the basis for a multi-stakeholder dialogue, where participants will review the findings and propose recommendations for the way forward.

The project scope will focus on formal private sector service delivery providers (both for profit and non-profit) and their clients (mothers and newborns). Furthermore, we are focused on service delivery of quality care and MNH. This focus includes provision of care in the private sector, including preventive, promotive and curative services. Traditional and informal private sector providers are beyond the scope of this project, as are private service aspects in relation to service delivery (e.g., supply chain, education/training, insurance providers).

3.1 Study design

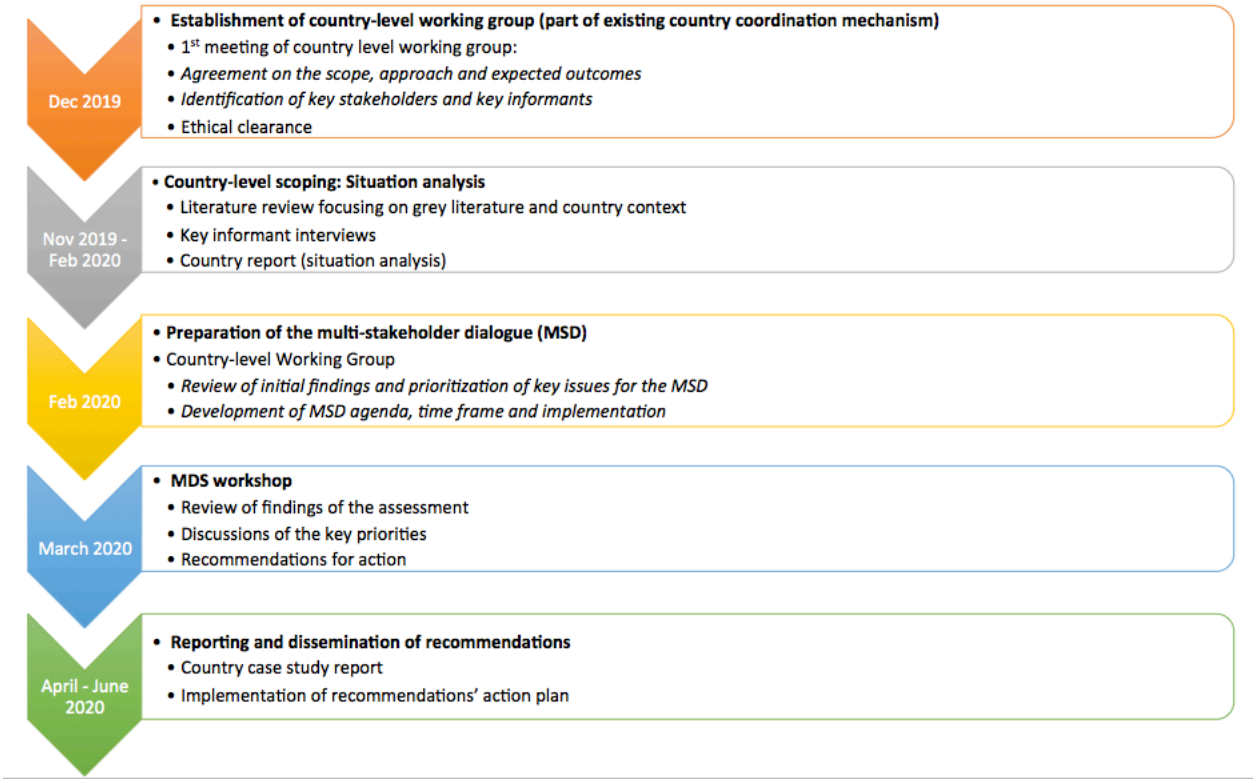
Project activities are occurring in two parallel streams. At the global level (Figure 2), the project has convened a global advisory working group to provide advice to the WHO-based Secretariat of the Network for Improving Quality of Care on framing the project, sharing relevant resources related to private sector engagement in health, developing the methodology for project implementation, discussion of findings and articulation of recommendations. In addition, WHO is conducting a systematic review on private sector delivery of quality care for maternal, newborn and child health in LMIC. This systematic review, along with country case studies and an overall summary paper, will be packaged as a series for publication in a journal like *Health Policy and Planning.* Finally, the project will develop a package of finalized tools and process guidelines for other Network countries to use to replicate this process.

Figure 2: Global-level activity stream



Project activities will also occur at the country-level in Bangladesh, Ghana, and Nigeria (Figure 3). These activities include human subjects research, necessitating our application for ethical review. Work in each country will be supported by the WHO and Network Secretariat as well as country-level working groups that exist as part of the Network's country coordination mechanism. In each country, the exploratory research involves conducting a situational analysis on the private sector's involvement in delivering quality of care for maternal and newborn health. Three components will comprise this analysis: (1) a literature review focusing on grey literature and country context; (2) a stakeholder assessment; and (3) key informant interviews. This situational analysis will be shared with attendees at a multi-stakeholder dialogue in each country, where participants will review the initial findings and prioritize key actionable issues to take forward in each country. Findings from the situational analysis and multi-stakeholder dialogue will be combined to develop country case studies.

Figure 3: Country-level activity stream



Within Ghana, the study involves the collection and analysis of both primary and secondary data. Secondary data and grey literature (e.g., policies, facility-based assessments, reports) will be used to provide background context on the private sector to situate the country case study. Country-specific literature will be forwarded from the systematic review, and efforts will be made to obtain additional grey literature from key informants. As seen in Table 1, this secondary data will address the following: policies, strategies and plans related to quality of care and maternal and newborn health; the regulatory/legal framework; harmonization and implementation of national plans; and a range of health-related outputs, outcomes, and impacts.

Table 1: Data sources mapped to the project logic model

Inputs		
Topic	*Interviews*	*Literature Review*
Policy, strategies and plans related to MNH, quality of care and the private sector	x	x
Regulatory/legal framework related to MNH, quality of care and the private sector	x	x
Leadership: - Organization of the private sector - Governance structures and institutions for quality	x	
Resources for the private sector (human resources, financing, tools and know-how)	x	
Process		
Topic	*Interviews*	*Literature Review*
Harmonization and implementation of national plans	x	x
Mechanisms for social and regulatory accountability (e.g., setting and monitoring standards, incentives and sanctions)	x	
Values, ethics and motivation of the private sector	x	
Relationship between the public and private sector and its organization (e.g., trust, information systems, referrals)	x	
Market competitiveness	x	
Outputs		
Topic	*Interviews*	*Literature Review*
Improved health system functioning (mix of public and private sectors and how they function as a unified system)	x	
Improved readiness of the private service providers for the provision of quality MNH services (e.g., infrastructure, data systems, supplies)		x
Improved access to and availability of quality MNH		x
Improved utilization		x
Adherence to standards		x
Outcomes		

Topic	*Interviews*	*Literature Review*
Quality (the six dimensions)		x
Coverage		x
Service responsiveness		x
Experience of care		x
Behaviour change		x
Impact		
Topic	*Interviews*	*Literature Review*
Reduce maternal and newborn mortality		x
Improve the experience of care		x

Key informant interviews will be used to gather primary data on inputs, processes, and outputs related to the private sector's engagement in delivering quality for maternal and newborn health as part of Ghana's national health system (Table 1). Key informants will be identified by a stakeholder assessment and input from the national technical working group.

3.2 Study locations

Since we are interested in national policies and practices involving the private health sector in Ghana, we are not geographically bound to a specific region or city. However, in consultation with the Quality of Care Network's national technical working group, we will target key informants and stakeholders from five of the 16 administrative regions of Ghana: Ashanti, Ahafo, Greater Accra, Northern and Western. We have prioritized these five regions based on data from the Society of Private Medical and Dental Practitioners that reveal 87.9% of the Society's registered members (254/287) are located in these regions, as at 31st December 2019 (P. Larnyo, Pers. Comm., Feb. 25, 2019). The Greater Accra, Ashanti and Western regions are predominantly urban, while the Ahafo and Northern regions are predominantly rural. The Greater Accra and Ashanti regions have the largest referral facilities (i.e. Korle Bu and Komfo-Anokye Teaching Hospitals) in the country. The Ahafo region, located in the middle belt of Ghana, has numerous facilities operated by CHAG and offers an opportunity to understand the issues related to private practice in facilities operated by faith-based organizations. A participant residing in any of these regions will be eligible to participate, if s/he meets the eligibility criteria. When possible, interviews will be conducted in person with a member of the research team. However, to overcome limitations of distance, we will offer participants the opportunity to participate in the interviews via telephone or over the internet.

3.3 Study population

The study population will include formal health service providers in the public and the private sectors of Ghana. Individuals from this population may be invited to participate in the key informant interviews and/or the multi-stakeholder dialogue that will discuss findings from the key informant interviews.

For the purpose of this study, we are using the Ghana Ministry of Health's definition of the private sector as: any non-governmental health actor including private self-financed (also referred to as for-profit), not-for-profit, and mission-or faith-based facilities involved in delivering health services directly, the supply of inputs (e.g., pharmaceuticals, equipment), health training institutions and research, informal and traditional providers, education and promotion of health and financing (Makinen et al., 2011; MoH, 2013).

3.4 Inclusion criteria

Individuals will be invited to participate in the key informant interviews and/or multi-stakeholder dialogue if they meet the following inclusion criteria:

- have experience in and knowledge of service delivery of QoC and/or MNH in Ghana;
- are currently working in the public health sector and/or the private formal health sector in Ghana;
- have been working in their current role for at least two years; and
- work in the Ashanti, Ahafo, Greater Accra, Northern or Western regions.

3.5 Data collection

We will take a mixed-method approach, integrating both qualitative and quantitative data throughout the data collection, analysis and interpretation phases. For the literature reviews, secondary quantitative and qualitative data will be collected from grey and published literature on the size, scope, distribution of the private sector and quality of care outcomes related to MNH in Ghana. Both data (i.e. primary and secondary) will be collected at the same time subsequently integrated to facilitate an appropriate interpretation of the overall results. It is anticipated that a

more trustworthy result will be attained with this study method other than using the two approaches separately.

For the key informant interviews, trained interviewers will conduct the interviews using one of six possible semi-structured interview guides (Appendix 1). These guides are tailored to the three roles that we are targeting with our sampling matrix (see Table 2): policy/administration, service delivery, and regulation. Each of these three roles has one guide for private sector respondents and one guide for public sector respondents. The interviewer will choose the appropriate guide based on the participant's role and whether s/he works within the public or private health sector. These guides were developed based on the logic model framework (Figure 1) and an assessment of existing tools. Specifically, the research team reviewed the existing tools and resources for existing interview questions on the private sector:

- GFF (2016). *Exploring Partnership Opportunities to Achieve Universal Health Access.*
- GFF (2016). *Private Sector Contributions to Maternal and Reproductive Health.*
- SHOPS PLUS (2018). *Madagascar Private Health Sector Assessment*.
- SHOPS PLUS (2019). *Democratic Republic of the Congo Private Health Sector Assessment.*
- SHOPS PLUS (2014). *Assessment to Action: Stakeholder Questions*.
- SHOPS Project (2016). *Strengthening Health Outcomes through the Private Sector Project: Final Report 2009-2016.*
- USAID (2009). *Nigeria Private Sector Health Assessment.*
- USAID (2017). *Exploring Partnership Opportunities to Achieve UHC: 2016 Uganda Private Sector Assessment in Health.*
- Wadge (2017). *Evaluating the Impact of Private Providers on Health and Health Systems*.
- World Bank (2011). *Private Health Sector Assessment in Ghana*.

Potentially relevant questions from the documents above were mapped against the logic model framework (Figure 1). Existing questions were tailored to the logic model, and new questions were added based on where gaps remained. The questions were reviewed by the global advisory working group and updated based on their feedback. These guides will enable the study team to pool the information gathered by different interviewers while at the same time giving the interviewers

flexibility to explore issues unique to respondents. While a possible disadvantage of using an interview guide is not asking the right questions, stakeholder discussions and piloting the guides will help formulate the interview guides and see that they include the correct questions. In order to ensure high quality of the data, the interview guides will be piloted prior to the study's commencement. These exploratory interviews will aim to explore appropriate language and terminology, assess validity of the survey questions, test the flow of the questions, and formulate the final interview guides.

The interview guides include open-ended questions that cover the following topics: policies, plans and strategies related to quality MNH; regulatory/legal framework; accountability; leadership; availability of resources; values, ethics and motivation of the private sector; market competitiveness; relationships between the public and private sectors; improved health systems functioning; improved readiness of private sector service providers for the provision of quality MNH; and improved access to and availability of quality MNH. Interviews are expected to last approximately 60 minutes and will be audio recorded, if the participant consents. In cases where the participant does not consent to the interview being audio recorded, the interviewer will take handwritten notes.

Based on findings from the key informant interviews, we will organize a multi-stakeholder dialogue. Planning the dialogue meeting will involve project staff and members of the national technical working groups (e.g., representatives from the Ministry of Health, partners). For the meeting, eligible participants will be invited to attend a two- to three-day meeting to discuss project findings and generate actionable recommendations for effective engagement of the private sector in the national health system for delivering, and demonstrating accountability for quality of care for MNH. The meeting will not be recorded, but project staff will take notes that will be used in writing up the meeting report. Participants travel-related expenses will be covered to ensure their participation.

3.6 Sample selection

We will purposively select individuals for participation in the key informant interviews and/or multi-stakeholder dialogues based on the inclusion criteria, stakeholder assessment and input from

the national technical working group. Stakeholder assessments will: (1) identify all the stakeholders in the space and assess their influence, positions, and interests; (2) explore stakeholders' responses with respect to policies, strategies, regulations, incentives, private investments, etc.; and (3) be conducted using the PolicyMaker software or an adapted Excel spreadsheet based on PolicyMaker. Following this step and prioritization of stakeholders with the technical working group, eligible interview participants will be selected purposively using a sampling matrix (Table 2) to capture a range of viewpoints and experiences with private sector service delivery of quality MNH. Participants will be invited via email or telephone. A formal letter of invitation will be provided, if participants need one to obtain formal permission from their employers.

Determining the number of interviews one must conduct for qualitative research is such a frequent question that the National Council on Research Methods (NCRM) approached 14 renowned social scientists and five early career researchers for an answer; ultimately, the experts concluded that "it depends," (Baker and Edwards 2012). According to Harry Wolcott, "in general the old rule seems to hold that you keep asking as long as you are getting different answers, and that is a reminder that with our little samples we can't establish frequencies but we should be able to find the RANGE of responses," (Baker and Edwards 2012). Given the exploratory nature of qualitative research, many of the NCRM-approached experts recommend sampling until saturation occurs; however, others encouraged set figures. Alan Bryman suggests that in order to be published, qualitative studies require a minimum of 20-30 interviews (Baker and Edwards 2012). While having a set figure can be useful for writing proposals and planning one's research, sample size is ultimately affected by factors such as the research questions and the population's heterogeneity.

In this proposed research, the qualitative sample will be selected using a non-probabilistic stratified purposive sampling approach. This approach will allow for comparisons between subgroups while displaying variation on individuals' roles and the level at which they operate (Patton 2002). Not only must the sample have "symbolic representation," but it must also illustrate the diversity within the population's boundaries (Ritchie, Lewis et al. 2003). Based on these requirements and important characteristics put forth in the literature, the final sample size will be influenced by the sampling matrix depicted below (Table 2) that captures health sector (public or private), role (policy/administration, service delivery, regulation), and level (national, subnational, facility).

Informants will be selected based on these characteristics for a proposed total of 28 interviews (2 individuals per sector, role, and level) or until saturation occurs.

Table 2: Qualitative sampling matrix

Health Sector	Role	Level
Public Health Sector	Policy / administration	National
		Sub-National
	Service delivery	National
		Sub-National
		Facility (Manager/Director)
	Regulation	National
		Sub-National
Private Health Sector	Policy / administration	National
		Sub-National
	Service delivery	National
		Sub-National
		Facility (Manager/Director)
	Regulation	National
		Sub-National

For the multi-stakeholder dialogues, we anticipate inviting approximately 35 participants. These participants will be purposively selected based on the stakeholder assessment and input from members of the national technical working group.

3.7 Data management and statistical analysis

Qualitative data from the key informant interviews will be analyzed using the content analysis technique. They will also be organized around the logic model. NVivo Version 12 will be used to assist the organization and retrieval of themes from the data. All audio-recorded in-depth data will be transcribed verbatim immediately after each session and will be critically examined for accuracy and representation of the response of the participant. In order to ensure uniformity, coding of each transcript will be done via a process known as labeling phrases and quotations to identify themes and patterns (Creswell, 2014). Coding is the process of reading the data, breaking text down into subparts, and giving a label to that part of the text. The labels provide a way to begin to identify patterns in the data (Grove, Gray, & Burns, 2015). Coding serves as the pivotal link between data collection and explaining the meaning of the data. Themes are developed and put together into a story to represent the respondent's stories during the process of coding. The final step in the data management process will be the interpretation of the results. Various themes will be identified from the coded data that will be used to describe the thoughts of the respondents.

3.8 Dissemination of results and publication policy

The research team will prepare a detailed report containing appropriate recommendations that will be shared with the Ministry of Health and other stakeholders. Drs. Otchi, Doe, and Asiedu will also take the lead in preparing the Ghana case study for publication. Publications from this research will be disseminated to participants who consented to being contacted with copies of the final publications.

To be included as an author on publications about this research, authors will be required to meet all four criteria recommended by the International Committee of Medical Journal Ethics:

1. Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work; AND
2. Drafting the work or revising it critically for important intellectual content; AND
3. Final approval of the version to be published; AND
4. Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Anyone who makes a substantial contribution to this research but does not meet all four criteria for authorship will be noted in the acknowledgements.

3.9 Project management

A core team of six individuals is conducting this project. The role and responsibility of each member of the team are described in Table 3.

Table 3: Roles and responsibilities of each team member

No	Name (& Title)	Role	Responsibilities
1	Dr. Ernest K. ASIEDU	Principal Investigator for Ghana	Provide feedback on research protocol and tools, manage the Ghana technical working group, contribute to analysis and writing of Ghana report
2	Dr. Roseline DOE	co-Investigator for Ghana	Provide feedback on research protocol and tools, manage budget for Ghana, hire local assistance, manage the Ghana technical working group, contribute to analysis and writing of Ghana report
3	Dr. Samantha LATTOF	Co-Investigator	Draft research protocol and tools, obtain feedback on project documents, manage global advisory working group, obtain multi-country ethical approval, coordinate efforts between countries, analyze data, write reports, liaise with donor, conduct systematic review
4	Dr. Blerta MALIQI	co-Investigator	Provide feedback on research protocol and tools, participate in the global advisory working group, manage project finances, liaise with donor, analyze data, write reports, communicate with the Quality of Care Network
5	Dr. Elom Hillary OTCHI	co-Investigator for Ghana	Draft research protocol and tools, obtain ethical approval in Ghana, facilitate data collection in Ghana, analyze Ghana data, write Ghana report
6	Dr. Nuhu YAQUB	co-Investigator	Provide feedback on research protocol, participate in the global advisory working group, analyze data, write reports,

			communicate with the Quality of Care Network, facilitate work with WHO country offices

Dr. Ernest Asiedu, from the Ministry of Health, is involved in this research as both a member of the research team and as a member of the global advisory working group. The Ministry of Health has given its approval for us to conduct this research in Ghana (page IV). The principal investigator is currently not involved in other research activities beyond this study.

In addition, the project is being supported by staff at WHO and the Network Secretariat.

3.10 Project duration and work plan

It is anticipated that the project will be completed within a period of eight months (December 2019 to July 2020). Table 4 presents the detailed work plan that will take place during this period.

Table 4: Project work plan including timelines for specific activities

Task	**Timeframe**							
	Dec. 2019	Jan. 2020	Feb. 2020	March 2020	April 2020	May 2020	June 2020	July 2020
Constitute a national technical working committee								
Develop study protocol								
Undertake literature review								
Apply for ethical review from the appropriate institutions (WHO and GHS)								
Develop survey questionnaire and/or semi-structured interview questionnaire that address research questions								
Identify survey/interview participants								
Conduct survey/interviews								
Transcribe interviews (in Word or NVivo)								
Analyze the data								
Write a initial situational analysis report on private sector collaboration								

Task	Timeframe							
	Dec. 2019	Jan. 2020	Feb. 2020	March 2020	April 2020	May 2020	June 2020	July 2020
and involvement in planning and delivering quality MNH services								
Share preliminary findings from the report with the national technical working group and the Network Secretariat								
Prepare for the multi-stakeholder dialogue with private sector representatives and the national technical working group, identify meeting participants, and prepare meeting materials								
Host a two- to three-day multi-stakeholder dialogue meeting with assistance from the national technical working group and with private sector representatives to discuss the findings on different models of effective engagement of the private sector with the public sector and to agree on a way forward								
Submit a meeting report to the national technical working group and the Network Secretariat with written input on proposed models for effective engagement of the private sector with the public sector for implementing quality of care for MNH								
Write up the country case study and recommendations for other Network countries								

3.11 Budget

The total budget for the study is US$ 35,000. These funds will be used to support research activities in Ghana. An itemized budget appears below (Table 5). Costs were converted from US$ to GH₵ on 11 January 2020 using data provided by Morningstar for Currency.

Table 5: Project budget

Budget Item	**Cost (US$)**	**Cost (GH₵)**	**Justification**
Technical working group meeting	5,000	28,375	Convening a meeting of the Network's technical working group to discuss the project and seek input on potential research participants
Multi-stakeholder dialogue meeting	10,000	56,750	Hosting a two- to three-day meeting with approximately 35 participants to (1) discuss the findings and lessons learned from the country-level assessments and (2) articulate actionable recommendations
Local consultant	8,000	45,400	Hiring of local consultant to support research activities and organization of the multi-stakeholder dialogue
Primary research activities	12,000	68,100	This line covers all expenses related to conducting the key informant interviews (e.g., travel, photocopies, communication), writing the report, and preparing the country case study.
TOTAL	*35,000*	*198,625*	

4.0 Ethical Considerations

The global research proposal was submitted to the World Health Organization for ethical review in February 2020. We also seek in-country ethical approval from the Ghana Health Service Ethics Review Committee. Each member of the research team has signed a statement stating that they will comply with all the ethical principles and guidelines throughout the conduct of this study.

Informed consent will be sought from the respondents before they can participate in this research, specifically the key informant interviews and multi-stakeholder dialogue. Respondents will be informed of what the entire study is about and the processes involved in the data collection, and the risks and benefits of taking part. Respondents will be given the opportunity to ask questions before consent will be obtained through signing of the consent form. Confidentiality of the respondents will be maintained by use of identification numbers on the interview guides and the audio files. Each of these components is discussed in detail in the following sections.

4.1 Confidentiality, privacy, and data security

All study-related information will be stored securely, and all records will identify participants by identification numbers in order to maintain their confidentiality. Records that contain names or other personal identifiers (e.g., the organizations at which participants work), such as the signed informed consent forms, will be locked in a drawer and kept separate from records using identification numbers. Audio files and interview transcripts will not include identifying information. If participants discuss their organization by name or identifiable information, this information will be removed from the transcripts and an anonymized term will be used in its place (e.g., at my organization, in my company).

Data entry will be conducted on password-protected computers. Audio recordings for the key informant interviews will also be translated (when necessary), transcribed, and verified in country. Since the respondent's voice is a potential identifier, only the study staff will have access to the audio files. Electronic data will be stored on password-protected computers. Any data transmitted electronically will not contain any identifying information. The recordings will be destroyed after two years, in order to ensure enough time for writing up the findings. Should the final publications be written up and published in less than two years, the recordings will be destroyed earlier.

Only study staff will have access to the data. While regulatory agencies, study monitors, and auditors may have access to study records if requested, the participants' identities will remain confidential.

4.2 Potential risks

There is a risk that participants may share some personal or confidential information by chance, or that they may feel uncomfortable talking about some of the topics. However, we do not wish for this to happen. To minimise potential risks, participants will be reminded during the informed consent process that their participation is voluntary. At any point in the process, participants will be able to skip a question or stop their participation. If participants become stressed, they can take some time to recuperate. If they become uncomfortable from the prolonged sitting (approximately 60 minutes), they can take a break to stretch. Participants can also stop their participation at any time.

Interviewers will practice how to best monitor and respond to respondents' distress, offering respondents time to recuperate and terminating the interview if deemed necessary by the interviewer (WHO 2001). The research team will also emphasise the importance of ending interviews on a positive note; interviewers will remind participants that this research will be used to help improve private sector delivery of quality care for maternal and newborn health in their country (Parker and Ulrich 1990).

4.3 Potential benefits

The intention of this study is to contribute to an improved understanding of the mechanisms for engaging the private sector in planning, delivering and demonstrating accountability for quality maternal and newborn health services. There will be no direct benefit to participants, and they will not be provided with any incentive to take part in the research; however, they will be informed that their participation is likely to help us find out how to design more effective policies and ways for engaging the private health sector in the national health system's efforts to improve MNH.

4.4 Informed consent

Voluntary informed consent for the key informant interviews and multi-stakeholder dialogue will be obtained from all research participants in writing. Informed consent forms appear in Appendices 3-6. Study staff will ensure that all participants receive the required information in a manner that is understandable to potential participants so that consent is obtained without coercion or undue influence. This information and

the consent forms will be provided to participants in English and/or translated (whenever necessary) into a language that is understood by the respondent. Given that our study population is comprised of high-level professionals in the public and private health sectors, we do not anticipate low literacy levels and suspicion over signing documents.

As part of the informed consent process, study staff will inform potential participants of:

(1) the study's title and purpose;
(2) the study procedures;
(3) potential risks/discomfort;
(4) potential benefits;
(5) reimbursement;
(6) confidentiality;
(7) their rights to withdraw from the study at any time;
(8) alternatives to participation;
(9) the identity of the investigators and contact information in case they have any questions about the study;
(10) information about participants' rights (e.g. participation is voluntary); and
(11) contact information for the ethics committees that reviewed the study.

There will be no adverse consequences of a decision not to participate or to withdraw during the course of the study. All potential participants will receive this information verbally during the informed consent process, and this information will appear on the consent forms. Study participants will be informed during the consent process that they should feel free to raise any questions or problems with the researcher. They will be welcome to pause their participation in the study to raise queries and/or problems. Participants will also be free to withdraw at any point in the interview or the research process. The study information sheet that participants will receive during the informed consent process will include the researcher's contact information should participants wish to address queries or problems at a later time.

4.5 Compensation

Participants will not be provided with any monetary incentive to take part in the interviews or the multi-stakeholder dialogue meeting. However, for the multi-stakeholder dialogue meeting, participants' travel will

be covered, and they will receive lunch, snacks, and beverages during the meeting. Meeting participants will also be able to network with other individuals working on topics of similar interest. Interview and meeting participants who agree in the consent forms to public acknowledgement (as an individual and/or as an organization) will be duly acknowledged in the appropriate sections of any publications and reports.

4.6 Declaration of conflict of interest

We declare that the members of the research team have no conflicts of interest.

4.7 Protocol funding information

This work is supported by MSD for Mothers and the Maternal, Newborn, Child, Adolescent Health and Ageing Department of the World Health Organization. MSD for Mothers had no role in the design and development of the study protocol.

4.8 Safety

The safety of the respondents is of utmost importance. Interviews with study participants will be conducted in offices or venues chosen by them. We will also ensure that the interviews are conducted in quiet places without pollutants. We will further ensure that the setting has security as required and is enclosed to ensure the participants' confidentiality.

4.9 Follow-up

Participants will be contacted with findings of the study, if they consent to our contacting them at a later date. Some key informant interview participants will be contacted to join the multi-stakeholder dialogue following analysis of the interview findings.

4.10 Quality assurance

To ensure quality, we have developed a standardized protocol to be used in each of the project countries. Project documents (e.g., interview guides, logic model, report outline) are reviewed by global and country-level advisory working groups. Trained interviewers will use a semi-structured interview guide to ensure that key informant interview data are collected in a routine manner whilst allowing for flexibility to explore potential leads. Interviewers will monitor the rights and wellbeing of participants during the interviews. The research team will meet regularly throughout the data collection and analysis phases to monitor the progress.

Required documents for ethical review and closeout will be filed with the relevant authorities (i.e. WHO and GHS).

4.11 Anticipated problems

As an exploratory project, we have limited time and resources. We must be strategic with our decisions. One difficulty that may affect completion of the project within the stipulated timeframe is the availability of the key informants for the interviews and the multi-stakeholder dialogues. However, with collaboration and support from the national technical working group in each country, we should be able to identify backup participants. Moreover, we will give participants advanced notice and information once they have been identified to ensure their participation.

4.12 Study limitations

Several methodological limitations may affect our study. With regards to data collection, the key informant interviews may be limited by potential observer bias, in which participants do not objectively share information. When interviews are conducted over the telephone or Internet due to the current COVID-19 situation, we may miss observing respondents' body language that could provide useful observational data. In addition, the interviewer's personal biases and power dynamics between the interviewer and participant could lead to the possibility of a one-sided dialogue or affect participants' responses. To minimize these limitations, the trained interviewer will offer the participant a choice of how the interview is conducted (e.g., telephone, videoconference, in person), seek to establish a good rapport with the participant before the interview begins, guarantee confidentiality, and use active listening to develop trust with the participant.

Our non-probabilistic sampling strategy (section 3.6) limits our ability to generalize the findings. Our approach and final sample, however, will have "symbolic representation" that illustrates the diversity within the population's boundaries and allows for comparisons between subgroups (e.g., gender, rural/urban location, public/private sector). By consulting members of our technical working group on the research design and in the selection of participants, we aim to reduce sample bias and ensure that the final sample reflects the population of interest. We will also sample participants until saturation is reached so as to ensure a sufficient sample size and conclude valid findings.

Lastly, to minimize the effects of these limitations, we will (1) use mixed methods to triangulate the

findings; (2) validate the interview findings at the multi-stakeholder dialogue meeting; and (3) include benchmarking with regional and global experiences in the final report to ensure that the team does not miss opportunities and lessons learned from other countries experiences in private sector engagement.

5.0 References

Adua, E., Frimpong, K., Li, X., & Wang, W. (2017). Emerging issues in public health: a perspective on Ghana's healthcare expenditure, policies and outcomes. *EPMA Journal*, *8*(3), 197–206. https://doi.org/10.1007/s13167-017-0109-3

Akhtar, A. (2011). *Health care regulation in low-and middle- income countries : a review of the literature*. Retrieved from http://www.hanshep.org/resources/further-reading/2011-healthcare-regulation-in-low-and-middle-income-countries-literature-review

Allied Health Professions Council. (2018). Allied Health Professions Council. Retrieved February 7, 2020, from Allied Health Professions Council website: http://www.moh.gov.gh/allied-health-professions-council/

Basu S, Andrews J, Kishore S, Panjabi R, S. D. (2012). Comparative performance of private and public healthcare systems in low- and middle-income countries: a systematic review. *PLoS Medicine*, *9*.

Bevan, G., & Skellern, M. (2011). Does competition between hospitals improve clinical quality? A review of evidence from two eras of competition in the English NHS. *BMJ (Online)*, *343*(7830). https://doi.org/10.1136/bmj.d6470

Bhattacharyya S, Berhanu D, Taddesse N, et al. (2016). District decision-making for health in low-income settings: a case study of the potential of public and private sector data in India and Ethiopia. *Health Policy Plan*, *31*, 25–34.

Centre for Plant Medicine Research. (n.d.). Vision & Mission. Retrieved February 7, 2020, from Vision & Mission website: https://www.cpmr.org.gh/about/vision-mission

Cooper, Z., Gibbons, S., Jones, S., & Mcguire, A. (2011). Does hospital competition save lives? Evidence from the English NHS patient choice reforms. *Economic Journal*, *121*(554), 228–260. https://doi.org/10.1111/j.1468-0297.2011.02449.x

Creswell, J. . (2014). *Research Design: Qualitative , Quantitative and Mixed Methods Approaches (4t ed.)*. London: Sage Publications.

Das, J., Das, V., & Tabak, D. (2012). *In Urban And Rural India, A Standardized Patient Study Showed Low Levels Of Provider Training And Huge Quality Gaps*. (December). https://doi.org/10.1377/hlthaff.2011.1356

Food and Drugs Authority. (n.d.). Who We Are. Retrieved February 7, 2020, from Who We Are website: https://fdaghana.gov.gh/index.php/who-we-are/

Gaynor, M., Moreno-Serra, R., & Propper, C. (2013). Death by market power: Reform, competition, and

patient outcomes in the national health service. *American Economic Journal: Economic Policy*, *5*(4), 134–166. https://doi.org/10.1257/pol.5.4.134

Ghana Health Service. (2018). *The Health System in Ghana, Facts and Figures*. Retrieved from internal-pdf://0240438844/Facts-and-figures-2015_GHS.pdf%0Ahttp://www.moh.gov.gh/wp-content/uploads/2017/07/Facts-and-figures-2015.pdf

Ghana Statistical Service, Ministry of Health, T. D. P. (2014). *Ghana Demographic and Health Survey*. Retrieved from https://dhsprogram.com/pubs/pdf/FR307/FR307.pdf

Ghana Statistical Service, Ministry of Health, T. D. P. (2017). *Ghana Maternal Health Survey*. Accra.

Goddard, M. (2015). Competition in healthcare: Good, bad or ugly? *International Journal of Health Policy and Management*, *4*(9), 567–569. https://doi.org/10.15171/ijhpm.2015.144

Grove, S. ., Gray, J. ., & Burns, N. (2015). Understanding nursing research: Building an evidence-based practice. *St. Louis, MO: Elsevier Saunders*.

Korle Bu Teaching Hospital. (2019). Korle Bu Teaching Hospital Goes Paperless. Retrieved February 8, 2020, from Korle Bu Teaching Hospital website: http://kbth.gov.gh/korle-bu-teaching-hospital-goes-paperless/

Kruk, M. E., Gage, A. D., Arsenault, C., Jordan, K., Leslie, H. H., Roder-DeWan, S., … Pate, M. (2018). *High quality health systems-time for a revolution: Report of the Lancet Global Health Commission on High Quality Health Systems in the SDG Era*. https://doi.org/https://doi.org/10.1016/S2214-109X(18)30386-3

Lábaj, M., Silanič, P., Weiss, C., & Yontcheva, B. (2018). Market structure and competition in the healthcare industry: Results from a transition economy. *European Journal of Health Economics*, *19*(8), 1087–1110. https://doi.org/10.1007/s10198-018-0959-1

Makinen, M., Sealy, S., Bitrán, R. A., Adjei, S., & Muñoz, R. (2011). *Private Health Sector Assessment in Ghana*. Washington DC.

Medical and Dental Council. (n.d.). About Us.

Ministry of Finance (MoFEP). (2011). *National Policy on Public Private Partnerships (PPP).pdf*. Retrieved from https://www.mofep.gov.gh/sites/default/files/reports/economic/ppp_policy.pdf

Ministry of Health (MoH) Ghana. (2014). *Ministry of Health Ghana Holistic Assessment of the Health Sector Programme of Work 2014*. Retrieved from http://www.moh.gov.gh/wp-content/uploads/2016/02/Holistic-Assessment-2015.pdf

Ministry of Health, G. (2014). Health sector medium term development plan. *Ministry of Health (MOH)*, p.

75.

Ministry of Health Ghana. (n.d.). Policy, Planning, Monitoring & Evaluation Policy Planning, Budgeting, Monitoring and Evaluation Directorate (PPBMED). Retrieved February 6, 2020, from http://www.moh.gov.gh/policy-planning-monitoring-evaluation/

Ministry of Health Ghana. (2018). Alternative Medicine Council. Retrieved February 7, 2020, from Alternative Medicine Council website: http://www.moh.gov.gh/alternative-medicine-council/

MoH. (2013). *Private Health Sector Dev Policy*. Accra.

MOH. (2014). Health sector medium term development plan (2014-2017). *Ministry of Health (MOH)*, 75. https://doi.org/10.1016/S0041-3879(54)80075-4

National Academies of Sciences, Engineering, and M. (2018). *Crossing the Global Quality Chasm: Improving Healthcare Worldwide*. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK535653/pdf/Bookshelf_NBK535653.pdf

Nursing and Midwifery Council. (2020). Nursing and Midwifery Council of Ghana. Retrieved February 7, 2020, from Nursing and Midwifery Council of Ghana website: https://www.nmcgh.org/t3f/en/

Nyabor, J. (2018). Doctor Jailed 10 years for defrauding NHIS. Retrieved February 7, 2020, from Citi Newsroom website: https://citinewsroom.com/2018/06/doctor-jailed-10-years-for-defrauding-nhis/

Parliament of the Republic of Ghana. *Health Institutions and Facilities Act, 2011*. , (2011).

Pharmacy Council. (2017). About Us. Retrieved February 7, 2020, from About Us website: https://www.pcghana.org/about-us/

Powell-Jackson T, Macleod D, Benova L, Lynch C, C. O. (2015). The role of the private sector in the provision of antenatal care: a study of demographic and health surveys from 46 low- and middle-income countries. *Trop Med Int Health*, *20*, 230–239.

Rochefort, C., Adams, O., Calhoun, L., & Shaw, D. (2017). Professionalism: Super Hero or Human. *Canadian Journal of Physician Leadership*, *3*(3). Retrieved from https://physicianleaders.ca/assets/cjplvol3num32017.pdf

Saleh, K. (2013). *The Health Sector in Ghana: A Comprehensive Assessment*. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK535653/pdf/Bookshelf_NBK535653.pdf

Survey, M. H., & Indicators, K. (2017). *Ghana Maternal Health Survey Key Indicators 2017*.

Wadge, H., Roy, R., Sripathy, A., Prime, M., Carter, A., Fontana, G., Marti, J., & Chalkidou, K. (2017). *EVALUATING THE IMPACT OF PRIVATE PROVIDERS ON HEALTH AND HEALTH SYSTEMS*. London, UK.

Wang, W., Temsah, G., & Mallick, L. (2017). The impact of health insurance on maternal health care utilization: Evidence from Ghana, Indonesia and Rwanda. *Health Policy and Planning*, *32*(3), 366–375. https://doi.org/10.1093/heapol/czw135

WHO. (2013). The Health Sector in Ghana: Facts and Figures 2018. *Centre for Health Information Management of the Policy, Planning, Monitoring and Evaluation- Ghana Health Service*, 1–50. https://doi.org/10.1596/978-0-8213-9599-8

Appendix 1: Key Informant Interview Guides

This appendix includes the six interview guides that will be used in this study:

A. Interview Guide for Key Informants in Policy and Administrative Roles in the Private Sector
B. Interview Guide for Key Informants in Policy and Administrative Roles in the Public Sector
C. Interview Guide for Key Informants in Regulatory Roles in the Private Sector
D. Interview Guide for Key Informants in Regulatory Roles in the Public Sector
E. Interview Guide for Key Informants in Service Delivery Roles in the Private Sector
F. Interview Guide for Key Informants in Service Delivery Roles in the Public Sector

The interviewer will choose which guide to use based on the participant's role (policy/administration, service delivery, or regulation) and the health sector (public or private) in which the participant works.

Study on Private Sector Delivery of Quality Maternal and Newborn Health Services

A. Interview Guide for Key Informants in Policy and Administrative Roles in the Private Sector

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Participant ID: _____

Date: _____ / _____ / _____
Start time: _____: _____
End time: _____: _____
Language of interview: _____
Translator's name: _____
Facilitator's name: _____

Have you already:

- Introduced yourself?
- Explained the study's objectives?
- Completed the informed consent procedure?
- Explained the interview process?
- Shared the project's definition of the private sector?
- Presented the six dimensions of quality care (i.e., care that is safe, equitable, accessible, acceptable/patient-centred, effective, and efficient)?

Ask participant if s/he is still ok with audio recording the interview. If yes, TURN ON THE RECORDER AND NOTE THE PARTICIPANT'S ID NUMBER ON THE RECORDING.

[*This interview has seven sections about topics related to policy and administration. At the start of each section, I will provide a brief overview of what we will discuss. If you do not feel capable of answering a particular section based on your role and expertise, we can skip that section. For each of the questions, our focus is on quality of care and maternal and newborn health. We are especially interested in services for childbirth and immediate neonatal care.*]

1. To begin, can you tell me about your role? How does it relate to quality of care (QoC) for maternal and newborn health (MNH)?
2. From your perspective, how open is the private sector to working with the government and/or Ministry of Health?
3. What role do you see for the private sector in providing quality health services and products, particularly for mothers and newborns?

A. POLICIES, STRATEGIES AND PLANS

[*I would like to discuss issues related to policies, strategies and plans for the private health sector, QoC, and/or MNH.*]

1. What national policies, strategies and plans most impact how the private health sector contributes to national goals for MNH and QoC?

a. How well are these policies being implemented?
    i. PROBE: If challenges exist, what are they and how can they be addressed?
b. What platforms exist for private sector participation in the formulation and implementation of policies/strategies/plans related to MNH/QoC?
    i. PROBE: How are these platforms working?

2. What policies/strategies/plans exist to facilitate public-private collaboration for QoC and for MNH?
    a. How well are these policies/strategies/plans being implemented?
    b. What can be done to encourage better coordination and public-private partnerships in health?
        i. PROBE: What can the private sector do?
    c. What is the potential for better coordination and/or public-private partnerships to expand access to priority health services and products?
        i. What are concrete areas in which to expand the private sector's role in addressing national health priorities for MNH?
    d. What technical assistance would your agency/organization require in order to actively collaborate with the public sector?

B. LEADERSHIP

[*I would like to discuss the effectiveness of the existing leadership systems and structures for quality MNH services within the private health sector.*]

1. I would like to discuss the effectiveness of existing structures and systems for governance of quality of healthcare. [*Briefly describe the existing structures and systems based on the literature review*.]
    a. Do existing structures and systems for governance of QoC/MNH extend to the private sector? If yes, how do you engage with them? How effective are existing structures and systems in providing support/framework to deliver quality?
2. How can the national health system influence activities of the private health sector so that they contribute to meeting the national MNH QoC goals and objectives?
3. From your perspective, how effective is the private sector at governing (e.g. committees, groups, platforms, processes), leading, and advocating for itself?
    a. PROBE: Do you have any specific examples?

C. ACCOUNTABILITY

[*I would like to discuss how to ensure accountability, including social accountability, for the delivery of quality MNH services in the private sector. This may include things like incentives, sanctions, regulatory mechanisms, and community/client engagement.*]

1. How do patients/consumers hold the private health sector accountable in its delivery of quality MNH services (e.g. feedback systems, monitoring, public reporting, sanctions)?
    a. How does patient experience influence private sector delivery of quality MNH services?
        i. PROBE: Do you have any specific examples?
    b. Is the private sector required to use patient feedback to improve the quality of MNH services?
        i. What mechanisms (e.g., to reduce abuse, to assure adherence to MNH standards/protocols, to improve care outcomes and learning) exist to support improved service delivery through feedback and learning?

ii. PROBE: Are there any specific challenges and/or opportunities that you would like to share?

2. How do the government and/or Ministry of Health hold the private health sector accountable in its delivery of quality MNH services (e.g. monitoring, sanctions)?
    a. What mechanisms (e.g., to assure adherence to MNH standards/protocols, to improve care outcomes and learning) exist for the government and/or Ministry of Health to support improved quality of service delivery in the private sector?
3. Does the structure of the national health insurance scheme or any other scheme (e.g., vouchers, subsidies, other financial risk protection mechanisms) adequately motivate private providers to offer quality MNH services?
    a. If not, what changes might be made to increase incentives?
4. What mechanisms motivate the private health sector to provide quality MNH services?
    a. What incentives and sanctions exist for reporting by the private sector?
    b. Can the private health sector monitor changes over time with data to measure sustained improvements or deterioration in the provision of health services?
        i. How and by whom is this done?

D. RELATIONSHIPS BETWEEN THE PUBLIC AND PRIVATE SECTORS

[*I would like to discuss types of relationships between the private and public sectors, such as trust, collaboration, information systems, and knowledge exchange. I would like to explore the extent to which these types of relationships exist and their impact on the provision of quality MNH care services.]*

1. What form of collaboration exists between the government and private sector in MNH services?
    a. What role can the private health sector play in facilitating the provision of effective referrals and pre-hospital emergency services?
    b. What are the gaps in the public sector that the private sector fulfills in terms of the provision of quality MNH services?
    c. What motivates the private sector to engage with the national health system in the delivery of quality MNH?
        i. If impediments exist, how can they be addressed?
    d. How open and transparent is the relationship between the public and private sectors?
        i. PROBE: If the relationship is closed, how can it be made more open and transparent?
    e. What lessons can be drawn from successful examples or models of public-private relationships?
2. How is knowledge and learning shared between the public and private health sectors?
    a. How can practices that lead to quality improvement in the private health sector be shared with the public health sector and vice versa?
3. How is the private health sector contributing to national health information systems?
    a. What opportunities/systems exist to facilitate greater reporting to national health information systems (e.g. DHIS 2) by the private health sector?
        i. What will the private health sector require to routinely report and share its data?
        ii. If constraints to reporting by the private sector exist, how can they be overcome?
        iii. If consequences exist for not reporting, what are they?

E. RESOURCES FOR THE PRIVATE SECTOR

[*I would like to discuss resources that the private sector has to improve the quality of MNH services. This could include things like human resources, tools, financial resources and technical support.]*

1. To what extent does the private health sector have required resources (e.g., infrastructure, personnel, equipment) for meeting national standards for the provision of quality MNH services?
    a. What challenges/constraints does the private health sector face in accessing resources (e.g., financial, access to credits, training, mentoring/supervision, guidelines) from the national health system or international bodies/organizations?
    b. From your perspective, what is the quality of MNH services being provided by the private health sector?
    c. How can the private health sector sustain efforts to deliver quality MNH care?
    d. What additional resources does the private health sector require to improve the provision of quality MNH services?
        i. What opportunities (e.g. credits, loans) exist for obtaining these resources?
2. What incentives exist for private investments in the provision of quality MNH?
    a. PROBE: In rural areas? In urban areas?
3. What is capacity (e.g. skills, knowledge, technology) does the Ministry of Health have to support private sector provision of quality MNH services?
4. What lessons can the private health sector share with respect to mobilizing and investing resources to improve quality and access to MNH services?

F. IMPROVED HEALTH SYSTEM FUNCTIONING

[*I would like to discuss how the health system is functioning as a cohesive system to facilitate the delivery of quality care for mothers and newborns.]*

1. How well is the health system, both public and private sectors, functioning as a unified system to deliver quality MNH services, specifically childbirth and immediate neonatal care?
    a. What constraints does the national health system experience?
    b. How can the partnership between the public and private sectors be made more effective and more equitable for the provision of quality MNH care services?

G. CONCLUDING QUESTIONS

[*We are almost finished. I have some short concluding questions for you.*]

1. Generally speaking, what should be done differently in public-private engagement to attain the necessary impact on MNH care outcomes?
2. Is there anything else you think that I should know about private sector delivery of quality MNH care services?
3. Is there anyone else you would recommend that I speak with about this research?
4. Do you have any questions for me?

Thank the participant for their time. If the participant identified any resources, ask them to share copies with you.

Study on Private Sector Delivery of Quality Maternal and Newborn Health Services

B. Interview Guide for Key Informants in Policy and Administrative Roles in the Public Sector

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Participant ID: _____

Date: _____ / _____ / _____
Start time: _____: _____
End time: _____: _____
Language of interview: _____
Translator's name: _____
Facilitator's name: _____

Have you already:

- Introduced yourself?
- Explained the study's objectives?
- Completed the informed consent procedure?
- Explained the interview process?
- Shared the project's definition of the private sector?
- Presented the six dimensions of quality care (i.e., care that is safe, equitable, accessible, acceptable/patient-centred, effective, and efficient)?

Ask participant if s/he is still ok with audio recording the interview. If yes, TURN ON THE RECORDER AND NOTE THE PARTICIPANT'S ID NUMBER ON THE RECORDING.

[*This interview has seven sections about topics related to policy and administration. At the start of each section, I will provide a brief overview of what we will discuss. If you do not feel capable of answering a particular section based on your role and expertise, we can skip that section. For each of the questions, our focus is on quality of care and maternal and newborn health. We are especially interested in services for childbirth and immediate neonatal care.*]

1. To begin, can you tell me about your role? How does it relate to quality of care (QoC) for maternal and newborn health (MNH)?
2. From your perspective, how open is the government and/or Ministry of Health to working with the private sector?
3. What role do you see for the private sector in providing quality health services and products, particularly for mothers and newborns?

A. POLICIES, STRATEGIES AND PLANS

[*I would like to discuss issues related to policies, strategies and plans for the private health sector, QoC, and/or MNH.*]

1. What national policies, strategies and plans most impact how the private health sector contributes to national goals for MNH and QoC?
    a. How well are these policies being implemented?
        i. PROBE: If challenges exist, what are they, and how can they be addressed?
    b. What platforms exist for engaging the private health sector's participation in the formulation and implementation of policies/strategies/plans related to MNH and QoC?
        i. PROBE: How are these platforms working?
2. What policies/strategies/plans exist to facilitate public-private collaboration for QoC and for MNH?
    a. How well are these policies/strategies/plans being implemented?
    b. What can be done to encourage better coordination and public-private partnerships in health?
        i. PROBE: What can the government and/or Ministry of Health do?
    c. What is the potential for better coordination and/or public-private partnerships to expand access to priority MNH services and products?
        i. What are concrete areas in which to expand the private sector's role in addressing national health priorities for QoC and MNH?
    d. What technical assistance would your agency require in order to actively engage the private health sector?

B. LEADERSHIP

[*I would like to discuss the effectiveness of the existing leadership systems and structures for quality MNH services within the private health sector.*]

1. I would like to discuss the effectiveness of existing structures and systems for governance of quality of healthcare. [*Briefly describe the existing structures and systems based on the literature review.*]
    a. How effective are these structures and systems for governing quality of healthcare in the private sector?
2. How can the national health system influence activities of the private health sector so that they contribute to meeting the national MNH QoC goals and objectives?
3. From your perspective, how effective is the private sector at governing (e.g. committees, groups, platforms, processes), leading, and advocating for itself?

C. ACCOUNTABILITY

[*I would like to discuss how to ensure accountability, including social accountability, for the delivery of quality MNH services in the private sector. This may include things like incentives, sanctions, regulatory mechanisms, and community/client engagement.*]

1. How do the government and/or Ministry of Health hold the private health sector accountable in its delivery of quality MNH services (e.g., monitoring, sanctions)?

    a. What mechanisms (e.g., to assure adherence to MNH standards/protocols, to improve care outcomes and learning) exist for the government and/or Ministry of Health to support improved quality of service delivery in the private sector?
2. Does the structure of the national health insurance scheme or any other scheme (e.g., vouchers, subsidies, other financial risk protection mechanisms) adequately motivate private providers to offer quality MNH services?
    a. If not, what changes might be made to increase incentives?
3. From your perspective, what mechanisms motivate the private health sector to provide quality MNH services?
    a. What incentives and sanctions exist for reporting by the private sector?
    b. Can the government and/or Ministry of Health monitor changes over time in the private sector with data to measure sustained improvements or deterioration in the provision of health services?
        i. How and by whom is this done?

D. RELATIONSHIPS BETWEEN THE PUBLIC AND PRIVATE SECTORS

[*I would like to discuss types of relationships between the private and public sectors, such as trust, collaboration, information systems, and knowledge exchange. I would like to explore the extent to which these types of relationships exist and their impact on the provision of quality MNH care services.]*

1. What form of collaboration exists between the government and private sector in MNH services?
    a. What role can the government and/or Ministry of Health play in facilitating the private health sector's provision of effective referrals and pre-hospital emergency services?
    b. What are the gaps in the public sector that the private sector fulfills in terms of the provision of quality MNH services?
    c. What motivates the national health system to engage the private sector in the delivery of quality MNH?
        i. If impediments exist, how can they be addressed?
    d. How open and transparent is the relationship between the public and private sectors?
        i. PROBE: If the relationship is closed, how can it be made more open and transparent?
    e. What lessons can be drawn from successful examples or models of public-private relationships?
2. How is knowledge and learning shared between the public and private health sectors?
    a. How can practices that lead to quality improvement in the public health sector be shared with the private health sector and vice versa?
3. How do the government and/or Ministry of Health engage the private health sector in national health information systems?
    a. What opportunities/systems exist to facilitate greater reporting by the private health sector to national health information systems (e.g. DHIS 2)?
        i. What will the public health sector require to routinely engage the private sector in reporting and sharing its data?
        ii. If constraints to engaging the private sector in data reporting exist, how can the government and/or Ministry of Health overcome these constraints?
        iii. Do the government and/or Ministry of Health impose any consequences on the private health sector for not reporting data? If yes, what are they?

E. RESOURCES FOR THE PRIVATE SECTOR

[*I would like to discuss resources that the private sector has to improve the quality of MNH services. This could include things like personnel, financial resources and technical support.]*

1. To what extent do the government and/or Ministry of Health provide the private health sector and private clinical providers with required resources (e.g. infrastructure, personnel, equipment) for meeting national standards for the provision of quality MNH services?
    a. PROBE: Are there private health financing needs that the government and/or Ministry of Health supports? If so, please describe them.
    a. What challenges/constraints does the private health sector face in accessing resources (e.g. financial, access to credits, training, mentoring/supervision, guidelines) from the national health system or international bodies/organizations?
        i. PROBE: How can these challenges/constraints be addressed?
2. What incentives exist for private investments in the provision of quality MNH services?
    a. PROBE: In rural areas? In urban areas?
3. What capacity (e.g. skills, knowledge, technology) does the Ministry of Health have to support private sector provision of quality MNH services?
4. What lessons would the government and/or Ministry of Health find most useful to learn from the private health sector with respect to mobilizing and investing resources to improve quality and access to MNH services?

F. IMPROVED HEALTH SYSTEM FUNCTIONING

[*I would like to discuss how the health system is functioning as a cohesive system to facilitate the delivery of quality care for mothers and newborns.]*

1. How well is the health system, both public and private sectors, functioning as a unified system to deliver quality MNH services, specifically childbirth and immediate neonatal care?
    a. What constraints does the national health system experience?
    b. How can the partnership between the public and private sectors be made more effective and more equitable for the provision of quality MNH care services?

G. CONCLUDING QUESTIONS

[*We are almost finished. I have some short concluding questions for you.*]

1. Generally speaking, what should be done differently in public-private engagement to attain the necessary impact on MNH care outcomes?
2. Is there anything else you think that I should know about private sector delivery of quality MNH care services?
3. Is there anyone else you would recommend that I speak with about this research?
4. Do you have any questions for me?

Thank the participant for their time. If the participant identified any resources, ask them to share copies with you.

Study on Private Sector Delivery of Quality Maternal and Newborn Health Services

C. Interview Guide for Key Informants in Regulatory Roles in the Private Sector

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Participant ID: _____

Date: _____ / _____ / _____
Start time: _____: _____
End time: _____: _____
Language of interview: _____
Translator's name: _____
Facilitator's name: _____

Have you already:

- Introduced yourself?
- Explained the study's objectives?
- Completed the informed consent procedure?
- Explained the interview process?
- Shared the project's definition of the private sector?
- Presented the six dimensions of quality care (i.e., care that is safe, equitable, accessible, acceptable/patient-centred, effective, and efficient)?

Ask participant if s/he is still ok with audio recording the interview. If yes, TURN ON THE RECORDER AND NOTE THE PARTICIPANT'S ID NUMBER ON THE RECORDING.

[*This interview has seven sections about topics related to regulation. At the start of each section, I will provide a brief overview of what we will discuss. If you do not feel capable of answering a particular section based on your role and expertise, we can skip that section. For each of the questions, our focus is on quality of care and maternal and newborn health. We are especially interested in services for childbirth and immediate neonatal care.*]

1. To begin, can you tell me about your role? How does it relate to quality of care (QoC) for maternal and newborn health (MNH)?
2. From your perspective, how open is the private sector to working with the government and/or Ministry of Health?
3. What role do you see for the private sector in providing quality health services and products, particularly for mothers and newborns?

A. REGULATORY/LEGAL FRAMEWORK

[*I would like to discuss the regulatory/legal framework(s) or mechanism(s) that guide the governance of the private health sector to deliver quality MNH services. I'm particularly interested in services for childbirth and immediate neonatal care.]*

1. How is the private health sector organized in your country? Please describe if private providers are organized into networks (either as a network within the private sector or a network that includes a mix of public and private providers).
2. Can you please tell me about the institutions, organizations or mechanisms that exist for the governance and regulation of the health sector (public and private) in the provision of quality MNH services?
    a. How do these mechanisms impact how the private health sector contributes to national health goals?
    b. What aspects of the regulatory mechanisms work well, and what aspects do not?
    c. How engaged is the private sector in regulatory and/or accreditation efforts?
        i. Is there private sector self-regulation?
3. From your perspective, what are some of the legal and/or regulatory barriers to a greater role for the private health sector in addressing QoC and MNH priority areas?
4. How effective are the national mechanisms for monitoring and ensuring the private sector's compliance with the required standards (e.g. infrastructure, personnel, equipment and adherence to clinical standards) for quality MNH services?
5. What constraints and challenges does the private sector encounter in regulating (e.g. licensing, accreditation, credentialing) and governing its provision of quality MNH services?
    a. Is there a need to develop or enforce QoC standards?
    b. Is there a need for licensing or certification of any health care providers or facilities?
6. What changes in legislation are needed–if any–to make dual practice (i.e., health providers who work in both public and private sector facilities) more beneficial to the public?

B. LEADERSHIP

[*I would like to discuss the effectiveness of the existing leadership systems and structures for quality MNH services within the private health sector.*]

1. I would like to discuss the effectiveness of existing structures and systems for governance of quality of healthcare. [*Briefly describe the existing structures and systems based on the literature review*.]
    a. Do existing structures and systems for governance of QoC/MNH extend to the private sector? If yes, how do you engage with them? How effective are existing structures and systems at providing support/framework to deliver quality?
2. How can the national health system influence activities of the private health sector so that they contribute to meeting the national MNH QoC goals and objectives?
3. From your perspective, how effective is the private sector at governing (e.g. committees, groups, platforms, processes), leading, and advocating for itself?
    a. PROBE: Do you have any specific examples?

C. RESOURCES FOR THE PRIVATE SECTOR

[*I would like to discuss resources that the private sector has to improve the quality of MNH services. This could include things like human resources, tools, financial resources and technical support.]*

1. To what extent does the private health sector and private clinical providers have required resources (e.g. infrastructure, personnel, equipment) for meeting national standards for the provision of quality MNH services?
    a. What challenges/constraints does the private health sector face in accessing resources (e.g. financial, access to credits, training, mentoring/supervision, guidelines) from the national health system or international bodies/organizations?
    b. From your perspective, what is the quality of MNH services being provided by the private heath sector?
    c. How can the private health sector sustain efforts to deliver quality MNH care?
    d. What additional resources does the private health sector require to improve the provision of quality MNH services?
    e. What opportunities (e.g. credits, loans) exist for obtaining these resources?
2. What incentives exist for private investments in the provision of quality MNH?
    a. PROBE: In rural areas? In urban areas?
3. What is capacity (e.g. skills, knowledge, technology) does the Ministry of Health have to support private sector provision of quality MNH services?
4. What lessons can the private health sector share with respect to mobilizing and investing resources to improve quality and access to MNH services?

D. MARKET COMPETITIVENESS

[*I would like to discuss how the existing business environment affects and influences market competitiveness in the private health sector.*]

1. How does the existing business environment (e.g. quality assurance/accreditation, health insurance, preferred provider networks) influence market competitiveness within the private sector?
    a. How can the private sector influence this environment to make it more effective for the provision of quality MNH services by the private sector?

E. ACCOUNTABILITY

[*I would like to discuss how to ensure accountability, including social accountability, for the delivery of quality MNH services in the private sector. This may include things like incentives, sanctions, regulatory mechanisms, and community/client engagement.*]

1. How do patients/consumers hold the private health sector accountable in its delivery of quality MNH services (e.g. feedback systems, monitoring, public reporting, sanctions)?
    a. How does patient experience influence private sector delivery of quality MNH services?
        i. PROBE: Do you have any specific examples?
    b. Is the private sector required to use patient feedback to improve the quality of MNH services?
        i. What mechanisms (e.g., to reduce abuse, to assure adherence to MNH standards/protocols, to improve care outcomes and learning) exist to support improved service delivery through feedback and learning?

        ii. PROBE: Are there any specific challenges or opportunities that you would like to share?
2. How do the government and/or Ministry of Health hold the private health sector accountable in its delivery of quality MNH services (e.g. monitoring, sanctions)?
    a. What mechanisms (e.g., to assure adherence to MNH standards/protocols, to improve care outcomes and learning) exist for the government and/or Ministry of Health to support improved quality of service delivery in the private sector?
3. Does the structure of the national health insurance scheme or any other scheme (e.g., vouchers, subsidies, other financial risk protection mechanisms) adequately motivate private providers to offer quality MNH services?
    a. If not, what changes might be made to increase incentives?
4. What mechanisms motivate the private health sector to provide quality MNH services?
    a. What incentives and sanctions exist for reporting by the private sector?
    b. Can the private health sector monitor changes over time with data to measure sustained improvements or deterioration in the provision of health services?
        i. How and by whom is this done?

F. IMPROVED HEALTH SYSTEM FUNCTIONING

[*I would like to discuss how the health system is functioning as a cohesive system to facilitate the delivery of quality care for mothers and newborns.]*

1. How well is the health system, both public and private sectors, functioning as a unified system to deliver quality MNH services, specifically childbirth and immediate neonatal care?
    a. What constraints does the national health system experience?
    b. How can the partnership between the public and private sectors be made more effective and more equitable for the provision of quality MNH care services?

G. CONCLUDING QUESTIONS

[*We are almost finished. I have some short concluding questions for you.*]

1. Generally speaking, what should be done differently in public-private engagement to attain the necessary impact on MNH care outcomes?
2. Is there anything else you think that I should know about private sector delivery of quality MNH care services?
3. Is there anyone else you would recommend that I speak with about this research?
4. Do you have any questions for me?

Thank the participant for their time. If the participant identified any resources, ask them to share copies with you.

Study on Private Sector Delivery of Quality Maternal and Newborn Health Services

D. Interview Guide for Key Informants in Regulatory Roles in the Public Sector

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Participant ID: _____

Date: _____ / _____ / _____
Start time: _____: _____
End time: _____: _____
Language of interview: _____
Translator's name: _____
Facilitator's name: _____

Have you already:

- Introduced yourself?
- Explained the study's objectives?
- Completed the informed consent procedure?
- Explained the interview process?
- Shared the project's definition of the private sector?
- Presented the six dimensions of quality care (i.e., care that is safe, equitable, accessible, acceptable/patient-centred, effective, and efficient)?

Ask participant if s/he is still ok with audio recording the interview. If yes, TURN ON THE RECORDER AND NOTE THE PARTICIPANT'S ID NUMBER ON THE RECORDING.

[*This interview has seven sections about topics related to regulation. At the start of each section, I will provide a brief overview of what we will discuss. If you do not feel capable of answering a particular section based on your role and expertise, we can skip that section. For each of the questions, our focus is on quality of care and maternal and newborn health. We are especially interested in services for childbirth and immediate neonatal care.*]

1. To begin, can you tell me about your role? How does it relate to quality of care (QoC) for maternal and newborn health (MNH)?
2. From your perspective, how open is the government and/or Ministry of Health to working with the private sector?
3. What role do you see for the private sector in providing quality health services and products, particularly for mothers and newborns?

A. REGULATORY/LEGAL FRAMEWORK

[*I would like to discuss the regulatory/legal framework(s) or mechanism(s) that guide the governance of the private health sector to deliver quality MNH services. I'm particularly interested in services for childbirth and immediate neonatal care.]*

1. Can you please tell me about the institutions, organizations or mechanisms that exist for the governance and regulation of the health sector (public and private) in the provision of quality MNH services?
    a. How do these mechanisms impact how the government and/or Ministry of Health engage the private health sector in contributing to national health goals?
    b. What aspects of the regulatory mechanisms work well, and what aspects do not?
    c. From your perspective, how engaged is the private sector in regulatory and/or accreditation efforts?
        i. Is there private sector self-regulation?
2. From your perspective, what are some of the legal and/or regulatory barriers to a greater role for the private health sector in addressing QoC and MNH priority areas?
3. How effective are the national mechanisms for monitoring and ensuring the private sector's compliance with required standards (e.g. infrastructure, personnel, equipment and adherence to clinical standards) for quality MNH services?
4. What can the Ministry of Health do to strengthen its stewardship of the private sector, both at the national and sub-national levels?
    a. What can other stakeholders, like national health insurance and local governments, do to strengthen their stewardship of the private sector?
5. What constraints and challenges does the government encounter in regulating (e.g. licensing, accreditation, credentialing) and governing the private health sector's provision of quality MNH services?
6. What changes in legislation are needed–if any–to make dual practice (i.e., health providers who work in both public and private sector facilities) more beneficial to the public?

B. LEADERSHIP

[*I would like to discuss the effectiveness of the existing leadership systems and structures for quality MNH services within the private health sector.*]

1. I would like to discuss the effectiveness of existing structures and systems for governance of quality of healthcare. [*Briefly describe the existing structures and systems based on the literature review*.]
    a. How effective are these structures and systems for governing quality of healthcare in the private sector?
2. How can the national health system influence activities of the private health sector so that they contribute to meeting the national MNH QoC goals and objectives?
3. From your perspective, how effective is the private sector at governing (e.g. committees, groups, platforms, processes), leading, and advocating for itself?

C. RESOURCES FOR THE PRIVATE SECTOR

[*I would like to discuss resources that the private sector has to improve the quality of MNH services. This could include things like human resources, tools, financial resources and technical support.]*

1. To what extent do the government and/or Ministry of Health provide the private health sector and private clinical providers with required resources (e.g. infrastructure, personnel, equipment) for meeting national standards for the provision of quality MNH services?
    a. PROBE: Are there private health financing needs that the government and/or Ministry of Health supports? If so, please describe them.
    b. What challenges/constraints does the private health sector face in accessing resources (e.g. financial, access to credits, training, mentoring/supervision, guidelines) from the national health system or international bodies/organizations?
        i. PROBE: How can these challenges/constraints be addressed?
2. What incentives exist for private investments in the provision of quality MNH services?
    a. PROBE: In rural areas? In urban areas?
3. What capacity (e.g. skills, knowledge, technology) does the Ministry of Health have to support private sector provision of quality MNH services?
4. What would the government and/or Ministry of Health find most useful to learn from the private health sector with respect to mobilizing and investing resources to improve quality and access to MNH services?

D. MARKET COMPETITIVENESS

[*I would like to discuss how the existing business environment affects and influences market competitiveness in the private health sector.*]

1. How does the existing business environment (e.g. quality assurance/accreditation, health insurance, preferred provider networks) influence market competitiveness within the private sector?
    a. How can the government and/or Ministry of Health influence this environment to make it more effective for the provision of quality MNH services by the private sector?

E. ACCOUNTABILITY

[*I would like to discuss how to ensure accountability, including social accountability, for the delivery of quality MNH services in the private sector. This may include things like incentives, sanctions, regulatory mechanisms, and community/client engagement.*]

1. How do the government and/or Ministry of Health hold the private health sector accountable in its delivery of quality MNH services (e.g. monitoring, sanctions)?
    a. What mechanisms (e.g., to assure adherence to MNH standards/protocols, to improve care outcomes and learning) exist for the government and/or Ministry of Health to support improved quality of service delivery in the private sector?
2. Does the structure of the national health insurance (capitation) scheme or any other scheme (vouchers, subsidies, or other financial risk protection mechanisms) adequately motivate private providers to offer quality MNH services?
    a. If not, what changes might be made to increase incentives?

3. From your perspective, what mechanisms motivate the private health sector to provide quality MNH services?
    a. What incentives and sanctions exist for reporting by the private sector?
    b. Can the government and/or Ministry of Health monitor changes over time in the private sector with data to measure sustained improvements or deterioration in the provision of health services?
        i. How and by whom is this done?

F. IMPROVED HEALTH SYSTEM FUNCTIONING

[*I would like to discuss how the health system is functioning as a cohesive system to facilitate the delivery of quality care for mothers and newborns.]*

1. How well is the health system, both public and private sectors, functioning as a unified system to deliver quality MNH services, specifically childbirth and immediate neonatal care?
    a. What constraints does the national health system experience?
    b. How can the partnership between the public and private sectors be made more effective and more equitable for the provision of quality MNH care services?

G. CONCLUDING QUESTIONS

[*We are almost finished. I have some short concluding questions for you.*]

1. Generally speaking, what should be done differently in public-private engagement to attain the necessary impact on MNH care outcomes?
2. Is there anything else you think that I should know about private sector delivery of quality MNH care services?
3. Is there anyone else you would recommend that I speak with about this research?
4. Do you have any questions for me?

Thank the participant for their time. If the participant identified any resources, ask them to share copies with you.

Study on Private Sector Delivery of Quality Maternal and Newborn Health Services

E. Interview Guide for Key Informants in Service Delivery Roles in the Private Sector

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Participant ID: _____

Date: _____ / _____ / _____
Start time: _____: _____
End time: _____: _____
Language of interview: _____
Translator's name: _____
Facilitator's name: _____

Have you already:

- Introduced yourself?
- Explained the study's objectives?
- Completed the informed consent procedure?
- Explained the interview process?
- Shared the project's definition of the private sector?
- Presented the six dimensions of quality care (i.e., care that is safe, equitable, accessible, acceptable/patient-centred, effective, and efficient)?

Ask participant if s/he is still ok with audio recording the interview. If yes, TURN ON THE RECORDER AND NOTE THE PARTICIPANT'S ID NUMBER ON THE RECORDING.

[*This interview has seven sections about topics related to service delivery. At the start of each section, I will provide a brief overview of what we will discuss. If you do not feel capable of answering a particular section based on your role and expertise, we can skip that section. For each of the questions, our focus is on quality of care and maternal and newborn health. We are especially interested in services for childbirth and immediate neonatal care.*]

1. To begin, can you tell me about your role? How does it relate to quality of care (QoC) for maternal and newborn health (MNH)?
2. From your perspective, how open is the private sector to working with the government and/or Ministry of Health?
3. What role do you see for the private sector in providing quality health services and products, particularly for mothers and newborns?

A. RESOURCES FOR THE PRIVATE SECTOR

[*I would like to discuss resources that the private sector has to improve the quality of MNH services. This could include things like human resources, tools, financial resources and technical support.]*

1. To what extent do private clinical providers and the private health sector have required resources (e.g. infrastructure, personnel, equipment) for meeting national standards for the provision of quality MNH services?
    a. What challenges/constraints does the private health sector face in accessing resources (e.g. financial, access to credits, training, mentoring/supervision, guidelines) from the national health system or international bodies/organizations?
    b. From your perspective, what is the quality of MNH services being provided by the private heath sector?
    c. How can the private health sector sustain efforts to deliver quality MNH care?
    d. What additional resources does the private health sector require to improve the provision of quality MNH services?
    e. What opportunities (e.g. credits, loans) exist for obtaining these resources?
2. What incentives exist for private investments in the provision of quality MNH services?
    a. PROBE: In rural areas? In urban areas?
3. Is your facility/organization adequately equipped (in terms of staff, space and equipment) to serve the needs of mothers and newborns?
4. Do you currently have a need for financing?
    a. If yes, for what purpose? How likely is it that you will be approved for a loan?
    b. If not, why not?
5. What donors are sources of funding for you?
    a. Which services/activities do these donors support?
6. What percentage of your revenues comes from donor funding versus health service provision?
7. Do you receive free or subsidized commodities? If so, from what source?
8. What lessons can you share from the private sector with respect to mobilizing and investing resources to improve quality and access to MNH services?

B. MARKET COMPETITIVENESS

[*I would like to discuss how the existing business environment affects and influences market competitiveness in the private health sector.*]

1. How does improving the provision of quality MNH affect business competitiveness (e.g. utilization rates, profits)?
2. How does the existing business environment (e.g. quality assurance/accreditation, health insurance, preferred provider networks) influence market competitiveness?
    a. How can this environment be made more effective in the provision of quality MNH services?
3. Are there barriers (knowledge or attitudinal) to increasing demand for privately provided quality MNH services?
    a. How might such issues be addressed?
4. What are the constraints to increasing the demand and the use of services from the private sector?
    a. How do private providers try to attract patients for MNH services?
5. Are you interested in expanding the MNH services you provide, or volume of patients you see? In which ways?
    a. What are the barriers to expansion?

C. ACCOUNTABILITY

[*I would like to discuss how to ensure accountability, including social accountability, for the delivery of quality MNH services in the private sector. This may include things like incentives, sanctions, regulatory mechanisms, and community/client engagement.*]

1. How do patients/consumers hold your facility/organization accountable in its delivery of quality MNH services (e.g. feedback systems, monitoring, public reporting, sanctions)?
    a. How does patient experience influence the delivery of quality MNH services in your facility/organization?
        i. PROBE: Do you have any specific examples?
    b. Is your facility/organization required to use patient feedback to improve the quality of MNH services?
        i. What mechanisms (e.g., to reduce abuse, to assure adherence to MNH standards/protocols, to improve care outcomes and learning) exist to support improved service delivery through feedback and learning?
        ii. PROBE: Are there any specific challenges and/or opportunities that you would like to share?
2. How do the government and/or Ministry of Health hold the private health sector accountable in its delivery of quality MNH services (e.g. monitoring, sanctions)?
    a. What mechanisms (e.g., to assure adherence to MNH standards/protocols, to improve care outcomes and learning) exist for the government and/or Ministry of Health to support improved quality of service delivery in the private sector?
3. Does the structure of the national health insurance scheme or any other scheme (e.g., vouchers, subsidies, other financial risk protection mechanisms) adequately motivate private providers to offer quality MNH services?
    a. If not, what changes might be made to increase incentives?
4. What mechanisms motivate the private health sector to provide quality MNH services?
    a. What incentives and sanctions exist for reporting by the private sector?
    b. Can you or someone in your facility/organization monitor changes over time with data to measure sustained improvements or deterioration in the provision of health services within the facility/organization?
        i. How is this done?

D. RELATIONSHIPS BETWEEN THE PUBLIC AND PRIVATE SECTORS

[*I would like to discuss types of relationships between the private and public sectors, such as trust, collaboration, information systems, and knowledge exchange. I would like to explore the extent to which these types of relationships exist and their impact on the provision of quality MNH care services.]*

1. Has your facility/organization ever been visited by the Ministry of Health? If yes, for what purpose?
2. Are you a participating provider/facility/organization in any government or private health insurance coverage scheme?
    a. If so, what led you to be contracted for health services? Which services are contracted?
    b. Have you experienced any challenges? If so, what do you see as critical to improving the contracting arrangement?
3. What form of collaboration exists between the government and private sector in MNH services?

a. What are the gaps in the public sector that the private sector fulfills in terms of the provision of quality MNH services?
b. What motivates the private sector to engage with the national health system in the delivery of quality MNH?
    i. If impediments exist, how can they be addressed?
c. How open and transparent is the relationship between the public and private sectors?
    i. PROBE: If the relationship is closed, how can it be made more open and transparent?
d. What lessons can be drawn from successful examples or models of public-private relationships?

4. What role can the private health sector play in facilitating the provision of effective referrals and pre-hospital emergency services?
    a. In what instances do you refer clients to the public health sector?
        i. Where do you refer clients? Why?
            1. PROBE: In your opinion, what is the quality of care provided at the referral site(s)?
            2. Do you communicate with the referral site(s)? When and how?
        ii. If you do not refer clients to the public health sector, why?
    b. In what instances are clients from the public sector referred to you?
    c. What is your experience with the mechanism(s) for referral to the private health sector?
    d. In your opinion, what needs to be done to improve referral?
        i. PROBE: Provide feedback to referring facility, more training, improved transportation, priority for referral patients, use of referral slips, improved communication, reduced medical costs at referral sites, improved counseling, etc.
        ii. Who is responsible for making the referral system a success?
5. How is knowledge and learning shared between the public and private health sectors?
    a. How can practices that lead to quality improvement in the private health sector be shared with the public health sector and vice versa?
6. Do you (or your organization) report any health service statistics to the Ministry of Health?
    a. If so, what information do you report and with what frequency?
    b. If not, why not?
    c. What opportunities/systems exist to facilitate greater reporting to national health information systems (e.g. DHIS 2) by the private health sector?
        i. What will the private health sector require to routinely report and share its data?
        ii. If constraints to reporting by the private sector exist, how can they be overcome?
        iii. If consequences exist for not reporting, what are they?
7. Amongst health providers in your facility/organization, how common is dual practice (i.e., working in both public and private health facilities)?

E. VALUES, ETHICS AND MOTIVATION

[*I would like to discuss values, ethics and motivation as they relate to delivery of quality MNH services by the health sector.*]

1. What are the main principles and values that govern the delivery of quality MNH services, specifically childbirth and immediate neonatal care?
    a. …in the public sector?
    b. …in the private sector?

    c. What principles and values can enhance the provision of quality MNH services?
2. To what extent are providers respectful of medical ethics and cultural appropriateness (respectful of the cultures of individuals, people and communities) in the provision of quality MNH care services?
    a. How is this different between the public and private sectors?
3. How can we strengthen ethical practices and cultural appropriateness in the delivery of quality MNH services?
    a. How is this different between the public and private sectors? How is this similar between the public and private sectors?

F. IMPROVED HEALTH SYSTEM FUNCTIONING

[*I would like to discuss how the health system is functioning as a cohesive system to facilitate the delivery of quality care for mothers and newborns.]*

1. What are the challenges or barriers you face in delivering quality childbirth and immediate neonatal care services to your clients?
    a. What do you see as potential solutions to these challenges?
        i. PROBE: Licensing or registration, training, payment/reimbursement, etc.
2. How well is the health system, both public and private sectors, functioning as a unified system to deliver quality MNH services, specifically childbirth and immediate neonatal care?
    a. What constraints does the national health system experience?
    b. How can the partnership between the public and private sectors be made more effective and more equitable for the provision of quality MNH care services?

G. CONCLUDING QUESTIONS

[*We are almost finished. I have some short concluding questions for you.*]

1. Generally speaking, what should be done differently in public-private engagement to attain the necessary impact on MNH care outcomes?
2. Is there anything else you think that I should know about private sector delivery of quality MNH care services?
3. Is there anyone else you would recommend that I speak with about this research?
4. Do you have any questions for me?

Thank the participant for their time. If the participant identified any resources, ask them to share copies with you.

Study on Private Sector Delivery of Quality Maternal and Newborn Health Services

F. Interview Guide for Key Informants in Service Delivery Roles in the Public Sector

---

Participant ID: _____

Date: _____ / _____ / _____
Start time: _____: _____
End time: _____: _____
Language of interview: _____
Translator's name: _____
Facilitator's name: _____

Have you already:

- Introduced yourself?
- Explained the study's objectives?
- Completed the informed consent procedure?
- Explained the interview process?
- Shared the project's definition of the private sector?
- Presented the six dimensions of quality care (i.e., care that is safe, equitable, accessible, acceptable/patient-centred, effective, and efficient)?

Ask participant if s/he is still ok with audio recording the interview. If yes, TURN ON THE RECORDER AND NOTE THE PARTICIPANT'S ID NUMBER ON THE RECORDING.

[*This interview has seven sections about topics related to service delivery. At the start of each section, I will provide a brief overview of what we will discuss. If you do not feel capable of answering a particular section based on your role and expertise, we can skip that section. For each of the questions, our focus is on quality of care and maternal and newborn health. We are especially interested in services for childbirth and immediate neonatal care.*]

1. To begin, can you tell me about your role? How does it relate to quality of care (QoC) for maternal and newborn health (MNH)?
2. From your perspective, how open is the government and/or Ministry of Health to working with the private sector?
3. What role do you see for the private sector in providing quality health services and products, particularly for mothers and newborns?

A. RESOURCES FOR THE PRIVATE SECTOR

[*I would like to discuss resources that the private sector has to improve the quality of MNH services. This could include things like human resources, tools, financial resources and technical support.]*

1. To what extent do the government and/or Ministry of Health provide the private health sector and private clinical providers with required resources (e.g. infrastructure, personnel, equipment) for meeting national standards for the provision of quality MNH services?
    a. PROBE: Are there private health financing needs that the government and/or Ministry of Health supports? If so, please describe them.
    b. What challenges/constraints does the private health sector face in accessing resources (e.g. financial, access to credits, training, mentoring/supervision, guidelines) from the national health system or international bodies/organizations?
        i. PROBE: How can these challenges/constraints be addressed?
2. What incentives exist for private investments in the provision of quality MNH services?
    a. PROBE: In rural areas? In urban areas?
    b. How do these incentives compare to those that exist for investments in the public sector?
3. What is capacity (e.g. skills, knowledge, technology) does the Ministry of Health have to support the provision of quality MNH services?
4. What lessons would the government and/or Ministry of Health find most useful to learn from the private health sector share with respect to mobilizing and investing resources to improve quality and access to MNH services?

B. MARKET COMPETITIVENESS

[*I would like to discuss how the existing business environment affects and influences market competitiveness in the provision of quality MNH services.*]

1. How does improving the provision of quality MNH affect business competitiveness (e.g. utilization rates, profits)?
    a. What competition do you see between the public and private health sectors?
2. How does the existing business environment (e.g. quality assurance/accreditation, health insurance, preferred provider networks) influence market competitiveness?
    a. How can this environment be made more effective in the provision of quality MNH services?

C. ACCOUNTABILITY

[*I would like to discuss how to ensure accountability, including social accountability, for the delivery of quality MNH services in the private sector. This may include things like incentives, sanctions, regulatory mechanisms, and community/client engagement.*]

1. How do the government and/or Ministry of Health hold the private health sector accountable in its delivery of quality MNH services (e.g. feedback systems, monitoring, sanctions)?
    a. What mechanisms (e.g., to assure adherence to MNH standards/protocols, to improve care outcomes and learning) exist for the government and/or Ministry of Health to support improved quality of service delivery in the private sector?

2. Does the structure of the national health insurance scheme or any other scheme (e.g., vouchers, subsidies, other financial risk protection mechanisms) adequately motivate private providers to offer quality MNH services?
    a. If not, what changes might be made to increase incentives?
3. From your perspective, what mechanisms motivate the private health sector to provide quality MNH services?
    a. What incentives and sanctions exist for reporting by the private sector?
    b. Can the government and/or Ministry of Health monitor changes over time in the private sector with data to measure sustained improvements or deterioration in the provision of health services?
        i. How and by whom is this done?

D. RELATIONSHIPS BETWEEN THE PUBLIC AND PRIVATE SECTORS

[*I would like to discuss types of relationships between the private and public sectors, such as trust, collaboration, information systems, and knowledge exchange. I would like to explore the extent to which these types of relationships exist and their impact on the provision of quality MNH care services.]*

1. What form of collaboration exists between the government and private sector in MNH services?
    a. What are the gaps in the public sector that the private sector fulfills in terms of the provision of quality MNH services?
    b. What motivates the national health system to engage the private sector in the delivery of quality MNH?
        i. If impediments exist, how can they be addressed?
    c. How open and transparent is the relationship between the public and private sectors?
        i. PROBE: If the relationship is closed, how can it be made more open and transparent?
    d. What lessons can be drawn from successful examples or models of public-private relationships?
2. What role can the government and/or Ministry of Health play in facilitating the private health sector's provision of effective referrals and pre-hospital emergency services?
    a. In what instances do you refer clients to the private health sector?
        i. Where do you refer clients? Why?
            1. PROBE: In your opinion, what is the quality of care provided at the referral site(s)?
            2. Do you communicate with the referral site(s)? When and how?
        ii. If you do not refer clients to the private health sector, why?
    b. In what instances are clients from the private sector referred to you?
    c. What is your experience with the mechanism(s) for referral to the private health sector?
    d. In your opinion, what needs to be done to improve referral?
        i. PROBE: Provide feedback to referring facility, more training, improved transportation, priority for referral patients, use of referral slips, improved communication, reduced medical costs at referral sites, improved counseling, etc.
        ii. Who is responsible for making the referral system a success?
3. How is knowledge and learning shared between the public and private health sectors?
    a. How can practices that lead to quality improvement in the public health sector be shared with the private health sector and vice versa?
4. Do you report any health service statistics to the Ministry of Health?

a. If so, what information do you report and with what frequency?
b. If not, why not?

5. How do the government and/or Ministry of Health engage the private health sector in national health information systems?
    a. What opportunities/systems exist to facilitate greater reporting by the private health sector to national health information systems (e.g. DHIS 2)?
        i. What will the public health sector require to routinely engage the private sector in reporting and sharing its data?
        ii. If constraints to engaging the private sector in data reporting exist, how can the government and/or Ministry of Health overcome these constraints?
        iii. Do the government and/or Ministry of Health impose any consequences on the private health sector for not reporting data? If yes, what are they?
6. Amongst health providers in your facility/organization, how common is dual practice (i.e., working in both public and private health facilities)?

E. VALUES, ETHICS AND MOTIVATION

[*I would like to discuss values, ethics and motivation as they relate to delivery of quality MNH services by the health sector.*]

1. What are the main principles and values that govern the delivery of quality MNH services, specifically childbirth and immediate neonatal care?
    a. …in the public sector?
    b. …in the private sector?
    c. What principles and values can enhance the provision of quality MNH services?
2. To what extent are providers respectful of medical ethics and cultural appropriateness (respectful of the cultures of individuals, people and communities) in the provision of quality MNH care services?
    a. How is this different between the public and private sectors?
3. How can we strengthen ethical practices and cultural appropriateness in the delivery of quality MNH services?
    a. How is this different between the public and private sectors? How is this similar between the public and private sectors?

F. IMPROVED HEALTH SYSTEM FUNCTIONING

[*I would like to discuss how the health system is functioning as a cohesive system to facilitate the delivery of quality care for mothers and newborns.]*

1. What are the challenges or barriers you face in delivering quality childbirth and immediate neonatal care services to your clients?
    a. What do you see as potential solutions to these challenges?
        i. PROBE: Training, payment/reimbursement, etc.
2. How well is the health system, both public and private sectors, functioning as a unified system to deliver quality MNH services, specifically childbirth and immediate neonatal care?
    a. What constraints does the national health system experience?

b. How can the partnership between the public and private sectors be made more effective and more equitable for the provision of quality MNH care services?

G. CONCLUDING QUESTIONS

[*We are almost finished. I have some short concluding questions for you.*]

1. Generally speaking, what should be done differently in public-private engagement to attain the necessary impact on MNH care outcomes?
2. Is there anything else you think that I should know about private sector delivery of quality MNH care services?
3. Is there anyone else you would recommend that I speak with about this research?
4. Do you have any questions for me?

Thank the participant for their time. If the participant identified any resources, ask them to share copies with you.

Appendix 2: Participants' Information Sheet for Key Informant Interviews in Ghana

PARTICIPANTS' INFORMATION SHEET: KEY INFORMANT INTERVIEWS

This informed consent information sheet is for health providers and representatives of health organizations in Ghana who we are inviting to participate in key informant interviews on the private sector's delivery of quality maternal and newborn health services.

This Informed Consent Form has two parts:

- *Participants' Information Sheet (to share information about the study with you)*
- *Certificate of Consent (for signatures if you choose to participate)*

Title of study
Mechanisms for engaging the private sector in planning, delivering and demonstrating accountability for quality maternal and newborn health services: Evidence from Bangladesh, Ghana and Nigeria

Introduction
We are doing research on the private health sector and its involvement in delivering quality maternal and newborn health services. This study is part of a global research project being conducted in Ghana, Nigeria and Bangladesh over eight months (December 2019 to July 2020). In Ghana, the Investigators are:

Dr. Ernest K. ASIEDU
Ministry of Health, Ghana
Quality Management Unit, Ministry of Health, P.O. Box M 44, Ministries, Accra, Ghana

Dr. Roseline DOE
World Health Organization Country Office – Ghana
No. 7 Ameda Street, Roman Ridge, Accra, Ghana (digital address: GA-089-9979)

Dr. Elom Hillary OTCHI
World Health Organization Country Office – Ghana
No. 7 Ameda Street, Roman Ridge, Accra, Ghana (digital address: GA-089-9979)

We are going to give you information and invite you to be part of this research. You do not have to decide today whether or not you will participate in the research. Before you decide, you can talk to anyone you feel comfortable with about the research.

This consent form may contain words that you do not understand. Please ask me to stop as we go through the information, and I will take time to explain. If you have questions later, you can ask them to me or to the committee who reviewed this research.

Background and purpose of research

This study seeks to explore the ways that exist for involving the private sector in planning, delivering and demonstrating accountability for quality maternal and newborn health services in Ghana, Bangladesh and Nigeria. The engagement and contribution of the private sector in implementing quality care standards; developing and identifying best practices for delivering quality maternal and newborn health care; and strengthening the health system for delivering quality care is an area with great potential that requires immediate attention. There is a need to understand what can be done to create, nurture and encourage a vibrant private sector that is fully engaged in improving and sustaining quality of care for mothers and newborns.

We want to find ways to more effectively involve the private sector in the national health system's efforts to deliver quality maternal and newborn health services. We believe that you can help us by telling us what you know about the private health sector, public health sector and national health system. We are particularly interested in identifying effective ways of engaging the private health sector in national efforts to improve maternal and newborn health and exploring how the private health sector can contribute towards the provision of quality maternal and newborn health services.

Declaration of conflicts of interest
We declare that the members of the research team have no conflicts of interest.

Nature of research (type of research intervention)
The research will involve conducting interviews with key informants (stakeholders) involved in both the public and the private health sectors in Ghana. We estimate conducting approximately 28 key informants' interviews amongst participants from the public and private health sectors. The interviews will last approximately one hour.

Participant selection
You are being invited to take part in this research because we feel that your experience and knowledge of Ghana's national health system, both the public and private sectors, can contribute much to our understanding and knowledge.

Participants' involvement

- **Duration/what is involved:** We are asking you to help us learn more about how the private sector works within the national health system to deliver quality maternal and newborn health services. If you accept, you will be asked to participate in a key informant interview lasting approximately 60 minutes. During the interview, I or another interviewer will sit down with you in a comfortable place at the World Health Organization Country Office, Ghana. If it is better for you, the interview can take place in your office or over the telephone. If you do not wish to answer any of the questions during the interview, you may say so and the interviewer will move on to the next question. No one else but the interviewer will be present unless you would like someone else to be there. The information recorded is confidential, and no one outside of the project research team will have access to the information documented during your interview. The entire interview will be audio-recorded, if you consent, but no one will be identified by name on the recording. The audio-recording and a transcript produced from this recording will be kept on a password-protected computer and backed up on a password-protected hard drive. The

recordings will be destroyed after 2 years, in order to ensure enough time for writing up the findings. Should the final publications be written up and published in less than two years, the recordings will be destroyed earlier. If you do not consent to the interview being audio-recorded, the interviewer will take written notes.

- **Potential Risks**
  There is a risk that you may share some personal or confidential information by chance, or that you may feel uncomfortable talking about some of the topics. However, we do not wish for this to happen. You do not have to answer any question or take part in the interview if you feel the question(s) are too personal, or if talking about them makes you uncomfortable. If you become stressed, you can take some time to recuperate. If you become uncomfortable from the prolonged sitting (approximately 60 minutes), you can take a break to stretch. You can also stop your participation at any time.
- **Benefits**
  The intention of this study is to contribute towards improved understanding of the private health sector's role in delivering quality maternal and newborn health services in Ghana. There will be no direct benefit to you, but your participation is likely to help us find out how to design more effective policies and ways for engaging the private health sector in the national health system's efforts to improve maternal and newborn health.
- **Costs**
  You will incur no costs for participating in this research, apart from a time and opportunity cost of approximately 60 minutes during which you will complete the interview.
- **Compensation**
  You will not be provided with any incentive to take part in the research.
- **Confidentiality**
  All the information that you provide during the interview will remain anonymous, which means that no one will be able to know who you are. This conversation usually takes around one hour but sometimes takes shorter or longer. I may ask you to share some information that is personal. The information you provide is confidential and will be kept private. I will not share personal information about you with anyone, and any mentions of your organization will be removed from the transcript and anonymized. The recording and any other information about you will have a unique number on it instead of your name. Only I and the other members of the research team will know what your number is. Findings from the research may be published, but no details from which you could be identified will be shared with anyone. All data from this project will be stored securely.
- **Voluntary participation/withdrawal**
  Your participation in the study is entirely voluntary. It is your choice whether to take part or not. If you choose not to take part, there will be no negative consequences. You may change your mind later and stop taking part even if you agreed earlier. You do not have to give reasons for choosing not to take part. If you would like time to think before you decide whether to take part, you can tell me and come back at a later date. If you agree to participate, I will ask you to consent to the information shared in this form to show that the study has been explained to you and that you agree to be part of it. You may decide to end your participation in the interview at any time if you do not feel comfortable about continuing.
- **Outcome and feedback**

Participants will be contacted in the event that any further clarification is required. Some interview participants may be contacted to participate in a multi-stakeholder dialogue meeting to discuss these topics in greater detail. The data gathered by this study will be analyzed and written up in a document that presents the findings on mechanisms for engaging the private sector for improved MNH services in Ghana. Reports and publications will be made publicly available through the Quality of Care Network.

- **Feedback to participant**
  You will be contacted in the event that any further clarification is required. If you are interested in being contacted once the findings from this research are publicly available, we will share the final report(s)/paper(s) with you.
- **Funding information**
  This research is supported by the World Health Organization and MSD for Mothers.
- **Sharing of participants Information/Data**
  The World Health Organization and Ghana Ministry of Health will own the data generated by this study in Ghana.

Provision of Information and Consent for Participants
This Informed Consent Form has two parts:

• Participants' Information Sheet (to share information about the study with you)

• Certificate of Consent (for signatures if you choose to participate)

You will be given a copy of the full Informed Consent Form (Participants' Information Sheet and Certificate of Consent) once it has been signed.

Who to Contact for Further Clarification/Questions?
If you have any questions, you can ask them now or later. If you wish to ask questions later about this research, please contact:

Dr. Elom Hillary OTCHI
World Health Organization Country Office
No. 7 Ameda Street, Roman Ridge, Accra (digital address: GA-089-9979)

This proposal has been reviewed and approved by the Ghana Health Service Ethics Review Committee, which is a committee whose task it is to make sure that research participants are protected from harm. For further clarification on ethical issues and your rights as a participant, if need be, please contact:

NAME: The Administrator
Nana Abena Apatu

Appendix 3: Consent Statements for Key Informant Interviews in Ghana

Certificate of Consent for Key Informant Interviews

PARTICIPANT'S STATEMENT

I acknowledge that I have read or have had the purpose and contents of the 'Participants' Information Sheet: Key Informant Interviews' read and satisfactorily explained to me in a language I understand (*English*). I have had the opportunity to ask questions, and any question I have asked has been answered to my satisfaction. I fully understand the contents and any potential implications as well as my right to change my mind (i.e. withdraw from the research) even after I have signed this form.

Description	YES	NO
I have been given an opportunity to ask any questions I may have, and all such questions or inquiries have been answered to my satisfaction. I have been informed orally and in writing of whom to contact in case I have questions.		
I give my consent to participate in this study.		
I agree to participate in a recorded interview.		
I give permission to include my information, without my name, in your research findings that will be shared and published.		
I give permission for my organization to be included in the acknowledgements section of any reports or papers.		
I would like to be contacted once the publications from this research are publicly available to be shared with me.		

I consent voluntarily to be a participant in this research study.

Printed name or initials of participant ……..

ID code ……..

Participant's signature …… OR Mark (please specify) …….

INVESTIGATOR STATEMENT AND SIGNATURE

I certify that I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following will be done. I

confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily. The participant has been given ample time to read and learn about the study. A copy of this informed consent form has been provided to the participant.

Researcher's name…….

Signature …… Date……

Appendix 4: Participants' Information Sheet for Multi-Stakeholder Dialogue in Ghana

PARTICIPANTS' INFORMATION SHEET: MULTI-STAKEHOLDER DIALOGUE

This informed consent information sheet is for health providers and representatives of health organizations in Ghana who we are inviting to participate in a multi-stakeholder dialogue on the private sector's delivery of quality maternal and newborn health services.

This Informed Consent Form has two parts:

- *Participants' Information Sheet (to share information about the study with you)*
- *Certificate of Consent (for signatures if you choose to participate)*

Title of study
Mechanisms for engaging the private sector in planning, delivering and demonstrating accountability for quality maternal and newborn health services: Evidence from Bangladesh, Ghana and Nigeria

Introduction
We are doing research on the private health sector and its involvement in delivering quality maternal and newborn health services. This study is part of a global research project being conducted in Ghana, Nigeria and Bangladesh over eight months (December 2019 to July 2020). In Ghana, the Investigators are:

Dr. Ernest K. ASIEDU
Ministry of Health, Ghana
Quality Management Unit, Ministry of Health, P.O. Box M 44, Ministries, Accra, Ghana

Dr. Roseline DOE
World Health Organization Country Office – Ghana
No. 7 Ameda Street, Roman Ridge, Accra, Ghana (digital address: GA-089-9979)

Dr. Elom Hillary OTCHI
World Health Organization Country Office – Ghana
No. 7 Ameda Street, Roman Ridge, Accra, Ghana (digital address: GA-089-9979)

We are going to give you information and invite you to be part of this research. You do not have to decide today whether or not you will participate in the research. Before you decide, you can talk to anyone you feel comfortable with about the research.

This consent form may contain words that you do not understand. Please ask me to stop as we go through the information, and I will take time to explain. If you have questions later, you can ask them to me or to the committee who reviewed this research.

Background and purpose of research

This study seeks to explore the ways that exist for involving the private sector in planning, delivering and demonstrating accountability for quality maternal and newborn health services in Ghana, Bangladesh and Nigeria. The engagement and contribution of the private sector in implementing quality care standards; developing and identifying best practices for delivering quality maternal and newborn health care; and strengthening the health system for delivering quality care is an area with great potential that requires immediate attention. There is a need to understand what can be done to create, nurture and encourage a vibrant private sector that is fully engaged in improving and sustaining quality of care for mothers and newborns.

We want to find ways to more effectively involve the private sector in the national health system's efforts to deliver quality maternal and newborn health services. We believe that you can help us by telling us what you know about the private health sector, public health sector and national health system. We are particularly interested in identifying effective ways of engaging the private health sector in national efforts to improve maternal and newborn health and exploring how the private health sector can contribute towards the provision of quality maternal and newborn health services.

Declaration of conflicts of interest
We declare that the members of the research team have no conflicts of interest.

Nature of research (type of research intervention)
The research will involve participating in a multi-stakeholder discussion with representatives from both the public and the private health sectors in Ghana. We estimate that the three-day multi-stakeholder dialogue meeting will include approximately 35 participants from the public and private health sectors. During this meeting, participants will be asked to review and assess mechanisms for engaging the private sector in delivering maternal, newborn and child health services with quality. Participants will also be asked to propose models for effective engagement of the private sector with the public sector for implementing quality MNH services. We expect that this meeting will lead to actionable recommendations for the effective engagement of the private sector in the national health system for delivering, and demonstrating accountability for quality of care for MNH.

Participant Selection
You are being invited to take part in this research because we feel that your experience and knowledge of Ghana's national health system, both the public and private sectors, can contribute much to our understanding and knowledge.

Participants' involvement

- **Duration/what is involved:** We are asking you to help us learn more about how the private sector works within the national health system to deliver quality maternal and newborn health services. If you accept, you will be asked to participate in three-day discussion with stakeholders from the public and private health sectors. During the meeting, participants will be asked to review and assess mechanisms for engaging the private sector in delivering maternal, newborn and child health services with quality. Participants will also be asked to propose models for effective engagement of the private sector with the public sector for implementing quality MNH services. We expect that participants will actively contribute

to the discussions. The meeting will not be recorded, but project staff will take notes for writing up the meeting report.

- **Potential Risks**
  There is a risk that you may share some personal or confidential information by chance, or that you may feel uncomfortable talking about some of the topics. However, we do not wish for this to happen. You do not have to answer any question or take part in the discussion if you feel the question(s) are too personal, or if talking about them makes you uncomfortable. If you become stressed, you can take some time to recuperate. If you become uncomfortable from the prolonged sitting during the meeting, you can take a break to stretch. You can also stop your participation at any time.
- **Benefits**
  The intention of this study is to contribute towards improved understanding of the private health sector's role in delivering quality maternal and newborn health services in Ghana. There will be no direct benefit to you, but your participation is likely to help us find out how to design more effective policies and ways for engaging the private health sector in the national health system's efforts to improve maternal and newborn health.
- **Costs**
  You will incur no costs for participating in this research, apart from a time and opportunity cost while you attend the meeting.
- **Compensation**
  You will not be provided with any incentive to take part in the research. However, your travel will be covered and you will receive lunch, snacks, and beverages during the meeting. You will also be able to network with other individuals working on topics of similar interest.
- **Confidentiality**
  All the information that you provide during the meeting will remain anonymous, which means that no one outside of the meeting will be able to know what you said. Findings from the meeting discussion may be published, but no details from which you could be identified will be shared with anyone unless you consent to your name being included in the meeting report's list of participants. All data from this project will be stored securely.
- **Voluntary participation/withdrawal**
  Your participation in the study is entirely voluntary. It is your choice whether to take part or not. If you choose not to take part, there will be no negative consequences. You may change your mind later and stop taking part even if you agreed earlier. You do not have to give reasons for choosing not to take part. If you would like time to think before you decide whether to take part, you can tell me and come back at a later date. If you agree to participate, I will ask you to consent to the information shared in this form to show that the study has been explained to you and that you agree to be part of it. You may decide to end your participation in the interview at any time if you do not feel comfortable about continuing.
- **Outcome and feedback**
  Participants will be contacted in the event that any further clarification is required. Some multi-stakeholder dialogue participants may be contacted when writing up the report for additional clarification. The data gathered by this study will be analyzed and written up in a document that presents the findings on mechanisms for engaging the private sector for

improved maternal and newborn health services in Ghana. Reports and publications will be made publicly available through the Quality of Care Network.

- **Feedback to participant**
  You will be contacted in the event that any further clarification is required. If you are interested in being contacted once the findings from this research are publicly available, we will share the final report(s)/paper(s) with you.
- **Funding information**
  This research is supported by the World Health Organization and MSD for Mothers.
- **Sharing of participants Information/Data**
  The World Health Organization and Ghana Ministry of Health will own the data generated by this study in Ghana.

Provision of Information and Consent for Participants
This Informed Consent Form has two parts:

• Participants' Information Sheet (to share information about the study with you)

• Certificate of Consent (for signatures if you choose to participate)

You will be given a copy of the full Informed Consent Form (Participants' Information Sheet and Certificate of Consent) once it has been signed.

Who to Contact for Further Clarification/Questions?
If you have any questions, you can ask them now or later. If you wish to ask questions later about this research, please contact:

Dr. Elom Hillary OTCHI
World Health Organization Country Office
No. 7 Ameda Street, Roman Ridge, Accra (digital address: GA-089-9979)

This proposal has been reviewed and approved by the Ghana Health Service Ethics Review Committee, which is a committee whose task it is to make sure that research participants are protected from harm. For further clarification on ethical issues and your rights as a participant, if need be, please contact:

NAME: The Administrator
Nana Abena Apatu

Appendix 5: Consent Statements for Multi-Stakeholder Dialogue in Ghana

Certificate of Consent for Multi-Stakeholder Dialogue

PARTICIPANT'S STATEMENT

I acknowledge that I have read or have had the purpose and contents of the 'Participants' Information Sheet: Multi-Stakeholder Dialogue' read and satisfactorily explained to me in a language I understand (*name of language*). I have had the opportunity to ask questions, and any question I have asked has been answered to my satisfaction. I fully understand the contents and any potential implications as well as my right to change my mind (i.e. withdraw from the research) even after I have signed this form.

Description	YES	NO
I have been given an opportunity to ask any questions I may have, and all such questions or inquiries have been answered to my satisfaction. I have been informed orally and in writing of whom to contact in case I have questions.		
I give my consent to participate in this study.		
I agree to participate in a multi-stakeholder dialogue where notes will be taken.		
I give permission to include my information, without my name, in your research findings that will be shared and published.		
I give permission for my name to be included in the list of participants in the meeting report.		
I give permission for my organization to be included in the acknowledgements section of any reports or papers.		
I would like to be contacted once the publications from this research are publicly available to be shared with me.		

I consent voluntarily to be a participant in this research study.

Printed name or initials of participant ……..

ID code ……..

Participant's signature …… OR Mark (please specify) …….

INVESTIGATOR STATEMENT AND SIGNATURE

I certify that I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following will be done. I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily. The participant has been given ample time to read and learn about the study. A copy of this informed consent form has been provided to the participant.

Researcher's name……………………………………….

Signature …………………………………………………   Date……………………………