Private sector delivery of quality maternal and newborn health services in Ghana

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List of Abbreviations

CHAG	Christian Health Association of Ghana
CHPS	Community-based Health Planning and Services
CS	cesarean section
CSOs	civil society organizations
GHS	Ghana Health Service
GHS-ERC	Ghana Health Service Ethical Review Committee
HeFRA	Health Facilities Regulatory Authority
HSMTDPF	Health Sector Medium Term Development Policy Framework
IHME	Institute of Health Metrics and Evaluation
MMR	maternal mortality rate
MNH	maternal and newborn health
MoFEP	Ministry of Finance and Economic Planning
MoH	Ministry of Health
NGOs	non-governmental organizations
NHIA	National Health Insurance Authority
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
NHQS	National Healthcare Quality Strategy
NHQSC	National Healthcare Quality Steering Committee
NMR	neonatal mortality rate
NMTDPF	National Medium Term Development Policy Framework
NQMU	National Quality Management Unit
OOP	out of pocket payment
PHFAG	Private Health Facilities Association of Ghana
PHSAG	Private Health Sector Alliance of Ghana
PPP	public private partnership
SCNC	Sub-committee for newborn care
UHC	Universal Health Coverage
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

1. Introduction

The Quality of Care Network, a consortium of 11 countries and their technical partners, aims to halve maternal and newborn deaths and stillbirths in participating health facilities in five years' time. While 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 private sector plays a key role in delivering sexual and reproductive health services. It provides a substantial proportion of family planning services among women aged 15-49 years in Asia (45%), Latin America and the Caribbean (44%), and sub-Saharan Africa (28%) (Ugaz et al., 2015). One in five births in low- and middle-income countries occurred with care delivered by the private sector (Benova et al., 2015). Data also show that the private sector delivers primary care to all income groups; approximately the same percentage (25%-30%) of the poorest *and* richest seek care in the private sector in Africa (Montagu and Chakraborty, 2019). Though the private sector's role is expanding in many countries, the quality of services varies.

Quality of care is fragmented and distributed inequitably between the public and private health sectors (SHOPS Project, 2012). Analyses of health care in both government- and private-sector health facilities have found poor quality across multiple dimensions with little difference between public and private facilities (Basu et al., 2012). Whilst some studies suggest that private providers deliver better service quality than public providers, technical quality amongst the private sector is as poor if not poorer than the public sector (Bhatia and Cleland, 2004, Morgan et al., 2016). A systematic review in lower-middle-income countries revealed that private sector providers (including unlicensed and uncertified providers) were less likely to follow the standards of medical practice, had poorer patient outcomes, and reported lower efficiency than public sector providers (Basu et al., 2012).

Public-private partnerships offer an important opportunity for quality improvement in health care generally and for maternal and newborn health services in particular. Improving quality of care outcomes requires an integrated system of care and productive interactions between the public and private sectors. Poor experience with the health system is believed to have significant impact on patients' health care seeking behaviours, loss to follow-up, and unnecessary spread of disease.

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 sectors invest in increasing coverage of interventions to sustainably deliver quality care at scale. 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. Towards that end, the World Health Organization has convened an Advisory Group on Governance of the Private Health Sector for Universal Health Coverage that drafted a strategy to strengthen member state capacity to steward a mixed health system that

includes specific governance behaviours that will improve public-private interactions, regulations, and quality (WHO, 2020).

2. Research objectives

The purpose of this study is to: (1) explore and identify the mechanisms for engaging the private sector in planning, delivering and demonstrating accountability for quality maternal and newborn health services in Ghana; 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 maternal and newborn health.

Specifically, the study aims to:

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

This report focuses on the first two aims, presenting evidence from key informant interviews on the current engagement of the private sector to deliver quality maternal and newborn health services in Ghana. The report concludes with recommendations for how to engage the private sector more effectively in the national health system to deliver quality maternal and newborn health services.

The resulting findings and recommendations will be reviewed and discussed by participants at a multi-stakeholder dialogue that will address the study's third aim.

3. Methods

This mixed-methods exploratory study sought 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 maternal and newborn health. The research involved conducting a situational analysis comprised of three components: (1) a literature review; (2) a stakeholder assessment; and (3) key informant interviews. The Ghana Health Service (GHS) Ethics Review Committee (ERC) approved this research, and the World Health Organization Research Ethics Review Committee exempted the study from review. A glossary of terms used in this report appears in Appendix 1.

3.1 Project logic model

Based on a review of the relevant literature as well as input from colleagues at the World Health Organization and a global advisory working group, we developed a logic model (Figure 1) to guide the project. The model depicts key components of the private sector's involvement in delivering quality maternal and newborn health services within the national health system. It was adapted from the evaluation framework for the scale-up for maternal and child survival (Bryce et al., 2011). At the top and bottom of this model, we include the domains under which different components operate, and we recognize that equity and contextual factors (e.g., political, technological, economic) may affect the progress of the above pathways.

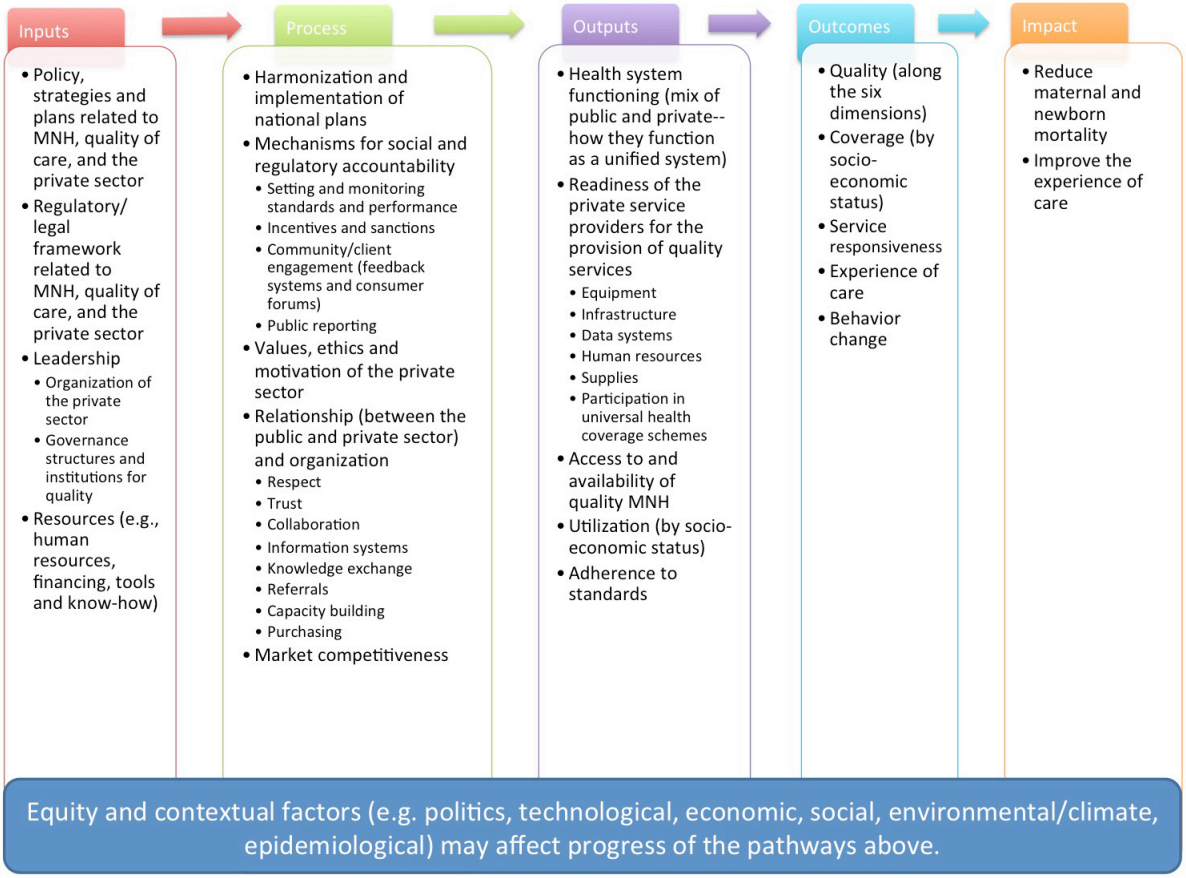


Figure 1. Project logic model

3.2 Study design and setting

We collected and analysed both primary and secondary data. Secondary data and grey literature (e.g., policies, facility-based assessments, reports) provided background context on the private sector (Appendix 2). Key informant interviews produced primary data on inputs, processes, and outputs related to the private sector's engagement in delivering quality care for maternal and newborn health as part of Ghana's national health system (Appendix 2). Key informants were identified by a stakeholder assessment and input from a national technical working group comprised of representatives from the Ministry of Health, Ghana Health Service, the Christian Health Association of Ghana, the Society of Private Medical and Dental Practitioners and the Private Health Facilities Association of Ghana (PHFAG).

Thirty-nine interview respondents from the public (n=19) and private (n=20) sectors discussed private sector engagement and delivery of maternal and newborn health services. We targeted key informants and stakeholders from five of the 16 administrative regions of Ghana: Ashanti, Bono East, Greater Accra, Northern, and Western. We prioritized these five regions because they had more private health facilities registered with the Society of Private Medical and Dental Practitioners (2019). Over half (52%) of Ghana's total population resides in these

regions.[1] The Greater Accra, Ashanti, and Western regions are predominantly urban, while the Bono East and Northern regions are predominantly rural (The World Bank, 2015). The Greater Accra and Ashanti regions have the largest referral facilities (i.e., Korle Bu and Komfo-Anokye Teaching Hospitals) in the country.

3.3 Study population and selection

For the purpose of this study, we defined the private sector as any non-government health actor: self-financing private sector (also referred to as for-profit), not-for-profit and mission or faith-based facilities involved in the delivery of health services; input suppliers (pharmaceuticals, equipment); health research and training institutions; traditional and [alternative medicine practice] informal providers[2]; health promotion and education; and health financing (Ghana Ministry of Health, 2013). However, the project scope focused on orthodox formal private sector service delivery of quality maternal and newborn health care. For this reason, we sampled a larger proportion of individuals involved in service delivery than in policy/administration or regulation. Suppliers, research and training institutions, and traditional and alternative medicine providers were excluded.

Individuals were deemed eligible and invited to participate in the key informant interviews if they:

- had experience in and knowledge of service delivery of quality of care and/or maternal and newborn health in Ghana;
- were currently working in the public health sector and/or the private formal health sector in Ghana;
- worked in the Ashanti, Bono East, Greater Accra, Northern or Western region; and
- had been working in their current role for at least two years.[3]

We selected interview respondents based on a stakeholder assessment for Ghana and input from the national technical working group. The stakeholder assessment: (1) identified all the stakeholders in the space and assessed their influence, positions, and interests; and (2) explored stakeholders' responses with respect to policies, strategies, regulations, incentives, private investments, etc. Following this step and the prioritization of stakeholders with the technical working group, eligible interview respondents in Ghana were selected purposively using a sampling matrix (Appendix 3) to capture a range of viewpoints and experiences with private sector service delivery of quality maternal and newborn health.

Using a non-probabilistic stratified purposive sampling approach and important characteristics put forth in the literature, the final sample size was influenced by the sampling matrix (Appendix 3). We identified respondents who had policy/administration, service delivery, and regulation roles within the public or private sector, at the national, regional,

[1] Projections from Ghana Statistical Service for 2019 show that the Greater Accra Region had a population of 4,943,075, the Ashanti Region had a population of 5,792,187, the Western Region had a population of 2,165,241, the Bono East Region had a population of 1,168,235, and the Northern Region had a population of 1,905,628. Ghana Statistical Service projected the country's total population to be 30,280,482 in 2019.

[2] Informal providers include drug peddlers for both orthodox and traditional and alternative medicines.

[3] For one institution, the Health Facilities Regulatory Agency, this eligibility criterion was not followed. The research team deemed it crucial to include a representative from the agency who could provide insight into Ghana's regulatory context, even if the participant had been in their role for less than two years.

district and facility level. Informants were selected based on these characteristics until saturation occurred.

3.4 Data collection and analysis

Both data (i.e., primary and secondary) were collected concurrently and subsequently triangulated to facilitate an appropriate interpretation of the overall results presented in this report. We anticipate more robust results from mixing methods rather than using the two approaches separately.

3.4.1 Primary data collection and analysis

An interviewer conducted the interviews using one of six semi-structured interview guides tailored to the three roles in the sampling matrix (Appendix 3): policy/administration, service delivery, and regulation. Each of these roles has one guide for private sector respondents and one guide for public sector respondents. Interview guides were developed based on the logic model framework (Figure 1) and an assessment of existing tools (Barnes et al., 2008, Brunner et al., 2018, GFF, 2016, Makinen et al., 2011, O'Hanlon et al., 2016, SHOPS PLUS, 2014, SHOPS Plus, 2019, SHOPS Project, 2016, Wadge et al., 2017).

The semi-structured interview guides, piloted prior to the study's commencement, included open-ended questions that covered the following topics: policies, plans and strategies related to quality maternal and newborn health; 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 maternal and newborn health; and improved access to and availability of quality maternal and newborn health.

Audio-recorded interview data were transcribed verbatim and critically examined for accuracy and representation of the response of the respondent. Data extraction templates were used to assist the organization and retrieval of themes from the data. Qualitative data from the key informant interviews were analysed using the content and thematic analysis technique and organized around the logic model. The quotations presented in this report are not verbatim and have been slightly edited for conventions of English grammar and readability.

3.4.2 Secondary data collection and analysis

For the literature review, secondary qualitative and quantitative data (e.g., facilities actively credentialed by the National Health Insurance Authority (NHIA), facilities licensed by Health Facilities Regulatory Authority (HeFRA)) were collected from grey and published literature on the private sector. A secondary analysis of data gathered by this review (Appendix 2) provides descriptive statistics of key features of the private health sector in Ghana, such as the size, scope, distribution, and quality of maternal and newborn health services delivered.

Given the size of the complete literature review, this report pulls in select content and findings. The complete literature review is available in the Quality Management Unit (QMU) of the MoH or the WHO Country Office upon request.

3.5 Methodological and data limitations

There are inherent limitations to the qualitative primary data collection inputs used for this research that need to be acknowledged and kept in mind when interpreting the findings. Key informant interviews are frequently used in social science research in order to gather information and identify key drivers/variables/information prior to the design and formulation of a relevant policy or intervention. Although useful, it is important to understand where biases can be introduced so as to cautiously interpret, frame, and validate the findings:

a. Selection bias: Findings may be biased if informants are not carefully selected. For example, the respondents selected may not be the right individuals within the organisation and/or may have inherent biases (political, etc.) that influence their responses.
b. Interviewer bias: Interviewer training, skill, and bias may sometimes provide bias, as the interviewer may unconsciously devise questions so as to secure/confirm certain views that s/he holds. On the other hand, interviewer presence stimulates respondents in terms of providing more detailed responses. Additionally, it is possible that the interviewer may inhibit the respondent from providing unencumbered responses because there is no anonymity; interviewers can attempt to overcome this challenge by using strategies like developing rapport with the respondent and choosing an appropriate location for the interview are crucial.

Acknowledging the limitations above, the research team has tried to mitigate these biases through: (1) careful selection of respondents, (2) use of an experienced interviewer, (3) reviews of transcriptions/analyses by multiple individuals, (4) and triangulation of the interview findings with findings from the secondary literature review.

Furthermore, it is important to note that the findings presented in this report are intended as initial inputs to a subsequent multi-stakeholder dialogue that will gather relevant stakeholders to further “validate” these findings before designing the final policy recommendations/interventions resulting from this research.

4. Landscape: Ghana Health Service and the private sector

4.1 Ghana Health care system

Ghana operates a pluralistic health system. In this system, the public sector primarily provides orthodox care while the private sector (self-financing, FBOs, CSOs, NGOs etc) provides varied types of services that include orthodox, traditional and alternative medicines(Ministry of Health (MoH), 2020c). The private sector in Ghana like in India provides mainly curative health services other than preventive services mostly because of the lack of interest, personnel, compliance from patients and incentives from government (Thomas et al., 2016).

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. The quasi-government facilities are another category of healthcare providers. There has been significant expansion in the provision of health services in the last two decades particularly in the private and FBOs. 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.

Healthcare has remained an important priority for successive governments over the years. This is evidenced in various efforts at improving both geographic and financial access, increasing the quantity, quality and distribution of human resource and the annual expenditure on health (University of Ghana, 2018). Ghana took a significant step to improve the quality of its healthcare in 2016 with the development and implementation of a National Healthcare Quality Strategy (NHQS). 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 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 establishment of a Private Health Sector 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 Unit has the responsibility of ensuring the coordination of all private sector related activities of the ministry and the implementation of the Private Health Sector Policy. It is further 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.). 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.

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. There is also 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 health 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 unit to facilitate policy coordination and dialogue between the public and private sectors, the unit has inadequate staff and resources. The Unit has recently been subsumed under the Resource Mobilization Unit of the Policy Planning Budgeting, Monitoring and Evaluation Directorate of (PPBM&ED) the MoH in its recent organogram (Appendix 5). This redesign has significantly affected the visibility and function of the "private sector unit". 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). It is suggested for instance that, the desired health outcomes and level of healthcare is yet to be achieved in Ghana because it has not comprehensively addressed all the key determinants of health particularly in ensuring effective multi-stakeholder collaboration and partnership with all the key actors (Ministry of Health (MoH), 2020c).

4.2 Actors in the Ghana health sector

The Ghana health sector comprises of a wide range of government and private sector groups. The landscape quickly reveals findings of relevance to private sector engagement in maternal and newborn health:

- The Ministry of Health is responsible for policy formulation, monitoring, evaluation and resource mobilization for effective health services delivery. It has several

implementing Agencies categorised into service delivery (Teaching Hospitals, Ghana Health Service, Christian Health Association of Ghana, Ahmadiyya Muslim Mission, National Ambulance Service, National Blood Service etc.) health training, health financing (National Health Insurance Authority), and regulation (Health Facilities Regulatory Agency, Professional Regulatory Agencies, Food and Drugs Authority etc.) among others.

- Additionally, there are other Ministries, Departments and Agencies (MDAs) that facilitate private sector engagement in health. These include but not limited to Ministry of Finance (Public Investment and Assets Division), Ministry of Trade and Industry (Ghana Investment Promotion Centre, Ghana Standards Authority, etc.).
- The private sector is diverse and complex. Faith-based organizations, like the Christian Health Association of Ghana and Ahmadiyya Muslim Mission, play a central role in health; however, many other types of private health care providers and representative organizations exist, including private businesses whose core activity is not health (e.g., medical insurance, banks, industry delivering/paying for health). Therefore, it is critical to engage both not-for-profit and self-financing providers as well as their representative associations.

5. Findings

This study documented the implementation experiences and lessons learned from the private sector and its interaction with the public sector for delivering quality maternal and newborn health services in Ghana. First, as part of the project literature review (Appendix 2), we present findings from an analysis of secondary data to orient readers to the private health sector in Ghana and private sector engagement in maternal and newborn health services. This secondary analysis and literature review provides descriptive statistics on key features of the private health sector in Ghana, such as the scale and quality of services delivered.

Then, we present findings from an analysis of primary in-depth interview data. These findings are organized around the project logic model (see Figure 1). As part of the confirmation of findings, boxes in each section below highlight relevant findings from the other section (e.g. findings from primary data appear in boxes in Section 5.1 that presents findings from secondary data).

5.1 Findings from secondary data

5.1.1 Overview of the private health sector in Ghana

In Ghana, private health care is one of the fastest growing segments of the health care system. Private health providers deliver 42% of all services used by consumers and are the second largest provider of outpatient services after government providers (Ghana Ministry of Health, 2014). Between 2014 and 2017, deliveries in private facilities increased from 8.1% to 11.2% (Ghana Statistical Service et al., 2018). Comparatively more doctors assisted with deliveries in Ghana's private facilities than in public facilities (Ghana Statistical Service et al., 2018).

Multiple government policies and an extensive regulatory landscape govern the growing private sector. Ghana has several policies for developing the private sector (Ministry of Health (MoH), 2020c; MoH, 2013; World Bank, 2017), strengthening public-private partnerships (Ghana Ministry of Finance, 2011), coordinating quality health care across the public and private sectors (Ghana Ministry of Health, 2016), and improving the investment climate. The National Health Policy articulates and advocates for a partnership between the public and private health sectors as well as an increasing role for the private sector in achieving national health outcomes (Ministry of Health (MoH), 2020c). The Private Health Sector Development Policy addresses the role and development of the private sector in health care delivery so that the private sector better serves the national health goals and objectives (Ghana Ministry of Health, 2013). The existence of policies, strategies, and plans for the private sector is a positive sign; however, the existence of such documents does not mean that these policies, strategies, and plans are being implemented effectively. Evidence from the in-depth interviews confirms that there is not much evidence to show that these policies, strategies, and plans are being implemented (see Box 1). Seven years after the adoption of the Private Health Sector Development Policy, for example, much of the agenda is yet to be fully implemented.

Box 1: In-depth interviews show limited implementation of policies, strategies, and plans for the private sector

The private sector policy dates back to DANIDA time. This is about 2003 there about and it was improved by Dr. Adjei of blessed memory. A lot of implementation that he thought they should implement never saw the light of day. All they did was to create a desk and interestingly, the first person that was put there on the desk had absolutely no idea about private practice. […] it is only sometimes at the tail end that they realize and especially where donor funding is involved and they come at the very last Aide Memoir then they realize that how is that we were given money hoping that private sector will play an active part and we are not seeing any private sector.

- Private sector respondent who delivers services at a facility

5.1.2 Private sector engagement in maternal and newborn health services

5.1.2.1 Type, size, and scope of private sector maternal and newborn health services

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. Unfortunately, there is no consensus on the size, scope and the performance of Ghana's private. However, it is suggested that, it is the second largest provider of outpatient department (OPD) services after government providers, contributing about 42% of services (Ministry of Health (MoH) Ghana, 2014; MoH, 2013). It is believed for instance that about a third of Ghana's health sector is owned by the private sector (Institute for Health Metrics and Evaluation (IHME), 2015) while another assessment by McKinsey (2008) estimates that the private sector contributes about 50% in the provision of healthcare in Ghana. A publication by Pharmaccess foundation however shows that the private sectors share of ownership is about 38% (PharmAccess, 2016). These inconsistencies suggest the need to improve upon the collection of the requisite data on the performance of the private health sector in Ghana. Unfortunately, HeFRA, the institution clothed with the mandate to among others address such anomalies in the size, scope and performance of both the public and private sector does not even know where some of the facilities are located (HeFRA, 2019). Presently, not all private health facilities in the country are routinely reporting the performance of their service delivery into DHIMS.

A large number of informal providers also practice in Ghana, and the scarcity of accurate and reliable data makes it difficult to give the 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).

Between 2007 and 2011 for instance, there was a 65% increase in inpatient visits in private facilities compared to a 44% increase in regional referral hospitals in Ghana (IHME, 2015). In 2017, the public sectors share of outpatient services declined to 59% while that of CHAG and the self-financing private sector's share were 28% and 21% respectively. There has also been an observed decline in the per capita outpatient attendance by about 8% over the 2016

performance of 58% (MOH Ghana, 2018). The Christian Health Association of Ghana (CHAG) which is the largest Faith-Based private sector network contributed 22.0% and 32.1% to the national outpatient and inpatient attendance respectively (Christian Health Association of Ghana (CHAG), 2019). CHAG have made the most significant contribution to the provision of healthcare and investments in the rural areas (Aikins & A, 2017).

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% was owned by the private sector. Of this total, the self-financing private sector owns 16.9% while the CHAG owned 3.6% respectively. This figure is about a 2% increase from that of 2012. This figure could however be more for the private facilities (faith-based and self-financing) because the authors admit that, "data for quasi-government, Islamic and private hospitals are incomplete". Less than 5% (i.e. 3.6%) of this was owned by the CHAG (Ghana Health Service, 2018; WHO, 2013). The public sector's share of the health sector has however seen a considerable increase from 75% in 2013 to about 79.0% in 2016 (GHS, 2017). In view of this, the private sector lags behind the public sector in terms of aggregate demand for healthcare services because of the elaborate and extensive network of infrastructure of the public sector in Ghana. Government recently for instance announced the construction of 88 district hospitals in 2020 to cater for the approximately 88 districts that are without one (Ministry of Health (MoH), 2020a). The role of the public sector healthcare systems however seems to be declining because of the eroding trust and confidence of the public in the quality and safety of care being provided in recent times (Anabila et al., 2019).

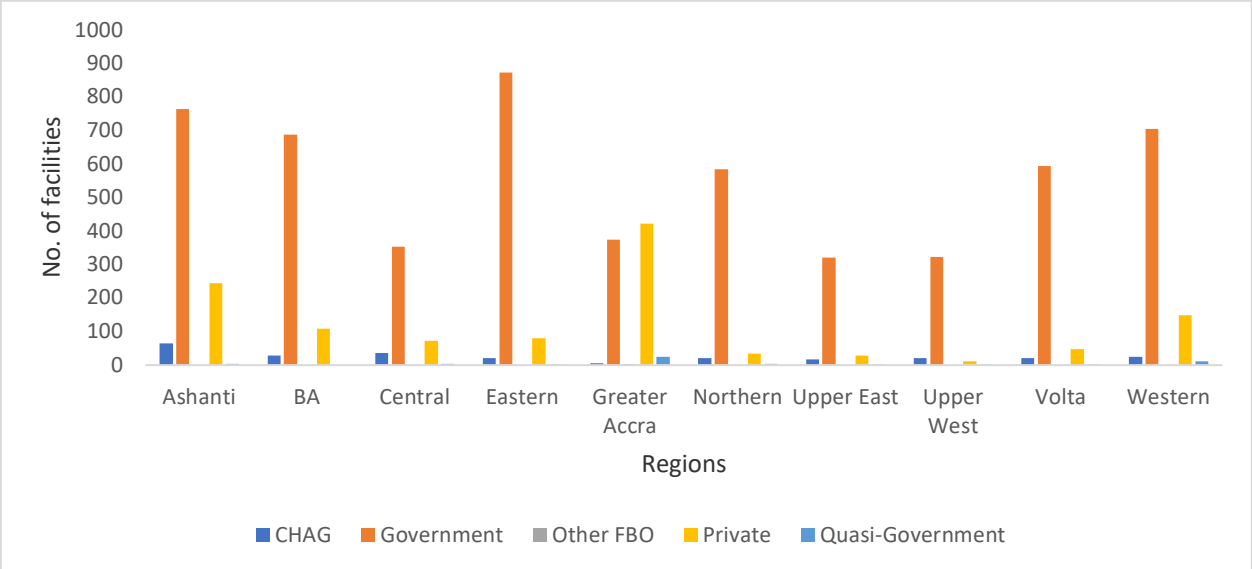


Figure 2: Distribution of health facilities by ownership in Ghana
Source: GHS Facts & Figures, 2017

It is however noteworthy that, the facilities (both public and private) are inequitably distributed across the country. Greater Accra and Ashanti regions alone have more than half (55.6%) of the total number of private (self-financing) facilities in Ghana (Figure 2). Similarly, of the total number (289) of private health facilities (self-financing) registered with the SPMDP, 60% are located in Greater Accra while the rest of the country shared the remaining 40% (Figure 2) affirming the long-held views that, private provider facilities particularly the self-financing ones are geographically located in wealthier and peri-urban areas in the country. The Ashanti Region has the highest number (15.2%) of health facilities in Ghana. It has a quarter (25%) of CHAG facilities and 13.7% of the total government facilities. The Christian Health Association of Ghana, the country's largest faith-based organization, operates 325 facilities across 33 church denominations and serves both rural populations and the urban poor (Christian Health Association of Ghana (CHAG), 2019). The country's second largest faith-based organization, Ahmadiyya Muslim Mission, operates seven hospitals that primarily serve the urban poor and are linked to Ministry of Health facilities. Faith-based organizations deliver maternal and newborn health services at the primary levels of care (Christian Health Association of Ghana (CHAG), 2019).[4] Sometimes, faith-based organizations operate the only available facilities in rural areas. While faith-based organizations like the Christian Health Association of Ghana tend to offer a full range of maternal and newborn health services, some self-financing facilities do not. Self-financing facilities tend to focus on providing antenatal care due to several reported market barriers (from the key informant interviews) that prevent them from expanding into tertiary neonatal intensive care (see Box 2).

Also, of the total number (i.e., 4051) of credentialed health facilities by the NHIA by March, 2020, a quarter (25%, 1005) are self-financing while 69% (2792) are public facilities. The FBOs constitute a little over 5% (217, 5.3%). Faith-based organizations provide the majority of Ghana's private sector health services. Self-financing private sector actors deliver about upwards of 20% of hospital care services in urban areas (World Bank, 2011), where they deliver antenatal care to predominantly middle- and high-income consumers. Again, majority of the NHIA credentialed facilities are located in Greater Accra and Ashanti regions respectively (NHIA, 2019) (Figure 3).

[4] We acknowledge the discrepancy with HeFRA data that show faith-based organizations operating at the secondary- and tertiary-levels.

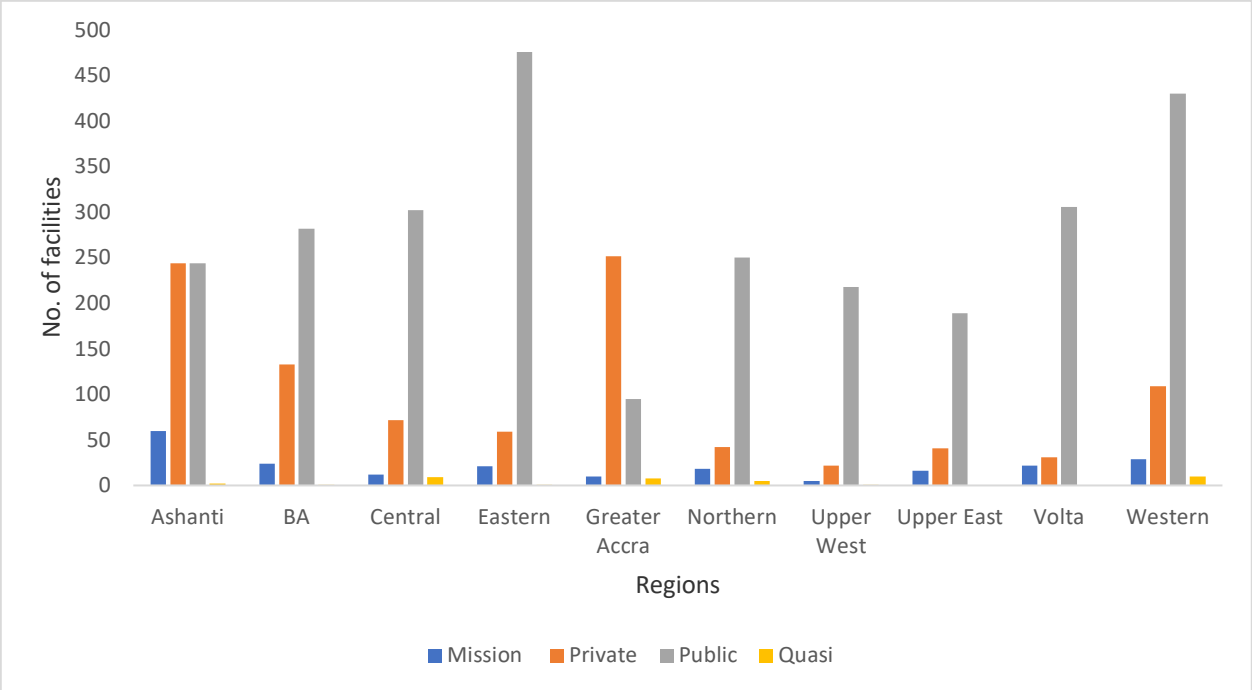


Figure 3: Distribution of NHIA Credentialed Facilities by Regions and Ownership, March 2020

Even though the private health sector in Ghana is highly patronized by the population evidenced in its size, it is insufficiently, less effectively organized and often times underutilized when it comes to accelerating the provision of the desired health outcomes consistent with the priorities of the health sector.

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 Ghana is to attain UHC.

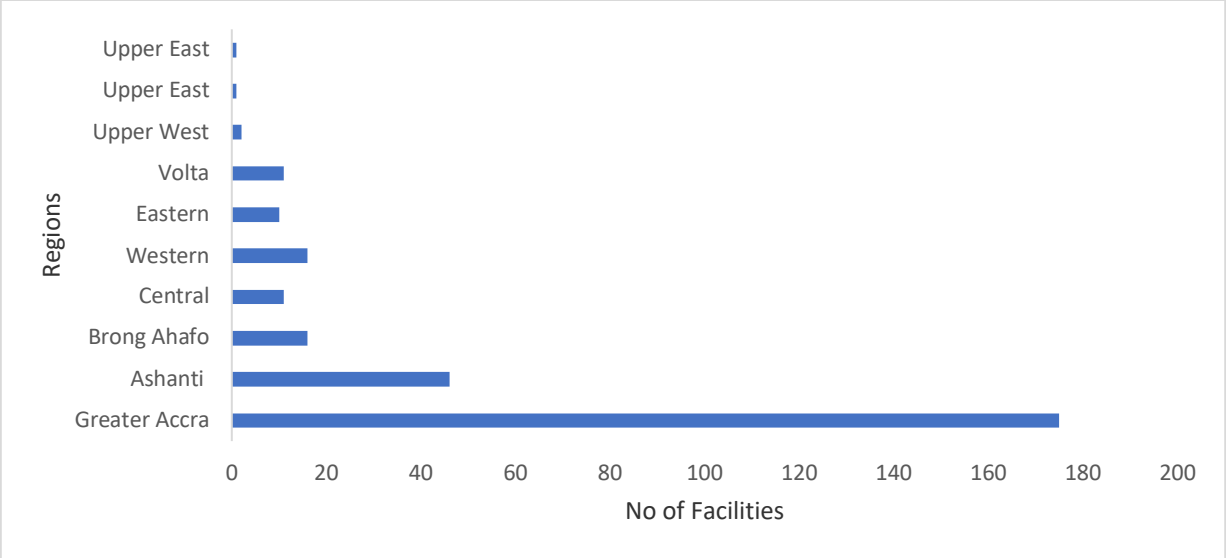


Figure 4: Distribution of SPMD Registered Private Health Facilities in Ghana, 2019

Source: SPMDP Secretariat, 2020

Box 2: In-depth interviews highlight barriers to expanding services

If someone even goes to setup a facility in a hard-to-reach area, you should even give them a 5-year tax holiday else you cannot recover your cost. If you take a facility from the bank, there is no way you can payback even in 5-years should you go into the rural areas. You get me, so that it serves as an incentive. But if you're going to from day one start servicing that facility when your business hasn't even established itself...there is no way you can do it… So that we can encourage people to go out there and do it. If the NHIS was doing what was expected of them, it wouldn't have been too much a problem but with this state of the NHIS and financing challenges, there is no incentive to go into the rural areas. Look, some years back, a proposal was made to the ministry of health to support members with funding to go into the rural areas, but it never materialized.

- Private sector respondent who delivers services at a self-financing facility

Most tertiary-level maternal and newborn health services are consolidated across a few large self-financing facilities; other maternal and newborn health services are delivered at primary-level facilities, small physician-led clinics, and maternity homes. In rural areas, self-financing maternity homes (run by midwives) provide limited maternal and newborn health services beyond antenatal care. As confirmed by the responses from key informant interviews, primary-level facilities and maternity homes in rural areas frequently refer more resource-intensive cases and neonatal intensive care cases to nearby facilities operated by the Christian Health Association of Ghana or Ghana Health Service (See Box 3).

Box 3: In-depth interviews highlight referral patterns between private sector actors for maternal and newborn health cases

Four years back, we started a series of training sessions involving our referring centres like maternity homes and clinics because of the poor quality of the referral, the need to refer and the poorly managed cases. So, after we've taken the clinic managers and the maternity homes through the training, there was a little bit of change. And after, we communicated with the regional and the municipal health director and we involved all the stakeholders to put some measures in place. Now the quality has improved […] they know how to do it because of the rapport we have developed between the facility and the districts. At times we also send our ambulance to convey the client from the clinic to the hospital. So, those kinds of measures are in place to address the challenge [of maternal deaths].

- Private sector respondent who delivers services at a facility operated by a Faith-Based Organization

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

Overall, the demand for maternal and newborn health services in Ghana is increasing across all public and private sector providers. Respondents from public facilities in urban areas validated this finding and indicated being overburdened by delivery demands, long wait times, and insufficient resources to cater to the growing demand (see Box 4).

Box 4: In-depth interviews amongst the public sector confirm challenges catering to growing demand

…we are overwhelmed with numbers at any point in time. And so, people in order not to come and wait endlessly, they will go to the private sector.

- Public sector respondent who delivers services at a teaching hospital

Labour/delivery services are largely provided by the public sector, leading to high caseload in these facilities, which is in turn a major threat to quality care. […] The private sector can share the burden of caseload, especially in metropolitan areas of the country.

- Public sector respondent who works in policy/administration

Recent consumer surveys [24] and interview respondents indicated that consumers of health services–across all socioeconomic levels, geography, and sexes–choose private providers half of the time, although this choice varies by the type of private provider. Surveys show that self-financing facilities as well as not for-profit private sector facilities serve consumers of all socio-economic levels; that trend has remained relatively unchanged with the advent and increasing coverage of the National Health Insurance Scheme [24]. A more recent secondary analysis of the Demographic and Health Survey focused on choice of provider for maternal health services. The survey demonstrated that consumers in the highest income quintiles chose private sector providers for family planning, antenatal care, and deliveries more often than those in the lower income quintiles (GFF, 2019).

The following results from a secondary analysis of the 2014 Demographic and Health Survey, sponsored by the Global Financing Facility (GFF, 2019), help illustrate consumer use of private providers for key maternal health services:

- **Antenatal care:** From 2008-2014, 87% of women in Ghana with a live birth attended at least four antenatal care visits at a health facility during pregnancy (see Figure 5). Among women accessing antenatal services, 11% accessed services through the private sector. This figure is higher than rates recorded for neighbouring countries (Burkina Faso 1%, Ivory Coast 8%). Other countries in the Economic Community of West African States also recorded a mix of higher and lower rates of private sector use (Nigeria 22%, Gambia 7%).

  In rural areas, 6% of women accessing antenatal services in Ghana used the private sector, while in urban areas, 16% accessed services through the private sector (see Figure 5). Among the lowest wealth quintile, less than 3% of women accessing antenatal services used private sector facilities, while among the highest wealth quintile, 24% accessed services through the private sector. Almost all women (84%) that used the private sector for antenatal services used hospitals/clinics, while 12% used mobile clinics.

- **Institutional deliveries:** From 2008-2014, 73% of live births in Ghana were delivered in a health facility. Of these births, 11% were delivered in private sector facilities. This figure is higher than rates recorded for neighbouring countries (Burkina Faso 1%, Ivory Coast 8%). Other countries in the Economic Community of West African States also recorded a mix of higher and similar rates of private sector use (Nigeria 36%, Gambia 11%).

In rural areas, 6% of women accessing antenatal services used the private sector, while 15% used private sector facilities in urban areas. Among the lowest quintile, 3% of women accessed services through the private sector, while among the highest wealth quintile, 21% accessed services through the private sector (see Figure 5). Almost all women (89%) that used the private sector for delivery services used hospitals/clinics, while 8% used mobile clinics.

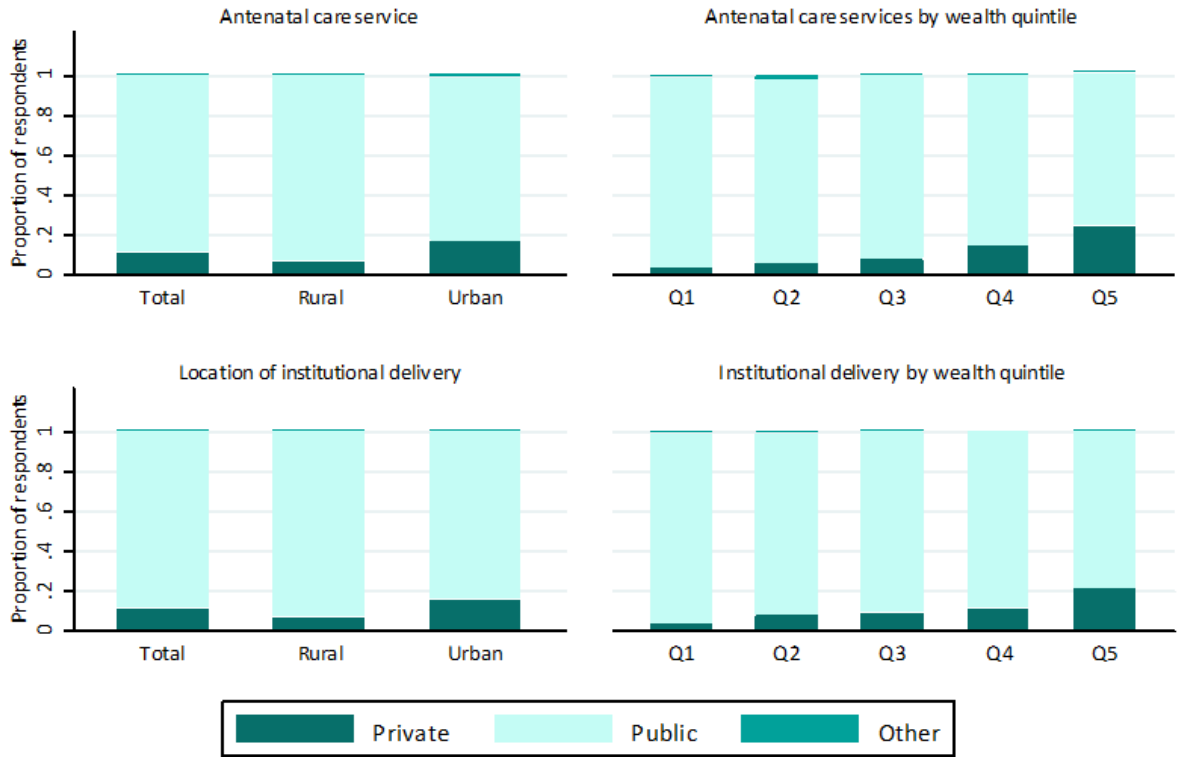


Figure 5. Source of private sector antenatal care and maternity services

Focus group respondents from these consumer surveys identified perceived quality of care as the most important factor in choosing the type of facility to go to for care. Consumers report choosing self-financing providers for quality services, customer service, and short waits [24]. Respondents also confirmed these factors in the key informant interviews (see Box 5). Quality, however, is generally perceived to be different by medical specialty, level of care, and type of disease (see Box 6).

Box 5: In-depth interview participants discuss reasons for choosing private providers

…you will take Greater Accra, for example. Most people that think they have ability to pay even if they are sick, unless that it is recommended, they will want to choose a private facility because they don't want to spend time or because they can book an appointment and you go, the thing is ready for you.

- Private sector respondent who works in service delivery at a self-financing facility

Box 6: In-depth interview participants highlight quality of private sector care

Private sector is not well resourced to provide newborn care, while maternal is not of bad quality… Without hesitating, I think that for maternal [health care], we are not bad because almost a lot of the gynaecologists are in private practice; again, that is affordability... I will hesitate to say that for neonates and simply because of the scope of OPD [outpatient department] because most of them, when the baby is born and there is an issue, they are referring [the case] and most of the facilities may not be equipped to have paediatricians or neonatologists or whatever on site.

- Private sector respondent who works in service delivery at a self-financing facility

For reproductive health services, consumers may choose private facilities for the quality of the client-provider relationship (interpersonal aspects of care), treatment effectiveness, short wait times, facility cleanliness, and continuity of care (i.e., seeing the same providers for antenatal care, delivery, and postpartum care) (Sieverding et al., 2015). Other secondary- and tertiary-level facilities are perceived to provide services of generally good quality. However, due largely to private facilities' challenge recruiting and retaining certain specialists, this perception is less so for specialized and emergency care services like complicated deliveries and neonatal intensive care.

5.1.3 Inputs

This section focuses on findings related to the first pillar of our logic model: inputs (see Figure 1).

5.1.3.1 Policies, strategies and plans related to MNH, quality of care and the private sector

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. The policies have also sought to improve the quality and care outcomes, increase access and utilization of health services. Some of these policies include: the National Health Policy (2007, 2020), the Private Sector Development Strategy I&II (2004; 2009), the National Public-Private-Partnership Policy Framework (2011), the Private Health Sector Development Policy (2003; 2013), the Child Health Policy (2007-2015), the National Newborn Health Strategy and Action Plan (2014-2018) and the Ghana MDG Acceleration Framework (MAF) (2015).

The National Health Policy (2007; 2020) 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). In January, 2020, a new National Health Policy was developed drawing on Article 34 of the 1992 constitution which requires the state to "ensure the realization of the right to good healthcare for people living in Ghana

irrespective of their color, race, geographical location, religion, and political affiliation" (Ministry of Health (MoH), 2020; pg.16). As a goal, the policy seeks to facilitate the promotion, restoration and maintenance of "good health for all people living in Ghana" (Ministry of Health (MoH), 2020; pg.16). The policy is guided by 5 main policy objectives with one of the key strategies being to facilitate the establishment of a mutually beneficial public-private relationship. This is very necessary because of the pluralistic nature of the healthcare system of Ghana and the need to foster the necessary synergy to accelerate improvement in care outcomes. In view of this, the policy indicates that: "*the healthcare delivery system, at all levels, will work in formal strategic partnerships with the local government systems as well as* ***private sector stakeholders*** *(CSOs, health and non-health industry players). Pluralism in service delivery will be encouraged and supported*" (Ministry of Health (MoH), 2020; pg.23 italics & bold added). Strategic partnerships with "non-state actor (CSOs, industry, development partners, FBOs, etc)" in all its forms" is identified as one of the five guiding principles and recognized as key to ensure the delivery of the necessary health and wellness interventions for the people (Ministry of Health (MoH), 2020; pg.17).

As a way of strengthening healthcare delivery and ensuring resilience, the Ghana National Health Policy seeks to ensure that: "services will be delivered, through an enhanced coordinated network of facilities (CHPS compounds, health centers and hospitals etc), both public and private, that collectively provides the appropriate package of healthcare services (preventive, promotive, curative, rehabilitative and palliative using a life-course approach) to the population". Furthermore, it seeks to ensure that, "a robust and sustainable [culture of quality] is institutionalized in the healthcare delivery system with clear measurable standards in terms of safety, timeliness, efficiency, effectiveness, equity and patient-centeredness" (Ministry of Health (MoH), 2020; pg.17-18).

The National Newborn Health Strategy and Action Plan (2014-2018) is one of the first and few sector specific policies and strategies that focuses on improving newborn outcomes in Ghana. The strategy has the goal of "reducing neonatal mortality from 32 per 1000 live births in 2011 to 21 per 1000 live births in 2018 and to also reduce institutional neonatal mortality by at least 35% by 2018" (Ghana National Newborn Health Strategy & Action Plan, 2014-2018; pg. 38). Unfortunately, this goal is yet to be achieved. The neonatal mortality rate in 2017 was estimated as 25 per 1000 live births (Ghana Statistical Service, Ministry of Health, 2017). The priority areas of this strategy include ensuring that every newborn receives basic preventive care and are also prevented from dying from any of the 3 major causes of newborn deaths which include complications of prematurity and low birth weight, adverse intrapartum events such as birth asphyxia and infections. The policy, as part of the process of ensuring successful attainment of the goals envisions the constitution of a national sub-committee for newborn care (SCNC). The membership of this committee did not however include representation from the self-financing private sector though it acknowledges the need for an expansion. There is however an acknowledgement of the need to bring the private sector fully on board and provide them with the needed support to facilitate the attainment of the newborn outcomes. This is evidenced in one of the key strategies in the plan as "strengthening public-private partnerships" (Ghana National Newborn Health Strategy & Action Plan, 2014-2018; pg. 50). Incidentally, a new National Newborn Health Strategy and Action Plan (2019-2023) have been developed to consolidate the gains made in the past. This new strategy seeks to further reduce the NMR from "25 per 1000 live births in 2017 to 18 per 1000 live births in 2023

(5%/year)" (Ministry of Health (MoH), 2020a; pg.30). It is noteworthy that, this strategy identifies the inadequate involvement of private health sector facilities and other key stakeholders such as obstetricians; inadequate data capture from the private sector, some teaching hospitals and FBOs; as well as "inadequate investment by the private sector due to weak resource mobilization"(Ministry of Health (MoH), 2020a; pg.15) as some of the key bottlenecks that made it impossible to attain the desired outcomes in the first strategy (2014-2018). In view of this, one of the main guiding principles of the strategy is to foster strong partnerships "including public-private ones" at all levels and with all stakeholders (Ministry of Health (MoH), 2020a; pg. 34). One of the strategies is also to "strengthen inclusive partnership, including public-private partnerships" (Ministry of Health (MoH), 2020a; pg. 35). The new strategy has further made improvement in the "quality of newborn care" at the facility level and "to promote more holistic care for newborns" as its focus (pg. 19). One of the desirables is to see to it that, "at least 75% of all healthcare facilities provide the required compassionate, quality package of healthcare services…" (pg. 30).

The Private Health Sector Development Policy which was developed in 2003 and 2013 specifically looks at the 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.

Maternal mortality is an important indicator for measuring the socio-economic conditions of women and girls, and the strength of the health system with respect to access (cost and geography) and the availability of health infrastructure for the prevention of maternal mortality (Beyai et al., 2013). In 2010, the MoH and its agencies in collaboration with its development partners developed the MAF strategy and operational plan as a national response to towards the MDG 5 by 2015. The aim of the strategy was to "augment implementation of the maternal and child health program with the objective of attaining the MDG indicators and targets" (Ghana Ministry of Health, 2014; pg. 6). It focused on improving maternal health at the community and institutional levels "using evidence-based, feasible and cost-effective interventions in order to achieve accelerated reduction in maternal and newborn deaths. [The strategy focused on 3 key priority interventions which included] improving family planning, skilled delivery and emergency obstetric and newborn care" (Ghana Ministry of Health, 2014; pg. 6) and assumed that "EmONC and child spacing will have a strong impact on neonatal and infant mortality. Unfortunately, and inspite of the huge investments, Ghana could not achieve the MDG 5 targets of halving its maternal mortality from 380 per 100,000 live births (in 2013) to 190 per 100,000 live births (by 2015) (Beyai et al., 2013; Ghana Statistical Service, Ministry of Health, 2017; HeFRA, 2019). It is noteworthy that, other than CHAG, the self-financing private sector was completely missing in the MAF implementation efforts in the country. There was no mention of them in the 2015 National Strategy and Operational Plan (HeFRA, 2019).

5.1.3.2 Leadership and governance

Leadership, governance and management is a key health system priority area in Ghana. The Ministry of Health provides the overall leadership, direction and high-level planning for the health sector in Ghana. It is also responsible for developing national policies, strategies and priorities across the entire health sector (i.e. public, private, development partners, FBOs/NGOs and health-related agencies). One of the key strategic objectives of the NHQS (2016) is to *"create a sustainable leadership and governance for quality planning, quality control and quality improvement at all levels of the healthcare system"* (Ministry of Health (MoH) Ghana, 2016 pg.20). Leadership in the areas of quality improvement and quality assurance are led by the service delivery agencies notably the Ghana Health Service, Teaching Hospitals, FBOs and the self-financing private sector. Leadership of the health sector is seen across the various levels of the healthcare delivery system i.e. national, regional and district respectively. Regional and District Health Directorates are responsible for the provision of quality and safe care at those respective levels.

The self-financing private health sector is highly fragmented, with most of the facilities being sole proprietors and often made up of private medical practitioners. The MoH established the Private Health Sector Alliance of Ghana (PHSAG) as a coordination platform to bring all the self-financing private sector actors to the table. Unfortunately, this did not see the light of day because of suspicion and the lack of or inadequate consultation among the stakeholders in the private sector space (Thomas et al., 2016). The self-financing private health sector is often characterized by poor management capacity, inadequate quality assurance/improvement, and inadequate access to finance which often leads to unsustainable business performance and poor patient outcomes similar to the situation in Nigeria (Makinen et al., 2011; National Academies of Sciences, Engineering, 2018). There are currently different private health provider associations in Ghana which include the Society for Private Medical and Dental Practice (SPMDP) whose membership is made up of medical practitioners; the Responsive Healthcare Service Providers Association of Ghana (ROPHESPAG) consisting of pharmaceutical companies and outlets, hospitals, clinics, maternity homes, and investigations and images companies in Ghana; the Private Health Providers Association of Ghana (PHFAG) (Nyabor, 2019) and the Health Insurance Service Providers Association (GhanaWeb, 2020a). Of these, the Ministry of Health recognizes and works with the SPMDP. Unlike the Christian Health Association of Ghana (CHAG) which is a network of 325 health facilities owned by 33 Christian denominations in Ghana. For CHAG, this is recognized as one of its key strengths- diversity of its membership! CHAG is recognized as an agency and an implementing partner of the ministry of health but is an advocate and takes independent position on issues in the health sector (Christian Health Association of Ghana (CHAG), 2019). CHAG has an Executive Secretariat tasked to represent the interest of its network and support its members to achieve the stated goals and objectives.

Unfortunately, these splinters and varied associations representing the private health sector in Ghana often times makes it difficult for the sector to harness its full potential and contribute meaningfully to the development and influence the implementation of the appropriate policies and strategies that would inure to the benefit of the health sector of the country.

Quality of care outcomes such as mortality, average length of stay, high organizational culture and patient satisfaction can greatly be improved with effective leadership (Sfantou et al., 2017). Leadership failings have been cited in the occurrence of many poor outcomes of care that occur in healthcare environments/settings (Lee & Scott, 2016; Neale et al., 2001; Otchi et al., 2019). Similarly, Brown (2019) noted that, the failings of healthcare governing boards and senior management to provide the requisite oversight, guidance and to respond promptly to quality and patient safety issues are a major factor that contributes to the occurrence of preventable adverse events (Brown, 2019).

5.1.3.3 Regulatory and legal framework related to maternal and newborn health, quality of care, and the private sector

Regulatory activities in Ghana's health sector focuses 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" (Health Institutions Act 829 Facilities Act , 2011 Act 829 Health Institutions and Facilities, 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).

Regulation of the health sector in Ghana include facility licensing before they are opened by the HeFRA and credentialing and/or provider certification or accreditation by the various professional regulatory councils and the National Health Insurance Authority (NHIA) for health facilities that would like to provide healthcare to health insurance (for both public and private) card holders. This NHIA role was changed by Act 852, the National Health Insurance Act, 2012 to "grant credentials to healthcare providers and facilities that provide healthcare

services to members of the National Health Insurance Scheme" (National Health Insurance Act, 2012, Act 852; pg. 7). The standards from HeFRA are the minimum national standards any health facility (public or private) has to meet before the commencement of the provision of healthcare service.

The question that is often asked however is, what is the right regulatory 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). Unfortunately, the regulatory institutions in Ghana are weak in their ability to enforce their required mandate. This is even deepened by the various independent Acts that establishes or creates them, the absence of a visible cross-collaboration and synergies that should have existed coupled with very little influence from the MoH. The regulatory agencies are therefore operating more in silos making it difficult for the health sector to derive the required maximum benefit from its regulatory efforts. Similarly, there have been weaknesses in the MoH's own capacity to facilitate the development of effective and appropriate legislation to ensure the regulation of professionals and their practice (NHP, 2020). In Ghana however, there are capacity and resource-related limitations of regulatory bodies to accredit, license, renew, monitor, supervise, enforce and provide technical support. HeFRA, the institution legally clothed with this mandate was able to license only 724 facilities and also registered 614 facilities in 2018 out of the over 4000 health facilities scattered all over the country. They (i.e. HeFRA) indicated that, this was mainly due to their inability to locate some of the facilities and inadequate capacity in the areas of staffing and equipment (HeFRA, 2019). This raises further concerns about the extent of collaboration between the agencies particularly between HeFRA and the regional/district health directorates of the GHS who have primary jurisdiction!

Further, 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.

Nationally, several technical working groups and steering committees provide regulatory input and guidance related to quality of care and maternal and newborn health services. The National Health Care Quality Strategy, for instance, sets quality key performance indicators and promotes hospital scorecards; however, participation from self-financing facilities is limited due to overall lack of trust, not understanding "profit", and fragmentation of self-financing providers that makes it difficult for the public sector to reach out and engage. Most participation from the private sector comes from the Christian Health Association of Ghana (Yeboah and Buckle, 2017). The effectiveness of these platforms for quality assurance is limited, in part due to fragmentation of the private sector.

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 et al., 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 and could include the use of incentives and/or penalties to ensure compliance with the defined standards governing the quality and safety of healthcare services. 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.

Like many countries in the Network, Ghana uses a web-based national database (District Health Information Management System 2-DHIMS2) for aggregate reporting from paper-based registers in health facilities. 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. Evidence suggest for instance that, hospital boards and management that spend majority of their time to review their data and "quality performance measures [or indicators] using dashboards or balanced scorecards" and also spend a lot of time to discuss quality and patient safety related issues during their board meetings often record improved care outcomes than those who do not (Brown, 2019; pg.2). Ghana, like many countries in the WHO QoC 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 of their data to the MoH, this rarely happens. The reason for this failure is sometimes due to the MoH's inadequate enforcement of its own 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) and goes a long way to increase the degree of variation in data reporting and presentation making it imperative to institute clinical and internal audits to determine the issues. Occasionally however, 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).

Private facilities are required to submit reports and feedback to the Ministry of Health as part of this system, but reporting remains low due to several challenges/barriers to reporting that are investigated as part of the primary data collection for this research.

5.1.4 Outputs

This section focuses on findings related to the third pillar of our logic model: outputs (see Figure 1).

5.1.4.1 Readiness of private providers for the provision of quality MNH services

The self-financing private sector provides a parallel but an expensive alternative to the public sector. They are however 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 like CHAG 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 and the Ahmadiyya Muslim mission are the few private sector players that are supported financially by the government. These 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(CHAG, 2019). 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 including Ahmadiyya and until recently the Ghana Association of Quasi Healthcare Institutions (Makinen et al., 2011; MoH, 2013) there are capacity and resource-related limitations of regulatory bodies to accredit, license, renew, monitor, supervise, enforce and provide technical support.

The NHIS is a social intervention program that seeks to ensure financial access to quality and safe care including MNH. 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(NHIA, 2019). Unlike the not-for profit private sector like the CHAG, 88% and 83% of their outpatients and inpatients are all insured clients (Christian Health Association of Ghana (CHAG), 2019). NHIS reimbursements accounts for a greater percentage of the source of funding for health facilities both public and private. Reimbursements from the NHIA accounted for 51%, 71% and 49% of all funds in private and maternity clinics, and public facilities in 2011 (Institute for Health Metrics and Evaluation (IHME), 2015). Incidentally, this was the same time around which Ghana introduced its Free Maternal Healthcare Policy. Generally, claims payment by the NHIS had seen a considerable decline from GHS890.44 million in 2014 to GHS855.03 million in 2016; and a 0.3% decline from GHS1143.47 million in 2017 to GHS1140.00 million in 2018. There was however an increase in 2017 (1143.47 million) because of the payment of arears to providers in order to ensure the restoration of confidence in the scheme(NHIA, 2019).

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. The tariffs for private self-financing facilities are slightly higher than the government and FBOs. However, private providers continue to express frustrations with the NHIS because of delayed reimbursements, incomplete credentialing (Makinen et al., 2011), unrealistic tariffs and political interference. The NHIA owes providers between 9 to 14 months contrary to the statutory 90 days within which they (NHIA) are supposed to have made claim payments or reimbursements. The Private Health Providers Association and the Health Insurance Service Providers Association of Ghana whose members are owed threatened the commencement of the dreaded “cash & carry” system in their facilities because of the increasing debts and their inability to purchase medicines and commodities to provide quality healthcare to their clients (GhanaWeb, 2020a).

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 public hospital was convicted and sentenced to 10 years in prison for defrauding the NHIS to the tune of 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 make informal payments to access care that have in many instances resulted in bad outcomes (National Academies of Sciences, Engineering, 2018).

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. Evidence suggest for instance that, hospital boards and management that spend majority of their time to review their data and "quality performance measures [or indicators] using dashboards or balanced scorecards" and also spend a lot of time to discuss quality and patient safety related issues during their board meetings often record improved care outcomes than those who do not (Brown, 2019; pg.2). Ghana, like many countries in the WHO QoC 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 of their data to the MoH, this rarely happens. The reason for this failure is sometimes due to the MoH's inadequate enforcement of its own 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) and goes a long way to increase the degree of variation in data reporting and presentation making it imperative to institute clinical and internal audits to determine the issues. Occasionally however, 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).

5.1.4.2 Access to and availability of quality MNH

Prior to the Alma Atta declaration in 1978, a strategy of health service delivery that used the services of Community Health Workers also referred to as Traditional Birth Attendants (TBAs) and Community Clinic Attendants worked to ensure improved service delivery outcomes at the community level in 1977 (Ministry of Health (MoH), 2016). Ghana is using the CHPS concept as a vehicle to accelerate its efforts at attaining quality UHC. The CHPS concept is a national mechanism for delivering "essential community-based health services involving planning and service delivery with the communities" (Ministry of Health (MoH), 2016; pg.13). Its primary aim is to accelerate the attainment of "reaching every community with a basic package of essential health services [including MNH] towards attaining UHC and bridging the

access inequity gap by 2020" (Ministry of Health (MoH), 2016; pg.13). The program has been touted as one of the key mechanisms in ensuring that the community become involved in and own all the primary healthcare interventions to ensure the attainment of UHC. It has been found that, maternal and newborn outcomes could be greatly improved if access to quality primary healthcare services that is clinically effective and affordable is pursued(Sheff et al., 2020).

The CHPS concept was to help improve geographical access and "make basic services available "close to the client"" (Ministry of Health (MoH), 2016;pg.16) while the NHIS was to improve financial access. Ghana is the first country in sub-Sahara Africa to have established such a large health insurance scheme with the requisite financial protection safeguards as a mechanism to attain UHC (Bonfrer et al., 2016). The NHIS was "to provide access to care irrespective of one's ability to pay for certain services" (MOH Ghana, 2018). The goal of the scheme is "to attain universal health insurance coverage for all persons resident in and or visiting Ghana in an equitable manner; and to provide them with access to quality healthcare services" (NHIA, 2019;pg.12). Ghana's national health insurance scheme has evolved from a district mutual health insurance in 2011 to a national health insurance scheme through the passage of Act 654. 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).

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 et al., 2017; Wang et al., 2017). The Free Maternal Healthcare aimed at increasing access of pregnant women to skilled birth attendants and facility deliveries. Prior to the implementation of this policy in 2008, Ghana's maternal mortality rate was greater than 400 deaths per 100,000 live births (WHO, UNICEF, UNFPA, 2019). This policy took away all related costs with intrapartum care in public and private facilities. This initiative has since been rolled unto the NHIA as one of its benefit packages(Institute for Health Metrics and Evaluation (IHME), 2015; MOH, 2014). Some self-financing private sector players end up charging insured clients additional fees (Makinen et al., 2011, pg. 59; Ministry of Finance (MoFEP), 2011; MoH, 2013).

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). In Ghana for instance, the private sector health services are still characterized by out-of-pocket payment at the point of service (University of Ghana, 2018). The NHIA has a very generous exemption regime that includes SSNIT pensioners, children below the age of 18-year, pregnant women, indigents and SSNIT contributors. Pregnant women (7.1%), children below 18 (47.0%) and indigents (3.7%) altogether constitute more than half (57.8%) of the exemption's category of the scheme (MOH Ghana, 2018; NHIA, 2019). Since the introduction of the duo, there have been significant gains and impacts made even though a lot more still needs to be done. CHPS contributed about 5% of the total OPD attendance nationwide while that of insured clients also increased from 55.8% in 2010 to 82.1% in 2011 (Ministry of Health (MoH), 2016). In 2018, 27.55million and 1.65million outpatient and inpatient visits were with national health insurance (NHIA, 2019). There has been modest improvement in ANC coverage by skilled providers from 96% in 2007 to 98% in 2017 (GHS, 2017) while the rate of skilled delivery has also improved by 44% from 55% in 2007 to 79% in 2017 (Ministry of Health (MoH), 2020b). However, the regional data in some parts of the country like the Volta region leaves much to be desired. A health facility assessment conducted in July, 2018 by Sheff et al. (2020) showed that, less than 20% (i.e., 16.9%) of women with children aged 12-23months had a valid NHIS even though 86% of them had indicated in the survey that they had ever registered as members of the scheme. The total sample size used in the assessment were 11,201 women (Sheff et al., 2020). Findings from the Demographic and Health Survey show that four-fifths of women aged 15-49 years are registered with any insurance, but less than half (i.e. 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).

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). It is interesting to note however that, the percentage of women who delivered at home (20.1%) was higher than those who delivered in any private healthcare facility (11.2%). Comparatively, more doctors provide assistance during deliveries in private health facilities than in public facilities. For instance, according to the 2017 Ghana MHS, 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). 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). It noteworthy that, more nurses/midwives conduct deliveries in public health facilities than in private health facilities unlike in the case of doctors. In private facilities, cesarean section (C/S) 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). For instance in the CHAG Network, the C/S rate was 23.2% out of a total of 143,242 supervised deliveries in 2018, and this is higher than the national target of 6.5% and the WHO rate of 10%-15%(Christian Health Association of Ghana (CHAG), 2019). 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).

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). 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 Statistical Service, Ministry of Health, 2014, 2017).

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). 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 Statistical Service, Ministry of Health, 2014).

5.1.5 Outcomes

This section focuses on findings related to the fourth pillar of our logic model: outcomes (see Figure 1).

5.1.5.1 Quality of care, quality maternal and newborn care

Improving service quality have become a strong desire over the recent decade because of the intense competition between public and private healthcare service providers (Anabila et al., 2019). There is a vast difference between the quality of service provided by the public and private sectors in Ghana. One would have expected a convergence in the quality of healthcare services between private and public health facilities because of the reliance on the same healthcare providers for service provision but this is not so. 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.

The issues of quality in healthcare are probably more important than in other sectors mostly because of the harm and other adverse events that are caused. There is a general consensus that the provision of quality healthcare has the potential of improving the safety, clinical effectiveness and health outcomes (World Health Organization (WHO), 2016). Unfortunately, however, investments and interventions aimed at improving quality of care outcomes over the years have been directed towards disease-specific other than facilitating institutionalization and sustainability of strengthened health systems. QoC is perceived more as a resource (equipment, supplies, numbers and competency of staffs) that is either available or no other than a health system issue (Kruk et al., 2018; Mwaniki et al., 2016). Healthcare quality is the "degree to which healthcare services for individuals and the population increases the likelihood of desired health outcomes and is consistent with current professional knowledge"(IOM, 2001;pg.44). Six dimensions of healthcare defines its quality—safety *(ensuring that patients are not harmed "from the care that is intended to help them")*; timeliness, accessibility and affordability *("reducing unwanted waits and harmful delays for both those who receive and those who give care; reducing access barriers and financial risk for patients, families, and communities; and promoting care that is affordable for the system")*; equity *(ensuring that the care that is being provided does not discriminate or vary on the basis of "gender, ethnicity, race, socioeconomic status and geographic location")*; efficiency *("avoiding waste, including waste of equipment, supplies, ideas, and energy, and including waste resulting from poor management, fraud, corruption, and abusive practices. Existing resources should be leveraged to the greatest degree possible to finance services")*; effectiveness *("providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit (that is, avoiding both overuse of inappropriate care and underuse of effective care")* and person-centeredness *("providing care that is respectful of and responsive to individual preferences, needs, and values and ensuring that people's values guide all clinical decisions. Care transitions and coordination should not be centered on health care providers, but on recipients")* (National Academies of Sciences, Engineering, 2018; pg.43). Parasuraman et al. (1988) also identified reliability, assurance, tangibles, empathy and reliability as service quality indicators which have been used extensively in other organizations including healthcare. In 2017 Ghana made a firm statement to improve its quality of care outcomes through the development and subsequent implementation of its National Healthcare Quality Strategy (NHQS) in 2016 with the goal *"to continuously improve the health and well-being of Ghanaians through the development of a better coordinated health system that places and communities at the center of quality care"* (Ministry of Health (MoH) Ghana, 2016; pg.19).

Healthcare quality is defined in Ghana as "the degree to which healthcare interventions are in accordance with standards and are safe, efficient, effective, timely, equitable, accessible, client-centred, apply appropriate technology and result in positive health outcomes, provided by an empowered workforce in an enabling environment" (Ministry of Health (MoH) Ghana, 2016; pg.4).

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).

Prior to this national coordinated quality effort, there had been efforts by individual institutions public and private alike to improve their quality of care outcomes. The GHS which is the largest provider of public health services had developed a Quality Assurance Strategic Plan (2007-2011) to guide its quality efforts. It had also established a quality assurance unit within its institutional care division (ICD) to provide the necessary coordination and oversight of its quality management program such as the development of standards, protocols and guidelines; development of the Patient's Charter; and training and capacity building of its personnel in the concepts of quality and patient safety (Ministry of Health (MoH) Ghana, 2016). Currently, they have signed an MoU with the Africa Institute of Healthcare Quality Safety and Accreditation (AfIHQSA) to support their quality efforts in the next 5-years. Similarly, the Faith-based organizations had also made efforts at improving their quality of care outcomes. The faith-based organizations particularly the Christian Health Association of Ghana (CHAG) had in the recent past received direct support from the Institute of Healthcare Improvement (IHI) through its Project Five's Alive. It has recently, further signed an MoU with Pharmaccess Foundation to adopt its SafeCare program as a way of improving the quality of care within the CHAG network. Efforts by the self-financing private sector have mostly been at the individual facility levels even though efforts by their umbrella organizations such as the Society of Private Medical and Dental Practitioners (SPMDP) and the Community Practice Pharmacists Association (CPPA) through the Medicines Transparency Alliance (MeTA) project started in 2009 saw some modest gains and improvement in the areas of capacity building for medicines and therapeutic committees, formulation of effective medicines pricing policy, governance and transparency across the supply chain of medicines among others (World Health Organization (WHO), 2016). A study of 240 facilities across the country in 2015 by the GHS showed that the private sector is the main source of procurement of medicines for both public and private healthcare facilities (Aikins & A, 2017).

The quality of healthcare service received by patients have also been brought to the fore by some authors. Service users have expressed disgust both in public and private facilities alike but have been more abhorrent about the service quality received in public than private facilities. Kodom et al (2019) noted that patients with health insurance cards often make additional payment especially for their medication, diagnostics and imaging services before they could be accessed. They add that, "the NHIS did not cover medications for those who attended a private hospital" (Kodom et al., 2019; pg.576).

Unfortunately, it does not look like the quality of care particularly maternal and newborn is also as desired by the populace. For instance, the percentage of mothers who initiate breastfeeding within 1 hour of birth have seen a decline from 97.4% in 2014 to 92.9% in 2018 while exclusive breastfeeding has also declined from 80% in 2016 to 60% in 2018 (Ministry of Health (MoH), 2020b). There have been growing concerns and public outcry over some bad care outcomes some of which have resulted in legal suits that have been reported in the media. These concerns affect both the public and the private health sectors alike. A study that estimated the prevalence of adverse events among obstetric clients in a large secondary referral facility found that 12% of obstetric clients were harmed while seeking care (Otchi et al., 2019) similar to findings in the Iberoamerican study where 10.5% prevalence was estimated in 58 hospitals across 5 countries in Latin America (Aranaz-Andrés et al., 2011), 11.8% among 64,917 Swedish patients from 2013 to 2016 (Nilsson et al., 2018) and 12.8% among 4 general hospitals in Brazil (Mendes et al., 2018). Comparatively, adverse events in LMICs is higher than those in HICs even though their (HICs) quality of care equally leaves much to be desired (National Academies of Sciences, Engineering, 2018). A public hospital was sued by a husband who alleged that the pregnant wife died after the administration of a wrong medication. According to his account, he also observed nurses "laughing heartily" in the midst of his predicament even as one of the doctors was heard scolding his colleague "I can't believe you have done this again. This is the second time. This woman's case is similar to the other one but you have done it again" (Myjoyonline, 2020). In another related story, the same facility is accused of leaving a "huge towel in [the] tummy [of a pregnant woman] for nine months" after delivering the victim (a woman) of her baby via a caesarean section in 2015. According to the account of the victim, her situation was only noted after an X-ray and the item was subsequently removed via another surgical procedure (GhanaWeb, 2020b). In a similar incident in another public facility, a surgical towel was left in the abdomen of a young woman after a cesarean section for more than a year resulting in complications of bareness (Boateng, 2016). In 2018, it was also reported that, a 30-year old pregnant woman had died together with his unborn baby in a public health facility because he could not raise five hundred Ghana Cedis (GHS500) "motivation fee" demanded by a doctor before a cesarean section was performed in 2018. According to the spouse, the wife's delivery time had elapsed for seven days and had to wait for more than hours in a wheelchair till her condition deteriorated (GhanaWeb, 2018). Similarly, a doctor in a private facility was alleged to have "pulled the plug from [an] oxygen machine because of the inability of their parent to pay GHS533 or about $122 to keep their [9-week old baby alive] (Annor, 2018). In 2015, a 34-year woman also died in a private hospital after a fertility surgery (i.e. laparoscopic endometrioma surgery) aimed at helping the victim to become pregnant and give birth ended sadly (Daily Graphic, 2015). These and many other stories seem to affirm suggested inadequacies in the provision of quality and safe maternal and newborn care in Ghana and other developing countries.

An assessment of the structural capacity of 64 health facilities (51 public and 13 private) that performed deliveries in the Brong Ahafo region of Ghana in 2012 to provide quality immediate and essential newborn care (ENC) services revealed that, private health facilities scored higher marks in the two main categories assessed i.e. structure (the characteristics of the setting in which care is provided) and the processes (i.e. the essential procedures that guides the delivery of care). Specifically, private facilities scored higher in their newborn resuscitation, care for low birth weight (LBW) babies immediate care after resuscitation and

moderately in thermal care unlike public facilities that had varied scores. Again, the private hospitals assessed lacked only one (i.e. dexamethasone) of the four lifesaving drugs similar to other public facilities. Private facilities outperformed public facilities in the area of availability of reliable electricity supply but one of them lacked a bag and mask for newborn care. The authors concluded that "unless major gaps in ENC equipment, drugs, staff, practices and skills are addressed, strategies to increase facility utilization will not achieve their potential to save newborn lives" (Vesel et al., 2013; pg.1). Similarly, a qualitative study by Kodom et al. (2019) of 56 NHIS card holders in the Greater Accra region showed that patients who used private facilities were generally satisfied with the quality of care they received than those who used public facilities. Patients who visited private facilities were generally satisfied with the structure quality indicators such as cleanliness of washrooms and housekeeping than in public health facilities similar to (Vesel et al., 2013). The study further found the private health sector to be more receptive, responsive and had shorter waiting times (2 hours at the OPD) than the public sector which are less receptive, responsive and had longer waiting times (> 5 hours). Private facilities are more consistent with ensuring availability of necessary supplies than in public facilities and have ensured improvement over the years. For instance, the availability of some selected generic medicines improved in private facilities from 18% (2001-2008) to 44% (2001-2009) while the public sector recorded declines from 45% (2001-2008) to 17.9% (2001-2009) (University of Ghana, 2018). The NHIA did a facility mapping in clinical and non-clinical health facilities in five regions (i.e. Ashanti, Central, Upper East, Upper West and Volta regions) and noticed the lack of essential equipment and inadequate human resource capacity for the provision of primary healthcare. In the Central region for instance, the assessment revealed that out of 415 clinical facilities assessed, less than 20% (18%, 75) had the full set of equipment needed for the provision of primary healthcare (NHIA, 2019). The report however does not indicate the ownership type.

A similar study in the Kassena-Nankana municipality in rural Ghana found inadequate availability of essential inputs such as equipment, infrastructure, drugs, supplies, water, electricity, emergency transport, laboratory and other diagnostic services in a public facility. The authors further noted that, the women did not have any privacy during the labor and delivery process defying a critical quality dimension of person-centeredness. The women were also subjected to out-of-pocket payment for drugs, laboratory services and the purchase of items for childbirth even though they were supposed to be covered by the free maternal health policy (Dalinjong et al., 2018). It is interesting to note however that, this situation is not any different in Senegal (Witter et al., 2009) and Ethiopia (Pearson et al., 2011). In Senegal, the authors found that the care for the pregnant women was characterized by out-of-pockets payments for gloves, transport, bed, bleach and water inspite of the implementation of a maternal fee exemption policy similar to Ghana. And peculiar to Senegal is that "complications have to be paid for on top of these basic costs" (Witter et al., 2009). The situation was no different in Ethiopia where more than half of both public and private facilities (i.e. 68%) "charged a fee for normal delivery or required women to buy supplies for normal delivery" (Pearson et al., 2011; pg311). The authors added that, "private for-profit and nonprofit facilities were more likely to charge user-fees than government facilities"(Pearson et al., 2011; pg.312). It was interesting to note that facilities that charged user fees in Ethiopia irrespective of ownership had the requisite inputs and supplies available than those that did not (Pearson et al., 2011). Patients in Ghana (Dalinjong et al., 2018) were satisfied with the quality of service while their colleagues in Senegal (Witter et al., 2009) had mixed levels of

satisfaction. However, providers in both Ghana and Senegal were dissatisfied with the quality of care being provided (Dalinjong et al., 2018; Witter et al., 2009).

A study by Duku et al. (2018) of 1903 respondents in Greater Accra and Western regions showed that respondents perceived the quality of healthcare received by health insurance clients as sub-optimal. The verdict of the uninsured and the previously insured was very unanimous on the perception of the quality of healthcare on all seven quality indicators that were assessed i.e. services provided, complaints process, provision of information, waiting time, prescribed drugs availability, treating the insured and uninsured equally, a queuing system that is fair and the overall average perception index. This is similar to the findings by Fenenga et al. (2014) who also found that individuals who were insured in Ghana were not satisfied with the same indicators Duku et al. (2018) identified (Duku et al., 2018; Fenenga et al., 2013). This means that, individuals who are insured perceive the quality of care to be poor while those who make out-of-pocket payment perceive the quality of care to be high. This is likely so because of the documentation and claims processing that is associated with the NHIS unlike the uninsured who only have to pay and receive care. So, there is no issue of increased waiting time for the individual doing out-of-pocket payment unlike the insured. Similarly, NHIS credentialed providers are reimbursed for generic other than branded drugs hence there is no incentive to procure and stock the latter leading often to "artificial shortages" which further fuels the levels of dissatisfaction among the insured. The respondents were drawn from both public and private facilities but the authors did not make any specification in their findings (Duku et al., 2018).

It is suggested that, if quality improvement initiatives and efforts is not taken seriously by the public health sector, they will be overtaken by the rapid development of the private health sector (National Academies of Sciences, Engineering, 2018).

5.1.5.2 Experience of care

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 attitude of healthcare providers also goes a long way to influence the experience of care of patients at healthcare facilities. The experience and satisfaction of patients is influenced by several elements. For instance, authors such as Javed & Ilyas (2018) who evaluated outpatient satisfaction and service quality in Pakistan are of the view that, empathy and responsiveness that are shown towards patients by healthcare providers goes a long way to influence the satisfaction of patients. The authors for instance found that, the satisfaction of patients who visits public facilities is influenced by responsiveness *(i.e. timeliness)* of the service. Patients would want to be treated promptly and without delay while the satisfaction of those of them who visit private facilities is influenced by the reliability *(ability to accurately and dependably deliver on the promised service)* of the service. The authors generally found

responsiveness and empathy having a strong relationship with the satisfaction of patients from the healthcare services that they receive.

Kodom et al. (2019) have also identified how attitudes such as rudeness, disrespectfulness and being less empathetic of some categories of healthcare workers particularly nurses especially in public health facilities affects the quality of treatment and care that patients receive. In their study, the authors recount an experience of one patient in a public hospital as: *"Most of them prefer to spend time on their phones rather than to attend to patients. In my last visit, one of the nurses was browsing or chatting on her phone. I asked her a question and she didn't even mind me. When I asked again, she rudely asked me, 'Why are you shouting on me, am I a child to be shouted at?' I quietly left her to ask another person. The government must ban nurses from using phones at the hospitals"* (Kodom et al., 2019;pg.579). Though this attitude is not peculiar to only the public health facilities; patients acknowledge some levels of efforts by the private healthcare facilities to avert some of these occurrences as indicated in this quote: *"In the private hospital, there is an inscription that if you are not treated well by a staff, call this number [a number that has been provided]. So, most of them are quite cautious about how they behave towards patients. But in the midst of the inscription, some, especially the young nurses, are very rude as compared to the older nurses"* (Kodom et al., 2019;pg.579). Fortunately, it is not all doom and gloom, studies by Mensah et al. (2014) that documented birthing experiences of Ghanaian women in the 37 Military Hospital however showed nurses/midwives demonstrating a lot of empathy, concern and care towards pregnant women. One of the pregnant women is quoted as saying "…some massaged my back and also [showed] patience with me. Oh God! These nurses!! I had the right people to support me" (Mensah et al., 2014;pg.31).

Absenteeism, lateness and general indiscipline is very prevalent in public health facilities than private facilities in Ghana. The concept of dual practice has largely been blamed for this. Most healthcare providers have pointed out for instance that "the combination of 2 jobs is exhausting, leading to decreasing efficiency and bad attitudes towards patients" (University of Ghana, 2018;pg.94). To make matters even worse, Ghana like many other countries employs a care model that generates a negative birthing experience because of the absence of trust in and social support that is needed from healthcare providers. Healthcare has to be provided in a non-abusive and respectful manner. It has to be personalized to the needs and expectations of the woman and the newborn. It has to be provided by healthcare providers who are empathetic, kindles trust and are able to blend their interpersonal skills with the clinical acumen and competence. This is person-centered care! We should also be considering switching to a care model that ensures continuity of care, less use of regional analgesia, episiotomy and instrumental birth. Where there will be no intrapartum analgesia or anesthesia, or spontaneous vaginal birth. Ghana uses a blend of midwife- and doctor-led care models at different levels of care. For instance, care at the regional and tertiary hospitals are doctor-led while care at the district hospital and lower are mostly midwife-led. There is the need to design our healthcare systems to ensure that pregnant women and newborns receive care that is respectful, attentive and avoids needless interventions during and after delivery.

5.1.6 Impact

This section focuses on findings related to the fifth pillar of our logic model: impact (see Figure 1).

5.1.6.1 Reduced maternal and newborn mortality

CHAG has consistently from 2012 till 2018 outperformed the biggest public health provider in Ghana, i.e. GHS, on its maternal mortality scores shown in Appendix 4. Maternal mortality in the FBOs such as CHAG is lower than in public health institutions. For instance, the maternal mortality rate in CHAG was 124/100,000 live births while that in the public health institutions nationally was 127.3/100,000 live births (Christian Health Association of Ghana (CHAG), 2019). Data also from the largest teaching hospital, the Korle Bu Teaching Hospital (KBTH) also revealed that, more than two-thirds (75.7%, 156) of maternal deaths in that facility were from public health institutions. Private health institutions contributed less than 30% (50, 24.3%) of the total maternal deaths ion that facility from 2015 to 2018 (KBTH Obst & Gynae Department, 2020).

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). For instance, data from some of the teaching hospitals particularly the Korle Bu Teaching Hospital (KBTH) reveals for instance that, out of the 46 maternal deaths recorded in 2015, about a third (30.0%, 14) of them were referrals from private facilities (KBTH Obst & Gynae Department, 2020).

There is higher infant (8.9/1000LB) and under-five (6.5/1000LB) mortality in CHAG facilities than in public health facilities where the rates are 8.5/1000LB (infant) and 4.9/1000LB (under-five) respectively (Table 1).

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). 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). 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).

There had been marked improvements in outcomes in maternal and newborn health over the last two decades. Institutional deliveries have seen a 25% increase from 54% in 2007 to 79% in 2017 while home deliveries had also seen a decline from 45% to 20% within the same period. Maternal deaths have also showed a decline from 451 deaths per 100,000 live births to 343 deaths per 100,000 live births from 2007 to 2017. Comparatively, Ghana's maternal mortality point estimates between 2010 to 2017 of 343 deaths per 100,000 live births happens to be the least among its West African neighbors (Ghana Statistical Service, Ministry

of Health, 2017). This has since improved according to recent estimates in September, 2019 that puts Ghana's MMR at 308 deaths per 100,000 live births which is still higher than global estimates of 211 deaths per 100,000 live births (in 2019) but lower and better than the Sub-Sahara Africa (SSA) estimate of 533 deaths per 100,000 live births(WHO, UNICEF, UNFPA, 2019). Details of the trend in Ghana's maternal mortality ratio from 2000 to 2017 is presented in Figure 6. Unfortunately, efforts at improving maternal and newborn outcomes have mostly targeted the prevention of deaths of the patient with respect to her initial contact with the facility other than post-hospitalization period. A large burden of death has shifted to the post-discharge period and many mothers continue to die after they have been discharged from the hospital.

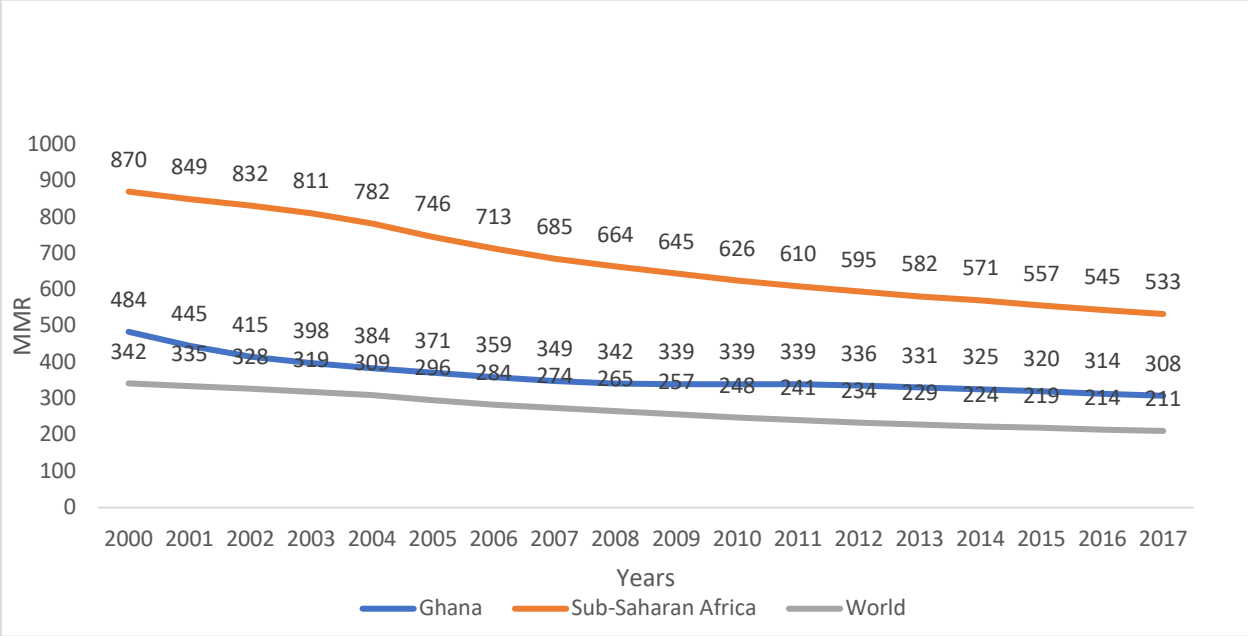


Figure 6: Maternal Mortality Rates (Ghana, SSA, World)
Source: WHO, UNICEF, UNFPA, World Bank Group and UNDP (MMEIG), 2019

There continue to be a disturbing increasing trend in maternal and newborn outcomes with its attendant overuse of some medical procedures and interventions during childbirth. For instance, maternal health interventions like caesarean section (CS) has increased from 12% to 16% and the use of intravenous fluids during births from 36% to 58% in the same period (i.e. 2007 to 2017) (Ghana Statistical Service, Ministry of Health, 2017). In Ghana, CS rate is however estimated to be higher in private health facilities (27% of deliveries) than public health facilities (20% of deliveries). The FBOs are also doing 19% CS rate among all their deliveries (University of Ghana, 2018). This is similar to India where CS rates in private facilities is thrice (34.6%) as high as the rate in public/government facilities(Renfrew et al., 2014). The deliveries by CS (23.2% of 143,2424 deliveries) was even much higher among the CHAG network in 2018. This rate is higher than the national target of 6.5% and 2% for Sub-Saharan Africa(CHAG, 2019). The Korle Bu Teaching Hospital is also doing a CS rate of 47.5% out of total deliveries of 8275. Also, more than two-thirds (86.5%) of all maternal admissions to that institution are due to external referral (KBTH Obst & Gynae Department, 2020). It is interesting to note that, these high CS rates do not have any direct association with a decrease in maternal and neonatal mortality consistent with a WHO publication in 2015 which suggested that "as caesarean sections increase above 10% [at the population level] and up to

30% no effect on maternal mortality rates was observed" (World Health Organization (WHO), 2015; pg.3). The authors concluded that, in as much as CS interventions are important, they should only be used for "medically indicated reason" (World Health Organization (WHO), 2015; pg.4). This is corroborated by Powell et al (2018) as they also posit that, most pregnant women do not often require medical interventions during their periods of pregnancy or childbirth but rather what they require are reliable systems and healthcare providers who will provide them with the necessary support to attain their desired potential to deliver safely. The CS rates are indicative of high institutional CS rates which will have to be addressed urgently to improve the safety *(one of the six healthcare quality dimensions)* of pregnant women and their newborns especially because of their tendency to cause life-threatening complications like any other surgery. There are other associated risks such as the development of surgical site infections as well especially in instances where surgical safety principles are compromised.

Our under-5 and infant deaths have equally seen a steady decline from the 1988 figure of 155 deaths per 1000 live births to 52 deaths per 1000 live births in 2017; and 77 to 37 deaths per 1000 live births over the same period (1988 to 2017) (Ghana Statistical Service, Ministry of Health, 2017). We however still have a lot of work to do in Ghana to reduce our newborn deaths which is estimated to be about 40% of all under five deaths in 2017 (Ministry of Health (MoH), 2020b). UNICEF estimates Ghana's newborn death rate at 23.9 deaths per 1000 live births (2018) which is still higher than the global estimates of 17.7 deaths per 1000 live births but lower than the sub-Sahara Africa estimates of 27.7 deaths per 1000 live births (UNICEF, 2019) (Figure 7). Ironically, institutional neonatal deaths continues to rise consistently from 2014 (3.8 per 1000 live births) to 2014 (8.4 per 1000 live births) across all the regions of the country (Ministry of Health (MoH), 2020b). There are variations across the various regions with Volta, Central and Western having the worse neonatal mortality rates while Greater Accra, Brong Ahafo and Upper East regions having the best rates. Unfortunately, it is further estimated that these deaths occur within the first 28 days of birth (GSS, 2015). It is noteworthy that, "the period from labor and delivery, through the first 24 hours to the end of the first week of life accounts for about 75% of neonatal deaths [in Ghana]" (Ministry of Health (MoH), 2014; pg.32) and about two-thirds of infants do not also live to celebrate their first month of birth in Ghana (Ghana Statistical Service, Ministry of Health, 2017). This makes Ghana one of the countries where it is unsafe to give birth. This statement is corroborated by Ghana's 150th place amongst 178 countries assessed to be the safest places for motherhood and child health globally (Ghana Health Service (GHS), 2017). Unfortunately, there has been little or no attention given to interventions and efforts at reducing newborn deaths to the events that occur during the neonatal and newborn care period. Most of the efforts and interventions have focused on the post-neonatal period.

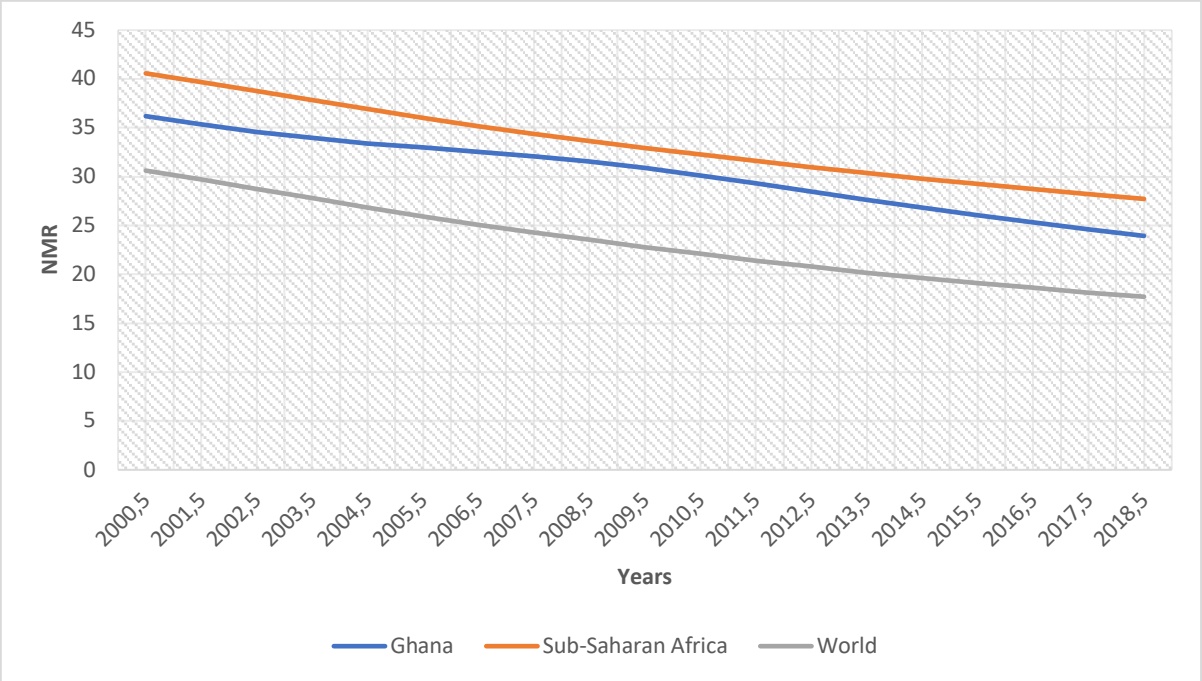


Figure 7: Neonatal Mortality Rates (Ghana, SSA, World)
Source: UNICEF, 2019

5.2 Findings from primary data

5.2.1 Characteristics of respondents

In total, 39 respondents were purposively selected from both the public and private sectors. The majority (43.6%) of respondents worked in service delivery, followed by policy (33.3%) and regulation (23.1%). More than half (51.3%) of the respondents were from the private sector while the remaining 48.7% were from the public sector. More male respondents (53.8%) participated than female respondents (48.7%). Less than a fifth (17.9%) of the respondents worked in rural areas, while the remaining 82.1% of respondents worked in urban areas. Table 1 provides further details on the characteristics of respondents.

Table 1: Characteristics of interview respondents

Variables	Public N (%)	Private (N, %)	Total (N, %)
Roles of respondents			
Policy	8 (20.5)	5 (12.8)	13 (33.3)
Regulation	5 (12.8)	4 (10.3)	9 (23.1)
Service delivery	5 (12.8)	12 (30.8)	17 (43.6)
Total	18 (46.2)	21 (53.8)	39 (100)
Geographical distribution of respondents			
Rural	2 (5.1)	5 (12.8)	7 (17.9)
Urban	17 (53.1)	15 (38.5)	32 (82.1)
Total	19 (48.7)	20 (51.3)	39 (100)
Sex*			
Male	9 (23.1)	12 (30.8)	21 (53.8)
Female	10 (25.6)	9 (23.1)	19 (48.7)
Total	19 (46.2)	21 (53.8)	40 (100)
Interview method			
Face-to-face	11 (28.2)	5 (12.8)	16 (41.0)
Phone	7 (17.9)	13 (33.3)	20 (51.3)
Zoom	0 (0.0)	1 (2.6)	1 (2.6)
Self-administered	1 (2.6)	1 (2.6)	2 (5.1)
Total	19 (48.7)	20 (51.3)	39 (100)

*Note: This variable summed up to 40 respondents because one of the interviews was a focus group discussion with 1 female and 4 male respondents. That particular 'respondent' has therefore been counted twice.

5.2.2 Available inputs for the private sector

This section focuses on findings related to the first pillar of our logic model: inputs (see Figure 1).

5.2.2.1 Key quality policies and strategies for the private sector

In Ghana, all policies are developed at the national level in consultation with key stakeholders and disseminated down to the regional and district levels for implementation. Policies, strategies, plans and guidelines, direct the quality of services in both the public and private sectors. However, many respondents reported enforcement capacity of the relevant government agencies for compliance as sub-optimal.

Faith-based organizations (FBOs), especially the Christian Health Association of Ghana (CHAG), tend to be more accountable to national quality standards than the self-financing private sector due mainly to a stronger and autonomous decentralized quality assurance governance structure that in turn ensures better availability of data and quality indicators for reporting to national level regulatory framework. Also, the FBOs are better organized than the self-

financing private sector. Furthermore, the existing management arrangement between the Ministry of Health and CHAG/Ahmadiyya ensures continuous allocation of resources especially human resource for efficient service delivery. Thus, these factors enable and facilitate stronger accountability to national quality standards as compared to self-financing private sector. For instance, the CHAG has significant community engagement, community ownership, and participation structures across all levels of care. This results in strengthened and validated quality assurance processes. Similarly, more resources like quality assurance training for certain diseases (e.g., malaria) are reported to be made more available to the FBOs than to self-financing facilities, further supporting the Association's likelihood of having stronger quality assurance processes and in turn being more easily accountable to national quality standards.

> *We have tailored the [national] quality strategy to our need, based on the funding that we will also receive from our group. We were taught that the best way to make sure that quality is sustained is to use the SafeCare program. And in a way, all our reporting, you know we do the HSS [health system strengthening], so, we go through the nine-health system blocks not six, that's what we have been doing for the past couple of years. […] So one of the blocks that we engage in very well, the health systems block, is community ownership and participation. All our facilities do community durbars, and those durbars are very brutal meetings where the community gives feedback as to what you're doing right and what you're not doing right. So, it puts the facility on their toes …*
>
> - Private sector respondent who delivers services at a facility operated by an FBO

Self-financing respondents reported difficulties in accessing Ministry of Health policies on quality, sector-specific policies and strategies, and the most recent clinical standards. In addition, they said that the Ministry of Health does not include them in clinical training and updates like they do with staff at the Christian Health Association of Ghana, nor does the Ministry of Health consistently involve them in developing relevant quality policies and regulations.

5.2.2.2 Regulatory and legal framework related to maternal and newborn health, quality of care, and the private sector

Ghana is noted to have all the relevant Acts that establishes the health regulatory bodies and gives them the appropriate mandate. However, "most of them do not have the legislative instruments that will translate the Acts into what exactly they have to be doing," according to a public sector respondent who works in policy and administration.

Box 7: Different agencies in Ghana

The Health Facilities Regulatory Authority licenses private and public facilities and inspects them using its own set of inspection tool. Also, National Health Insurance Authority has its own quality assurance guidelines and quality assurance teams that inspect and credential facilities. Furthermore, Pharmacy Council licenses pharmacies, chemical shops, and their professionals. The Ministry of Health's Quality Management Unit is responsible for "Day to day oversight of quality across all agencies, sub-sectors and all levels on behalf of Director PPME [Policy, Planning, Monitoring & Evaluation], MOH [Ministry of Health]," (Ghana Ministry of Health, 2016, p. 27).

Despite genuine interest to improve quality, self-financing respondents recounted several barriers in navigating the regulatory environment including perceived bias, and inequitable enforcement of regulatory standards that were admitted to an extent by some of the respondents in the regulatory space.

> *… I won't say it is an unfair comment but I think they are entitled to do that because of the historical antecedent of our current regulatory regime. Like I told you we used to have a law that looked at only private institutions. And once you have a new order you have to make sure that you continually train, retrain and reorient the regulators to understand that now it is everybody and not one, and therefore the tendency that old habits die hard may not be something that I can dispute. But the thing is you should be conscious and train your people in the public sector apart from the public policy consideration there are also political considerations. There are political considerations, so when you are going to make such a decision of the best interest what may be in the regulator's best interest is not necessarily the political best interest.*
>
> *- Respondent who works in one of the Regulatory agencies of the Ministry of Health*

In as much as biases are inherent in every human endeavour, there is the need for regulators to know and for the MoH to ensure that, they are adequately trained to ensure fairness in the discharge of their duties. A respondent in the private sector regulatory space however ascribed the "biasness" more to the structure and setup of the regulatory bodies:

> *…it's like fighting the government who is also the same person who is making you be. So, you could say it is a bias, but you could also say that it is a problem of a structure.*
>
> *- Respondent who works in private sector regulatory space*

Another respondent in the regulatory space indicated for instance that, the public interest consideration that will be generated when a facility like the Korle Bu Teaching Hospital is shut down will not be the same as when a private facility like Lister hospital is also shut down hence the bias that is exhibited at times.

Again, this also has to do more with the evolution and history of regulation within the health sector. HeFRA itself evolved from the "Private Hospitals and Maternity Homes Board" with interest and consideration in the regulation of the private sector than the public sector. Even among the private sector, regulation is also very heavy among the self-financing than the faith-based. This was explained more to be because of the level of organization and the

stringent accountability measures that are in place in the faith-based organization. Even though the self-financing private sector have an association, not every provider in that space is a member of an association and it also makes it difficult for the association to hold errant providers accountable. The extent of self-regulation can be described as very weak and suboptimal among the self-financing private sector compared to the public and the faith-based.

> *…in the MoH where they go round all these facilities making sure that, this facility is adequately taken care of, we are aware. So, it means there is at least a minimum monitoring mechanism over there. Let's take the private sector, if the council says no, we are also sitting back, how would they regulate, self-regulate they can't. So, the focus yes, is at the private sector because they form the bulk, they are the majority. So, if the Ministry of Health cannot do that, we should do it… We focus there because if we don't things will go haywire…*
>
> - Respondent who works in one of the regulatory agencies of the Ministry of Health

However, private sector providers (i.e. FBOs and self-financing) are believed to be most compliant when it comes to regulatory requirements than the public sector because of the fear of losing licences and the repercussions it might have on their corporate image and bottom line.

> *…they are most compliant, they are most ready to respond to corrective measures, because they are more afraid of losing licences and so on. The recalcitrant often is government-public because they know that you cannot close a government facility and sometimes issues can be there for years and getting any attention can be difficult. Nonetheless, its resilient system is always very important in providing care and government cannot close it so it becomes often like a backbone for that. But usually private is not an issue, there are a few recalcitrant ones that are often into, they will get a licence for specific ones say surgery then you will find out that they are doing cosmetic surgery which they have not obtained approval or they will go beyond their scope of licence but usually we are able to…*
>
> - Respondent from one of the regulatory agencies of the Ministry of Health

Private sector respondents also reported that the quality assurance tools and requirements of different regulatory agencies are unharmonised. This makes it difficult to meet the various regulatory requirements including additional required personnel and resources that are already scarce.

Both public and private sector respondents however acknowledged challenges associated with the regulatory environment such as: multiplicity of regulatory requirements which adds additional costs and disincentives private providers; weak coordination, harmonization of quality of care tools, and relationships between these agencies create barriers and at times, opportunities for non-compliance.

> *…credentialing tools are sometimes at variance with HeFRA [Health Institutions and Facilities Regulatory Authority], so there should be that harmonization of tools. So, what it means is that regulators are not talking to themselves. There should be a framework where regulators talk to themselves and know the common challenges and for them to handle it together.*
>
> - Public sector respondent who works at the Ministry of Health

There are also instances where regulatory agencies instead of complimenting one another have engaged in jurisdictional contestation and what has been described by one of the respondents as "regulatory unreasonableness". The respondent further indicated that:

> *… So, not that we should have fewer regulators but the fact that regulators could act in concert piggy-bagging on their sister regulatory agencies to do… so that it is much less disruptive to the organized work environment of private for profit actor…*
>
> - Respondent who works in one of the regulatory agencies of the Ministry of Health

The urgent need to strengthen the quality of regulatory oversight and ensure compliance to the regulatory standards have also been expressed by respondents in the public and private sector alike. Participants from the public and private sectors noted that district-level capacity varies significantly in the understanding of quality standards and their application. This is further compounded by limited resources and limited number of staff for regular inspection and supportive supervision. In addition, under-reporting, and incomplete private sector data, make monitoring quality challenging. Finally, a mandate for quality is reported to reside in multiple government agencies (e.g., Ministry of Health's Quality Management Unit, the Health Facilities Regulatory Agency, the National Health Insurance Authority).

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

Despite the increasing demand for maternal and newborn health services in the country as reported by the lit review, private providers reported several hindering market conditions including limited capacity, restrictive financial market conditions, and uneven engagement that could deter them from filling this gap in the market. Inadequate financial incentives demotivate the self-financing private sector to deliver quality maternal and newborn health services beyond antenatal care. Similarly, service provision in rural and underserved areas is challenging. Indeed, as seen in other countries with sufficient access to resources, the private sector could deliver critical care services, fill current market gaps, and help meet growing demand for maternal, newborn and child health services.

> *If you want someone who is a businessperson, it's got to be sustainable. It's not for charity. You've got to actually have revenue coming in. Then that means that if you want to get private players going into the rural communities, you need to look at your incentive structure. […] It's about what are the incentive structures that reduce cost and how do you ensure that the people who are in that rural community can afford the care? Is it going to be NHIS [National Health Insurance Scheme] paying for it? And if NHIS is going to pay for it, if NHIS don't pay within three months or whichever the times are, if they pay after a year or 18 months, that is actually extremely difficult for any private facility to survive.*
>
> - Private sector respondent who works in service delivery at a self-financing facility

Private sector respondents often spoke about a challenging investment and financing climate. Respondents reported that unreasonably high interest rates made local loans out of reach. This inability to access financing impedes the expansion of the private sector, especially expansion into higher-level services and services in rural areas. A lack of viable credit options for facilities also impedes procurement, supply of medicines, and supplies needed to comply with quality standards.

But loans, if we talk about the rates that you use in Ghana, the rates are such that if you are not making a return in a year, it's very difficult to pay off the loan. Healthcare costs so much, but you have to be long-term thinking to get returns. So, the financing needs to be long-term financing that comes at very good rates to allow for healthcare facilities because you don't make your money—its not like you are in consumables or in retail where you can make your money really quick

- Private sector respondent who works in service delivery at a self-financing facility

Generally, the private sector finances all of its operational costs through direct out of pocket patient payments, and/or health insurance reimbursements. Many self-financing respondents participate as providers in the National Health Insurance Scheme (see Box 7). They reported that low reimbursement tariffs and delayed payments threaten their businesses' financial viability and deter other private providers from becoming National Health Insurance Scheme providers.

…about 94% of all the people who access our services are using the NHIS card. […] Now if you have that large a percentage of clients, who are accessing your services and then the payment is delayed for 10 months, or 9 months, or 12 months, it's quite a worry. As we speak [in March 2020], the majority of our facilities have been paid up to April 2019. […] Now the tariff is not economical to start with. So, you are buying medicines that are more expensive than how much the NHIS is paying. […] With 9 out of every 10 clients on [NHIS] insurance, how do you maintain the service? How do you buy medicines? How do you buy consumables to ensure that you are providing the service continuously? Some [facilities] have taken bank overdrafts for a long time. So, it's a big issue. Especially at this time when we fear Coronavirus, some facilities are not able to buy gloves because NHIA hasn't paid.

- Private sector respondent who directs a faith-based organization that operates health facilities nationwide

Interviewer: *The facility you work in, do you see pregnant women?*
Respondent: *Unfortunately, no. We initiated it, but a lack of funds and the delay in reimbursements stalled the work.*

- Private sector respondent who works in policy/administration at the sub-national level

Box 7: National Health Insurance Scheme as a major financier of health

The National Health Insurance Authority has become a major financier of health (over 40% of total health expenditures) and has increased access for lower income groups. The National Health Insurance Scheme faces severe challenges of cash shortages, mismanagement, corruption, delayed reimbursement of facilities and weak and slow administrations, less pro-poor as it was envisaged, increased wastage and incessant political interference that threaten the sustainability of the scheme (Agbenorku, 2012; Christmals & Aidam, 2020).

In several instances, private sector respondents reported the need to revisit rates of National Health Insurance Authority reimbursement for more complicated cases, such as complicated childbirth and neonatal intensive care. The delayed reimbursement hampers the ability to timely recoup the costs of delivering these specialty services. If reimbursement rates were

adjusted, it could facilitate the delivery of more specialized maternal and newborn care in the private sector and perhaps incentivize hospitals to deliver higher quality care that results in fewer maternal deaths.

> *I was trying to convince national health insurance that they should build into their rates or tariffs some kind of incentives, so that if some people are providing first class hospital services, they should get [paid] a bit more than the person providing basic hospital services. If that is done, it could be an incentive for people to do well. If the government can also have some support mechanisms in place for hospitals that can deliver a zero death rate over a period of time, then that [incentive] will be something that will work.*
>
> - Public sector respondent who works in regulation at the national level

Respondents who work as self-financing private providers perceived 'unfair competition' with public and faith-based providers. Unlike public facilities, self-financing providers must invest their own funds to build a health facility, use revenues to pay their staff and cover other operating expenses, and purchase expensive inputs (e.g., medicines, equipment) at full market prices. In public facilities, the government pays for these upfront operating costs. Respondents also reported uneven government support, depending on whether an organization was faith-based or self-financing. The Christian Health Association of Ghana, for example, has a long-term memorandum of understanding with the Ministry of Health that includes access to free or sometimes free and/or subsidized medical equipment and the secondment of personnel.

All respondents – both public and private – reported human resources as a challenge. Those who work as self-financing private providers, however, identified their human resource challenges as more acute due to their inability to attract and retain the already scarce specialists. The main driver for the attrition is their inability to pay the market value of these specialists and competition with faith-based facilities. In some faith-based facilities, these human resources are seconded by the Ministry of Health, thus lowering their cost and increasing the ability to incentivize personnel and to pay better rates to retain them. Furthermore, specialists in the private sector do not have the same recognized career progression, job security, and incentives as when they work in the public sector, further accentuating recruitment and retention challenges.

> *…the constraints with personnel are concentrated to certain departments. The personnel prefer to work in the government hospital because of job security and when you get them, they prefer to do part-time and keep their government jobs… when I try and recruit a person from Ghana, I struggle. And then they come, you train them and they sell themselves higher to another facility.*
>
> - Private sector respondent who works in service delivery at a self-financing facility

> *…. Why can't government second staff to the private sector? Government has signed an MoU with CHAG and government seconds staff to CHAG. You know what it does, it reduces overhead costs, why can't that be done for the private sector? If we want to deliver the same quality service, we claim we want to deliver. Think about it. So, in a CHAG facility, operating cost goes down but you want the private sector individual to use his own money to pay salaries…in the CHAG institution any health worker who is seconded by government has his salary paid by the government.*
>
> - Private sector respondent who works in service delivery

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

Beyond the human resources challenges reported across both sectors, insufficient health budget allocation and old infrastructure that impedes quality of services delivered by the private sector. Additional barriers to private sector delivery of health care include shortages and procurement challenges, bureaucracy of national health insurance reimbursements, and duplication of services across key public agencies.

> *When they do the reimbursement, they consider the tariff on the primary care, so this disparity is a real challenge. If you are spending GHS 100 on a patient, you are receiving only GHS 30. And that GHS 30 is coming to you after a year. And insurance because of their inefficient system, let me say inefficient system because since 2014 they were not able to give us a vetting report. We do not know [whether] the claims we are generating are correct or [whether] they have given [us] all the money we have spent on that patient. At times there are will be huge deductions and when you call [them], there will not be any positive response from them- any vetting report or a reconciliation report. The reimbursements are not consistent.*
>
> - Private sector respondent who works in service delivery at a faith-based facility

Within the private sector, the Christian Health Association of Ghana stands out as a leader (Ghana Ministry of Health, 2016). It is well structured with lots of advocates and influence in policy development and implementation. The organization has effective quality assurance and decision-making capabilities. Other private sector respondents, particularly the self-financing private sector, tend to be fragmented and poorly organized with few representative organizations to advocate on their behalf on policy and other health system issues. The self-financing private sector report limited involvement in governance for quality (other than varying levels of patient case complaint reporting) and tends to be excluded from Ministry of Health policy development activities.

As noted by many respondents, there is no forum for all stakeholder groups to come together to discuss quality and other policy issues. As discussed below, public-private interaction is primarily focused on regulations rather than more systemic issues. Moreover, respondents reported that there are unequal relationships and dynamics between the Ministry of Health and different segments of the private sector. Faith-based organizations tend to have a stronger relationship with the Ministry of Health than self-financing organizations. The Christian Health Association of Ghana and Ahmadiyya Muslim Mission, considered agencies of the Ministry of Health, are the only two private sector service providers named in the Ministry's organogram (Appendix 5).

Both public and private sector interview respondents reported a strong willingness and intent to engage with one another. In some regions and districts, this engagement is happening and is strong. In other areas, these relationships are non-existent. From the Ministry of Health's side, inadequate capacity and resources hamper efforts to better engage the private sector. Despite the government's strong intent to improve private sector engagement, interview respondents reported that the Private Sector Unit in the Ministry of Health is ineffective and could be more proactive. Multiple respondents in the private sector did not even know that the Private Sector Unit existed. They proposed the development of a similar unit within the Ministry of Health and clearer information on the Ministry of Health's website about how the private sector can engage with the Ministry of Health.

If you really want to engage the private sector, the private sector needs to be represented within the [Ministry of Health] structure. Right now, when I look at the ministry website: you have PPME, HR, research and statistics. […] What is the structure for private sector? Now, it doesn't have to be a private sector desk! Because a private sector desk minimizes the role of private sector to a desk. […] The first step is to actually take a look at the structure to see are we being inclusive? So, I think that if we truly want to say that the MoH wants to cover both private and public [sectors], then you should be able to feel that not only in the website but in the structure that it actually intentional.

- Private sector respondent who works as the CEO of a self-financing facility

Respondents also reported national-level technical working groups do not represent the range of private sector actors.

They [representatives from the private sector] are not invited and often it is because you don't know who to invite. So there needs to be a bit more work around including them in what we are doing. Even in the health sector working group, they didn't have a representative.

- Public sector respondent involved in regulation at the national level

Respondents mentioned the development of a comprehensive private sector engagement plan and policy, but they noted that the policy had not been implemented due to high turnover at the Ministry of Health and a lack of political will and committed resources.

The role private sector can play depends on the role the government wants it to play. Government can even determine how much is charged for consultation, if they are ready to provide rebates and concessions to increase access.

- Private sector respondent who works in service delivery at a self-financing facility

5.2.3 Private sector processes

This section focuses on findings related to the second pillar of our logic model: process (see Figure 1).

5.2.3.1 Private sector accountability with reporting

Both public and private sector respondents discussed inadequate reporting of health service and quality indicators. Data reporting within the private sector is highly variable. Most of the Christian Health Association of Ghana's facilities report data to the national database (DHIMS2), whereas only about 50% of the private sector as a whole (see quotation below) is thought to report data to the Ministry of Health. Self-financing organizations do not fully comply with data reporting.

I understand about 50% of the private institutions are contributing [to the national health information systems]... but 50% of what denominator? So, I just don't buy into that. I always tell my M&E guys, "You guys, I don't believe this." So, some are contributing, but until we have a sizeable number. But this one, HeFRA [Health Institutions and Facilities Regulatory Authority], can tell us that we have X-number of facilities which are private for profit. Then, if Y-number is reporting into DHIMS [District Health Information Management System], then we can say that

out of the population of X, Y is reporting. Then we can see how significant it is. But for now, the figure we are bandying around is that between 50% and 60%, but I take it with a pinch of salt.

- Public sector respondent who works at the Ministry of Health

I will say that because from my little experience like the single owned facilities, I know that when it comes to data like entering into DHIMS [District Health Information Management System], most of them are not doing that.

- Private sector respondent who works in service delivery for a faith-based organization

In general, self-financing hospitals in urban areas meet data compliance standards better than self-financing clinics, due to availability of resources, capacity, relevant equipment and connectivity to report.

…some say they do not have the capacity in terms of health information officers to organize their data systems and report. Some also say they do not have the equipment to do that, and talking about equipment its laptop or desktop and internet connectivity, that's all. And also, some of the registers, as for the registers some print per the specification that they get from the regions. So the registers they have, but some are not to specification. But by and large, they are picking some data. So, I think the onus lies on us as a Ministry to make an effort to work on that data issue with the private sector. One, we look at capacity. Two, we look at the logistics requirements and also let them know why they need to report into it.

- Public sector respondent who works at policy/administration

Multiple factors contribute to why self-financing health facilities and providers are deterred from and/or under-report data to the Ministry of Health: (i) the Ministry of Health does not share data back with the private sector or Ministry of Health reports do not include or reflect private sector contributions in health; (ii) the private health sector is reluctant to report data because of how the Ministry of Health will use this information (e.g., taxation, facility closures, etc.); (iii) many self-financing private providers, small facilities, and individual practitioners considered the Ministry of Health reporting to be cumbersome and costly to comply with; and (iv) private sector actors reported the need for more streamlined and coordinated tools across numerous regulatory structures and expenses to ensure data is compiled and reported as well as the need for ministry to ensure private sector can access and use the data to better themselves and better able to develop ways/models to support national health priorities.

It's a matter of gathering all of us and giving us the statistics in the country and incentivizing us to move more into that field, and I think most of us will do it, but we need to know what's going on in the country.

- Private sector respondent who works in service delivery at a self-financing facility

The question is what will be the incentive for the private sector to say that, let me give you my data? […] What I have heard is that for CHAG [Christian Health Association of Ghana], it appears that they get benefit from the government directly in terms of human resource. So, it cuts down on their costs. […] So, it's more like a requirement—if you're getting benefits from me, then you need to submit some report. But the argument from the self-financing is that when they give their data, government uses it and then they don't bring the resources also to support them or things like that. So, I think there has to be a discussion to say that the data

that is being reported is not for the basis of economics or something but it is for the basis of quality.

- Private sector respondent who works in service delivery for a faith-based organization

Without accurate, timely data, the Ministry of Health cannot effectively regulate the private sector. Gaps exist mainly at the district level but also occasionally at the regional level, where some private facilities may bypass regional-level reporting and report directly to the national level. Similarly, respondents reported weak information systems, weak financial management, and weak reporting systems as major contributors to uneven reporting and dissemination.

In terms of the reporting into DHIMS [District Health Information Management System], they [private facilities] are required to do but it is not everybody that is doing it. So that is where there is a challenge. So it is difficult to say whether you can get the data to say that there are problems in these places, so let me go and then respond to that. So, for me I will say that is a weakness within the health sector that we are not able to disaggregate data and be able to find out where there are big challenges within the system whether it is in the public sector or it is in the private sector in particular areas within the country.

- Private sector respondent who works in service delivery for a faith-based organization

5.2.4 Private sector outcomes

This section focuses on findings related to the fourth pillar of our logic model: outcomes (see Figure 1).

5.2.4.1 Quality of care

The average health-seeking Ghanaian irrespective of his/her geographical location, socio-economic status or other indices is expected to receive quality healthcare at the point of service delivery whether in the public or private. However, there is evident variation in the quality of care received by maternal and newborns and the general Ghanaian populace. The views of respondents varied on the quality of care provided in the private sector (i.e. FBO and Self-financing) and the public sector. On the quality and availability of human resource, one respondent noted that:

… I think the private sector can deliver equal or better service than the government facilities. But there are several government facilities where the required provider is not there. They say a doctor but a doctor is not there and you are getting care from a physician assistant but in the private sector if there is a doctor, usually that doctor is there. Usually that doctor is there, you can see the actual doctor! That's what I have noticed. But when you go and all you get is from a nurse or a midwife…

- Respondent from one of the regulatory agencies of the Ministry of Health

The private facilities (both FBOs and self-financing) are mostly noted for the provision of person-centered care (PCC) than public facilities:

… if you take aside the fact that a lot of the qualified people want to be in the public sector for job security by-and-large the private sector provides a better service of customer care, of after

care service, of wanting to have repeat customers. So, those kind of things forces them to provide quality service whereas in the public sector, peoples mentality is whether I do my work or I don't do my work I get paid and whether I have a good reputation or I have a bad reputation people will still come because they can't afford the private sector. So, that mentality is there so, if you are able to change that mentality then maybe you could do that…

- Respondent who works in one of the regulatory agencies of the Ministry of Health

For FBOs, PCC and many of its variants like respect, integrity and value for human life are core values that are ingrained and lived by most of the providers other than just being a lip service comparatively in the public and self-financing facilities.

In the area clinical effectiveness and care outcomes, respondents in both public and private sector service delivery categories indicated that, for maternal and newborn health service, this was better in public than self-financing private facilities if the service is doctor-led and that most times some of the service providers in the self-financing private facilities go beyond their limits.

… the quality within doctor-led private service it is generally good. But the problem we have as far as maternity is concerned is the maternity homes, where even cases that are referred to the hospitals, and who don't want to go to the hospitals, with risk factors, high-risk cases they go to maternity homes, are being manned by people of very low standards and then they even receive those cases and attempt to deliver them there only to run into problems. So that is what is happening even in Accra. We've had some of them who came to die, who've been brought last minute to die. So, these are some of the things that we are talking about. So, the quality is improving but in some of the technical areas, the skills for resuscitation, the management processes, there are still gaps that is being grappled with…

- Respondent who works as a service provider in a public facility

However, respondents at the policy and administration levels were of the view that, clinical effectiveness and care outcomes was generally better in the FBOs compared with the public and self-financing facilities. One of such respondents indicated for instance that:

…Yea, not-for-profit I think it is super, it is up there. I can vouge for it. During the MAF project by the ministry which had institutions from selected public sector institutions and private not-for-profit, the private-not-for-profit recorded 100 days zero maternal mortality. It was one of the indicators they were tracking and afterwards they have stayed at an appreciable level of reduced mortality so I can say it as a fact that, maternal mortality issues or reproductive health issues in general is well taken care of within the private not-for-profit. With the private for-profit, because data is an issue and only a few are reporting, it is difficult to make a generalized statement for all the private for-profit. The few that are reporting they are also doing well. Mind you, some of them do not do the [full] maternal health services, they can only do the ANC which sometimes is even done by the district-they send staff there to do because of convenience for pregnant women within that catchment area. And so maternal mortality of course once they don't, they will not record it but those that do not record maternal mortality it's because they are prompt at referring. That one is noted for private facilities. They are prompt, when they see that the issues are beyond them, they quickly refer. And also, because they also sometimes rely on the public sector workers who are also experienced, for locum, they know what to do and so maternal deaths and complications are far and in-between.

- Public sector respondent who works in policy and administration

Private facilities (i.e. self-financing and FBOs) tend to have stronger quality governance structures that include an ethics committee, clinical governance for patient safety, the conduct of regular patient satisfaction surveys as a way of eliciting feedback from their clients, and effective complaints management systems. However, private facilities with limited resources and some of the public facilities struggle to comply with the required quality standards. Private sector respondents noted that scarcity of resources (e.g., limited resources to hire the relevant quality expertise and to run a solid quality assurance governance structure) is a challenge and results in variation in service provision to ensure quality throughout the private sector.

> *I think for us because of our international base and because of our other affiliation with MOH [Ministry of Health] and SafeCare, we do not compromise on some of the basics. But I feel that not all private sectors are doing the same.*
>
> - Private sector respondent who works in service delivery

Respondents were unanimous on the bad attitudes of providers in the public sector that negatively affects the outcomes of care especially in the area of relationship with the patients, referrals and transfers. It was interesting to note that, because of the concept of dual practice, most of the providers who work in the private facilities (particularly self-financing) also work in the public sector. However, most of these "bad attitudes" hardly find expression in the self-financing private sector and FBOs mostly because of the stringent disciplinary and accountability measures that have been established.

5.2.5 Available mechanisms to encourage private sector engagement

This section focuses on available mechanisms for engaging the private sector through existing inputs and processes (see Figure 1).

5.2.5.1 Regulatory mechanisms

The Health Facilities Regulatory Agency, established in 2011, has developed quality assurance measures, sanctions, and incentives for regular data reporting under section 20 of the Act 829 of the national health care quality strategy. Yet, implementation is uneven and has not been harmonized across sectors. Sanctions and incentives are unclear and inconsistently implemented. Selected private sector respondents reported having to abide to sanctions, such as paying a fine for a failed facility inspection, while other respondents reported no sanctions. Some private sector respondents were sanctions for delays in data reporting, whereas respondents in other districts experienced no sanctions. This variance in how sanctions and incentives are implemented across districts seemed to be driven by available budgets, how budgets were utilised, and district-level management offices.

All private sector interview respondents reported having some type of patient satisfaction survey as a quality assessment mechanism, mainly under a patient complaint reporting structure and conducting regular patient satisfaction surveys. Such activities are relatively easy to implement with limited resources and capacity. This 'self-assessment of quality' is rarely reported publicly or reported to the public sector and used as part of quality assurance mechanisms. Facilities in some regions have gone beyond minimal patient complaint

reporting mechanisms to self-implement hospital scoring mechanisms and physician performance data that are made available to consumers.

> *Faith-based are more organized… And you can see clear structure within them and in fact even within the SafeCare scoring, on a baseline, if you visit a health care facility within the faith based, that is, for example CHAG [Christian Health Association of Ghana], that is operating at the same level of with maybe a public health facility or a private-for-profit facility when you use the assessment… standards to assess, usually the faith based will be scored higher… …and that is because they have a clear structure, they're more organized and they have some form monitoring systems within their network that is working for them. But when you come to the private for profit… then it's really it's sometimes even almost a mess within there because there isn't any organized body or structure that is working to monitor them, to supervise them, to kind of guide them and as I have already indicated, the support from the district health is also not that strong so they kind of are operating on their own.*
>
> - Private sector respondent who works in private sector regulation

> *A peer review system; all facilities are part of and this is organized by the GHS [Ghana Health Service]. So, CHAG [Christian Health Association of Ghana] and the GHS facilities we form a group and we go to various facilities and we assess each facility based on our tool and we give them feedback for improvement.*
>
> - Private sector respondent who works in service delivery at a faith-based facility

As the largest and most established faith-based private health provider, the Christian Health Association of Ghana has the most extensive governance and community/client engagement structures among the private sector actors. In addition to an active client engagement structure for accountability and reporting of complaints, all of the Association's facilities will eventually self-report across the nine pillars of the SafeCare Quality Improvement Program launched in partnership with PharmAccess Ghana.

5.2.5.2 Values, ethics and motivation of the private sector

Private sector respondents reported many incentives (beyond profit) that motivate them to deliver quality services. On the business side, they strive to deliver quality (customer) services to uphold their reputation and maintain their competitive edge. Moreover, well-established private facilities want to be seen among their client base as ethical with respect to business practices and pricing. These motivations can drive less established private facilities who are looking to compete with more established private facilities, thereby creating "positive" competition that benefits quality.

> *The private sector by its nature seems to do a better job because they need to attract people, people who go there go there by choice, and therefore, they need to deliver better quality healthcare through the infrastructure, the service to people.*
>
> - Public sector respondent who works at policy/administration

> *If you are good, you retain your clients. If you are not, they will just leave you. And there are options, options for them to get to other places.*
>
> - Private sector respondent who works in service delivery at a self-financing facility

On values, responses from smaller healthcare providers – especially private maternity homes run by midwives – reveal that these business owners are motivated by a passion for the work and a desire to contribute to their community.

> *I derive joy and happiness from it [midwifery], especially when my clients come to me and I am able to address their health needs.*
>
> - Private sector respondent who works in a self-financing maternity home

6. Conclusion

Using primary and secondary data, this report examined the drivers and determinants of the current engagement of the private sector to deliver quality maternal and newborn health services in Ghana through the lens of the project logic model: inputs, processes, outputs, outcomes, and impact of formal private sector service delivery on quality maternal and newborn health services. Primary data also revealed potential mechanisms to encourage private sector engagement, such as regulatory mechanisms and motivation amongst the private sector. Based on these findings, there are numerous opportunities for involving the private sector in working within the national health system to deliver quality maternal and newborn health services in Ghana (see 'Recommendations' below).

Before addressing the initial recommendations, it is important to recognize that Ghana has already achieved a number of successes related to collaboration with the private health sector. Regionally, Ghana is a leader in recognizing the importance of the private health sector. The government has established and enacted relevant laws, regulations, policies, guidelines, plans, etc. that encourage the private sector's contribution to health. Since the approval of the first private health sector policy in 2003, the Ministry of Health created a Private Sector Unit which has now been subsumed by the Domestic and Bilateral Resource Mobilisation Unit of the Policy Planning, Budgeting Monitoring and Evaluation Directorate of the Ministry of Health. Ghana also remains one of the earliest countries on the continent to implement a national health insurance scheme that contracts a significant number of private facilities to deliver health services. Ghana has a solid foundation on which to build and create more successes in public-private collaboration. For example, the Ministry of Health has formalized its relationship with the Christian Health Association of Ghana, the Ahmadiyya Muslim mission and the Ghana Association of Quasi Health Institutions under a memorandum of understanding to deliver health services to various population groups including the under-served.

Yet, Ghana also has several barriers to private sector engagement that require attention, particularly in the enabling environment. These barriers include (i)inadequate data on the private health sector, (ii) limited dialogue and convening platform between the public/faith-based sectors and the self-financing sector that can create mistrust and misperceptions, (iii) an unlevel playing field between all three segments[5] active in delivering maternal and newborn services, (iv) a somewhat complicated quality policy framework and regulatory systems that can be better coordinated and streamlined, and (v) poor market conditions and limited, and ineffective incentives hindering a greater private sector role in maternal and newborn health services.

These challenges are further complicated by the fact that the self-financing private sector is fragmented among several different and competing interests. Whilst individual private facilities are not bound by law to come together, this existing fragmentation makes it difficult to have a concerted and collaborative engagement within the health system. Moreover, fragmentation hinders effective dialogue and engagement with the public sector on key

[5] Ghana has a pluralistic health care system that includes traditional, biomedical/formal, and informal care (Amegbor 2017).

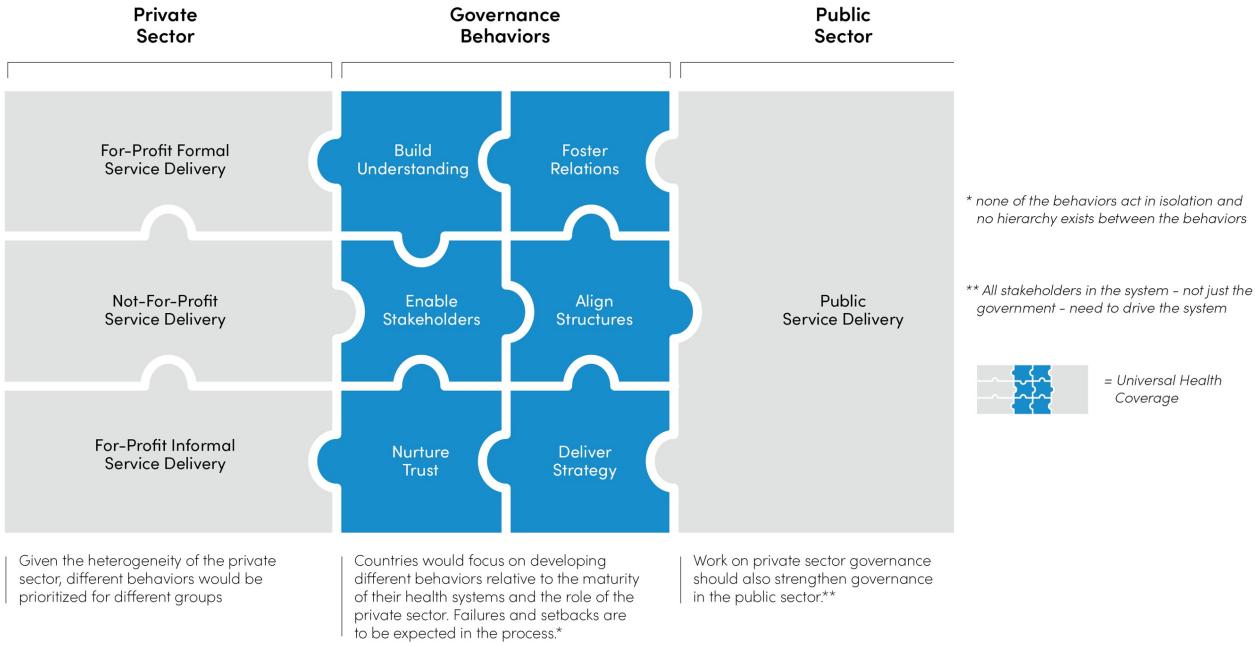
national priorities such as maternal and newborn health. Despite these barriers, the key informant interviews revealed genuine interest and willingness among the public, not-for-profit, and self-financing sectors to work together to overcome these challenges.

Ghana is on the path to improve quality of maternal and newborn health services. By building on its foundation of public-private collaboration and implementing the recommendations proposed here, Ghana can better engage the private sector and improve the quality of maternal and newborn health amongst self-financing providers. Indeed, many of these recommendations are based on successful experiences and examples from regional and lower- and middle-income countries (GFF, 2016, SHOPS Plus, 2019, Ministry of Health - Ethiopia et al., 2019) as well as the World Health Organization's draft strategy on private sector engagement (WHO, 2020). When the public and private health sectors come together to commit to improving the quality of maternal and newborn health services, improvements in health are both feasible and possible.

7. Recommendations

Based on the findings from key informants in Ghana, clear opportunities exist to strengthen private sector engagement for better delivery of quality maternal and newborn health services. These recommendations align with the World Health Organization's strategy to strengthen governance of mixed health sectors and to engage private sector providers to partner with governments to achieve universal health coverage (see Figure 8) (WHO, 2020). The first three recommendations align with the 'enable stakeholders' governance behaviour. The last three recommendations align with the 'align structures,' 'build understanding,' and 'foster relations' governance behaviours.

Figure 8. Six governance behaviours to strengthen private sector engagement



These initial recommendations, while broad, will be refined at the forthcoming multi-stakeholder dialogue workshop by stakeholders from the public and private sectors. Based on this initial report, participants will identify and prioritize key challenges and actionable issues to address during the workshop. These challenges will then be detailed out in specific problem statements for which concrete recommendations can be made. Then, participants will develop recommendations addressing these key challenges and actionable next steps. Finally, participants will finalize a plan for implementation of the recommendations along with partnership ideas.

7.1 Strengthen Ministry of Health capacity to engage *all* segments of the private sector ('enable stakeholders')

While the Ministry of Health has a Private Sector Unit (recently renamed "Resource Mobilization"), this unit is currently under resourced and under capacitated. The unit lacks the required resources and capacity to enact a clear dialogue platform by which to formally

and systemically engage and interact with all segments of the private health sector. Recommended actions and activities may include the following:

- Expand the mandate of the Private Sector Unit to become a dedicated department with a clear mandate and resources for staff and implementation; or make the existing Unit more prominent
- Raise awareness among Ministry of Health leadership both nationally and regionally on successful models to engage the private sector to improve quality of maternal and newborn health services
- Develop staff capacity within key ministry departments in skills needed to engage and implement private sector models
- Develop mechanisms for ensuring that the private sector benefits from health system strengthening interventions for improving quality
- Ministry of Health should convene private sector (both self-financing and not-for-profit) groups key to maternal and newborn health in order to develop a partnership strategy

7.2 Better organize the private sector so it can advocate for itself ('enable stakeholders')

The private sector, especially the self-financing private sector, needs to better organize and advocate for itself. This effort includes strengthening the existing platform to engaging the private sector. An organized umbrella of private sector actors can bring together different segments of the self-financing health sector to build the case why it is important for public and private sectors to work together to improve quality maternal and newborn services. Both the government and development partners can play an important role in encouraging the private sector to get organized. The government can signal to private sector organizations, like the Healthcare Federation of Ghana, its interest and willingness to bring them to the table on key policy issue, such as lack of access to financing and adjustment of National Health Insurance Scheme reimbursement.[6] As a matter of fact such initiative has already been undertaken by the Ministry and needs to be continued and supported. Development partners can play a role by providing seed funds and technical assistance to help strengthen existing associations important to maternal health (e.g., midwives).

7.3 Increase private sector opportunities through financing and economic incentives ('enable stakeholders')

There are several actions that both the Ministry of Health and development partners can take to create a more enabling environment to "crowd-in" new private sector providers to deliver and/or strengthen the quality of maternal and newborn services.

- Development partners, such as USAID and PharmAccess, can help educate financial institutions, such as banks and micro-finance institutions, on the viability of health businesses and introduce innovative financing schemes (e.g., micro-credit).
- The Ministry of Health should strengthen the enabling environment for continuous engagement on NHIS tariff structures and related issues for both public and private health service providers.

[6] The ministry is working with the private sector using the already existing platforms.

- The Ministry can explore other financing mechanisms, such as vouchers, that have successfully been used to increase demand for maternal health services while improving quality in both public and private health sectors
- The government can institute private health sector investment stimulus packages to support the private sector. It could also consider other incentives such as ease rules (e.g., remove import tax on key equipment) to encourage private investments in health with a focus on maternal and newborn services, explore other economic incentives (e.g., tax holidays, certificate of needs, subsidized inputs, etc.) to incentivize expansion of private maternal services in underserved areas, and explore finance and economic mechanisms (e.g., contracting, vouchers, and NHIS requiring individual practitioners to be part of a network) that would encourage private providers delivering maternal and newborn health services to "join" a network that is charged with the mandate to ensure quality on behalf of its members.

7.4 Harmonize quality framework, standards, and structures ('align structures')

The assessment revealed that multiple government agencies are involved in quality assurance with uncoordinated and unharmonised quality assurance tools and reportable indicators, thus resulting in increased costs due to the extra work in terms of manpower and resource to ensure monitoring and reporting against these indicators for private providers. The Ministry of Health can initiate several reforms that would address these barriers while laying the groundwork to strengthen quality in private health services in both sectors:

- Harmonize mandates, licensing, quality assurance tools, and key performance indicators to streamline processes and requirements to create a level playing field between the public and private sectors
- Improve coordination between existing government agencies responsible for quality
- Invest in quality assurance structures to execute quality assurance policy developed at the national level, building capacity and modernizing systems and procedures
- Capture, document, and share quality improvement experiences between the public and private sectors

In addition to harmonizing and streamlining quality standards and systems, other opportunities to improve the quality maternal and newborn health services delivered include:

- Reforming health education and the recognition of qualifications needed to expand quantity and quality of maternal and newborn health services
- Reviewing and improving current case referral processes between private and public sector facilities for maternal and newborn health cases as well as referral processes between private-private (e.g., revisiting private sector ambulance services)
- Using a platform for knowledge sharing and experiences, such as a public-private forum (see recommendation 5 below), share experiences and strategies on how to strengthen quality (e.g., include private providers in Ministry of Health trainings, private providers can teach public sector providers about patient experience, learn from regional experience on self-regulation)
- Explore digital health innovations to strengthen quality of care

7.5 Incentivize and facilitate the reporting of data by the private sector ('build understanding')

The assessment revealed challenges related to data collection on the scope of the private health sector and its activities in Ghana. The lack of accurate data on the private health sector is not a unique problem to Ghana — other countries in sub-Saharan Africa, like Kenya (Ghana Ministry of Health, 2016), are addressing this challenge head on. Ghana can learn and build on these experiences. It is opportune for the Ministry of Health to invest in improved systems and capacity to collect and analyse private sector data to better understand its role not only in maternal and newborn health but also in the entire health system. Areas to focus on include:

- Reaching consensus between government agencies responsible for governing the private health sector, in collaboration with the private health sector, on a standard definition of the private health sector to be used throughout all ministry reports and policies (Appendix 6)
- Discussing the implementation of a minimum number of reporting requirements, standardized information (e.g., indicators) across all government agencies, and simplified mechanisms to report and share data (preferably using technology) to increase private sector reporting
- Strengthening Ministry of Health capacity to collect and conduct[7] 'whole-of-system' analysis that reflect all segments of the Ghana health system contribution to health sector as well as maternal and newborn health services
- Exploring regional experiences (e.g., Ivory Coast, Uganda, Ethiopia, others) in modernizing data collection and reporting using web-based systems that link all ministry departments data so that Ministry of Health leadership can better govern and administer not only the public sector but also the private health sector

7.6 Strengthen and operationalise a mechanism for public-private dialogue ('foster relations')

As seen in other countries with strong private sector engagement, a strengthened public-private dialogue platform enables collaboration, especially when the platform is supported by complete, accurate data as well as a structured, formal and process facilitating the dialogue. The Ministry of Health can use a public-private dialogue platform to foster relationships with new segments of the private sector and civil society, create open and transparent communication on key policy issues, and co-develop and co-implement an agenda – similar to the one proposed here – that will strengthen quality of related to maternal and newborn health. Tasks and topics for discussion by this public-private dialogue platform include:

- Strengthening the dialogue platform between the public and private health systems.
- Building on the landscape analysis presented in this report, to mobilize stakeholders critical to maternal and newborn health to form a public-private dialogue platform
- Using existing and collecting new data, to inform and guide public-private dialogue stakeholders' deliberations on what strategies to pursue to improve quality of maternal and newborn services

[7] The holistic assessment addresses this.

- Mobilizing resources – Ministry, private sector, and development agencies – to fund a secretariat to structure and facilitate a public-private dialogue process and its activities (e.g., data collection, pilot programs, policy reforms, etc.)
- Building public and private sector stakeholders' capacity to model key behaviours (e.g., facilitation, negotiation, communication, adaptive learning, conflict resolution) recognized as essential to a public-private dialogue process's success
- Co-designing and co-implementing joint projects to strengthen private sector quality in maternal and newborn services. Potential thematic areas include: (i) consensus on a definition of the private sector and a minimum number of standard indicators, (ii) strategies and incentives to increase private sector reporting, (iii) policy options to harmonize quality framework and tools, (iv) benefit from capacity strengthening interventions/opportunities that are extended to public facilities, etc.
- As the public-private dialogue process on maternal and newborn health matures, the public-private dialogue platform can then start to address long-standing and possibly more difficult issues such as National Health Insurance Scheme reimbursement and timely payments, economic/financial incentives to harness the private health sector, and other topics of common interest.

8. References

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Appendix 1: Glossary

This glossary is intended to assist readers in understanding commonly used terms and concepts when reading, interpreting, and evaluating this research.

Bias – a loss of balance and accuracy in the use of research methods. Bias can appear in research via the sampling frame, random sampling, or non-response. It can also occur at other stages in research, such as while interviewing, in the design of questions, or in the way data are analysed and presented.

CHAG (Christian Health Association of Ghana) – CHAG is a network organisation of health facilities and health training institutions owned by 21 different Christian Church Denominations. CHAG provides health care to the most vulnerable and underprivileged population groups in all regions of Ghana, particularly in the most remote areas.

Councils – The Ghana health sector landscape includes a number of professional bodies that have for scope to support licensing and registration of health professionals, such as the Pharmacy Council; the Nursing and Midwifery Council; the Medical and Dental Council; the Allied Health Professions, etc.

FDA (Food and Drugs Authority) – This is a Ghanaian government agency responsible for the inspection, certification, and proper distribution of foods and food products as well as drugs in Ghana

Framework – the structure and support that may be used as both the launching point and the on-going guidelines for investigating a research problem.

GHS (Ghana Health Service) – GHS is one of the health service delivery agencies in Ghana established under Act 525 of 1996 as required by the 1992 constitution. It is an autonomous agency that has 16 regional health directorates responsible for implementing national health policies mostly at the primary and secondary level. As a result of decentralization and health sector reform, services are integrated as one goes down the hierarchy of health structure from the national to the sub-district.

HeFRA (Health Facilities Regulatory Agency) – This is Ghana's regulatory agency that was set up in 2011 to license facilities for the provision of both public and private services.

KII (Key Informant Interviews) – KIIs involve interviewing people who have particularly informed perspectives on an aspect of the program being evaluated. Key informant interviews are "qualitative, in-depth interviews of 15 to 35 people selected for their first-hand knowledge about a topic of interest.

Mixed-methods – This research approach uses two or more methods from both the quantitative and qualitative research categories. It is also referred to as blended methods, combined methods, or methodological triangulation.

NHIA (National Health Insurance Authority) – The NHIA was established under the National Health Insurance Act 2003, Act 650, as a body corporate, with perpetual succession, an Official Seal, that may sue and be sued in its own name. The NHIA is one of the agencies of the MoH whose object is to "secure the implementation of a national health insurance policy that ensures access to basic healthcare services to all residents".

Private (Health) Sector – This refers to all non-governmental health actors: self-financing, faith-based organisations, and non-governmental organizations in the Ghana health sector landscape.

Private Sector Engagement (PSE) – Public-private engagement in health is the mutually beneficial collaboration between public and private health sector entities for the purpose of advancing public health goals and achieving sustainable health outcomes.

SPMDP (Society of Private Medical and Dental Practitioners) – SPMDP is a major stakeholder in health care delivery in Ghana. Birthed in 1968, the society is formed by a group of doctors and dentists who moved into the private sector and established private self-financing medical facilities and dental clinics.

Appendix 2: Data sources mapped to the project logic model

Inputs		
Topic	*Interviews*	*Literature Review*
Policy, strategies and plans related to maternal and newborn health, quality of care, and the private sector	x	x
Regulatory/legal framework related to maternal and newborn health, quality of care, and the private sector	x	x
Leadership, including organization of the private sector and governance structures and institutions for quality	x	
Resources for the private sector	x	
Process		
Topic	*Interviews*	*Literature Review*
Harmonization and implementation of national plans	x	x
Mechanisms for social and regulatory accountability	x	
Values, ethics and motivation of the private sector	x	
Relationship between the public and private sector and its organization	x	
Market competitiveness	x	
Outputs		
Topic	*Interviews*	*Literature Review*
Improved health system functioning	x	
Improved readiness of the private service providers for the provision of quality maternal and newborn health services		x
Improved access to and availability of quality maternal and newborn health services		x*
Improved utilization		x*
Adherence to standards		x
Outcomes		
Topic	*Interviews*	*Literature Review*
Quality		x*
Coverage		x*
Equity		x*
Service responsiveness		x*
Experience of care		x
Behavior change		x
Impact		
Topic	*Interviews*	*Literature Review*
Reduce maternal and newborn mortality		x*
Improve the experience of care		x

* including secondary quantitative data

Appendix 3: Qualitative sampling matrix

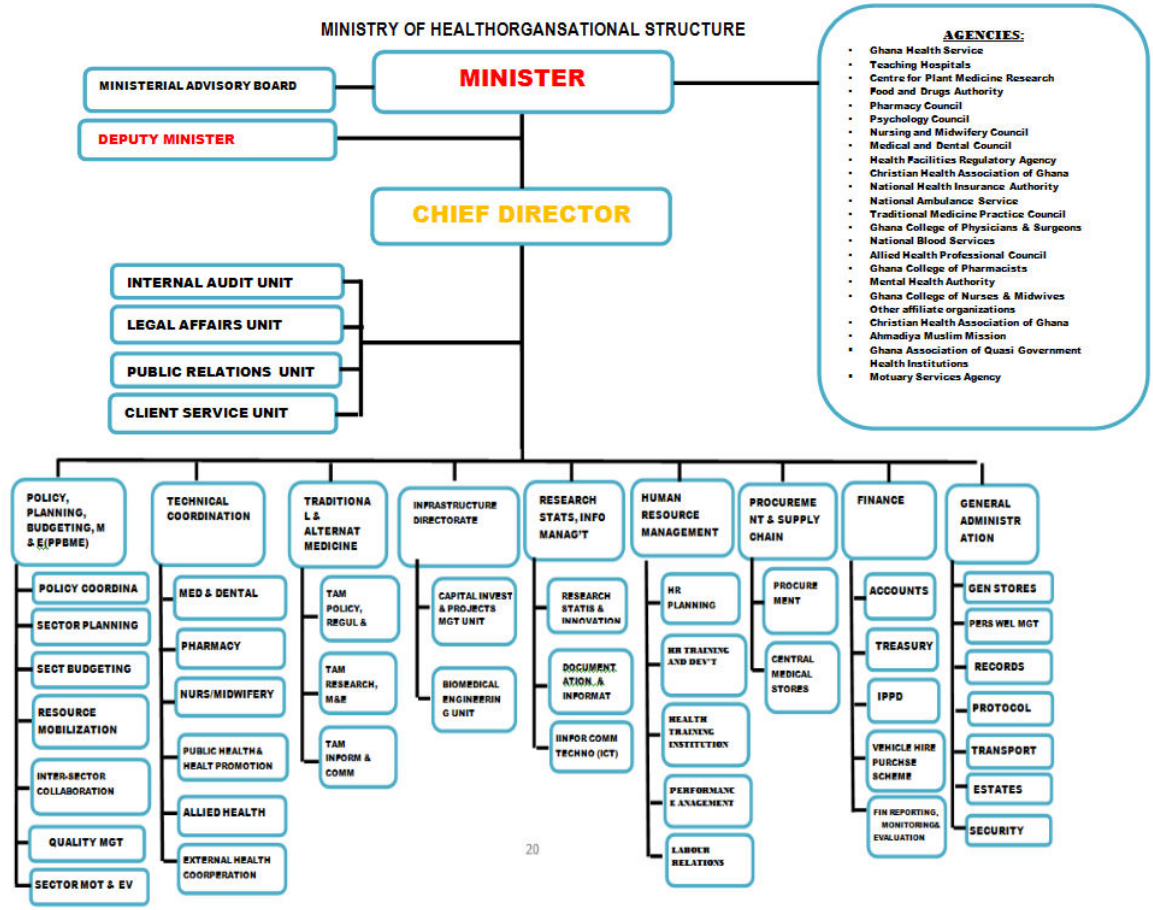
Health Sector	Role	Level
Public Health Sector	Policy / administration	National
		Sub-National
	Service delivery	National
		Sub-National
		Facility (Manager/Director)
	Regulation	National
		Sub-National
Private Health Sector	Policy / administration	National
		Sub-National
	Service delivery	National
	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

Appendix 4: Comparison of health status between CHAG and GHS

Health Status indicators: 2012-2018 (Pg. 48 CHAG Annual Report)											
Variable	2012	2013	2014	2015	2016	2017	2018	National	Source	Developing countries (2016)	Source
Total no of Deliveries	114,205	117,313	119,141	110,228	136,669	110,109	143,242				
Total ANC Attendance	507,034	632,282	620,223	560,394	641,554	684,800	748,657				
Maternal Mortality Rate (per 100,000 LB)	158	168	167	145	109	152	124	127.3	Inst. Mat Mort., DHIMS2, 2018	239	WHO: MNCAH, Stillbirths 2015
Neonatal Mortality Rate (per 1000 LB)	5.5	7.1	9.8	6.5	13	9	8.2	7.7	Inst. Mat Mort.,	52	WHO: MNCAH, Stillbirths 2016

									DHIMS2, 2019		
Infant Mortality Rate (per 1000 LB)	6.6	7.9	10.9	8.6	12.9	10.1	8.9	8.5	Inst. Mat Mort., DHIMS2, 2019	107	WHO: MNCAH, Stillbirths 2016
Under 5 Mortality Rate (per 1000 LB)	21.1	19.5	17.3	15.1	18.3	14	6.5	4.9	Inst. Mat Mort., DHIMS2, 2019	177	WHO: Key Facts 2015
Still Births Rate (per 1000 LB)	26	24	21	21	20	19	19	1.4	Facts & Figs, GHS, 2018	18.4	2015 Worldwide Est.: WHO Neglected Tragedy of Stillbirths

Appendix 5: Ministry of Health Organogram



Accessed on 28 September 2020 via https://www.moh.gov.gh/organogram/

Appendix 6: Definitions of the private sector

Whilst the private sector was defined in detail in the 2013 Private Health Sector Development Plan, subsequent strategies, policies, and plans have conceptualised and/or defined the private sector in different ways. At times, select private sector associations and organizations are listed by name. Examples appear below. Interview respondents also conceptualised and/or defined the private sector inconsistently. They tended to reserve the 'private sector' designation for self-financing organizations; faith-based organisations and non-governmental organizations were less frequently considered as belonging to the private sector.

Private Health Sector Development Policy (2013)

The private health sector includes "any non-government health actor: self-financing private sector (also referred to as for-profit), not-for-profit and mission or faith-based facilities involved in the delivery of health services; input suppliers (pharmaceuticals, equipment); health research and training institutions; traditional and informal providers; health promotion and education; and health financing."

National Healthcare Quality Strategy (2017-2021)

"The private sector is made up of private medical practitioners, most of whom are members of the Society of Private Medical and Dental Practitioners (SPMDP); health facilities of both private and public corporate organization associated with the Ghana Association of Quasi-Government Health Institutions (GAQHI); private pharmacists under the umbrella of the Community Practice Pharmacists Association (CPPA); private midwives associated with the Ghana Registered Midwives Association (GRMA); and private diagnostic scientists within the Association of Biomedical Scientists."

Quality Assurance Strategic Plan for GHS 2007-2011 (2016)

The private sector includes:

- "Private-not-for-profit: CHAG [Christian Health Association of Ghana] institutions and PPAG [Planned Parenthood Association of Ghana] clinics
- Private for profit: Hospitals and clinics, GRMA clinics, traditional medicine sector"

National Health Policy 2020

Private sector stakeholders include "CSOs, health and non-health industry players."