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

Evidence from Bangladesh

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ACKNOWLEDGEMENTS

The role and function of the Private in Bangladesh's Healthcare Delivery System is significant. The development of this has brought together the viewpoints of many individuals and groups that are involved in healthcare delivery. By discussing the role and function of the Private Sector enables careful consideration of how we can make improvements in the Provision, Quality and Experience of Care. I am also very grateful to have the suggestions from the private sectors on how best to work together to achieve what we want.

Firstly, I am thankful to all the people who provided support in developing the content of the report. Special mention has to go to the Hospital and Clinics Division of Director General of Health Services, Ministry of Health and Family Welfare whose leadership was instrumental in bringing people together to discuss this important topic.

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ACRONYM LIST

ANC	Antenatal Care
BDHS	Bangladesh Demographic and Health Survey
BHFS	Bangladesh Health Facility Survey
BMRC	Bangladesh Medical Research Council
BNC	Bangladesh Nursing Council
BMDC	Bangladesh Medical and Dental Council
BMA	Bangladesh Medical Association
BPC	Bangladesh Pharmacy Council
BPA	Bangladesh Pediatric Association
BBF	Bangladesh Breastfeeding Foundation
BNF	Bangladesh Neonatal Forum
BPMPA	Bangladesh Private Medical Practitioners Association
BPCDOA	Bangladesh Private Clinic Diagnostic Owners Association
BPMCA	Bangladesh Private Medical College Association
BIRDEM	Bangladesh Institute of Research and Rehabilitation in Diabetes, Endocrine and Metabolic Disorders
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CQI	Continuous Quality Improvement
DGDA	Directorate General of Drug Administration
DGHS	Directorate General of Health Services
DGME	Directorate General of Medical Education
Div-QIC	Divisional Quality Improvement Committee
D-QIC	District Quality Improvement Committee
DHIS2	District Health Information Software 2
HPNS	Health Population Nutrition Sector Program
HCFS	Health Care Financing Strategy
HSM	Hospital Service Management
HBB	Helping Babies Breathe
HMIS	Health Management Information System
ISIC	International Standard of Industrial Classification
KII	Key Informant Interview
MNH	Maternal and Newborn Health
MNCSP	Maternal and Newborn Care Strengthening Project
MoHFW	Ministry of Health and Family Welfare
MNC&AH	Maternal Neonatal Child and Adolescent Health
MoLGRD&C	Ministry of Local Government, Rural Development, and Co-operatives
N-QIC	National Quality Improvement Committee
NGO	Non-governmental Organization
NHP	National Health Policy
NNHP	National Newborn Health Program
OGSB	Obstetrical and Gynecological Society of Bangladesh
OP	Operational Plan
PPP	Public-Private Partnership
PHS	Private Health Sector

PNFP	Private Not-for-profit
PFP	Private For-profit
QA	Quality Assurance
QIS	Quality Improvement Secretariat
QoC	Quality of Care
SDG	Sustainable Development Goals
SMF	State Medical Faculty
SOP	Standard Operating Procedures
TQM	Total Quality Management
UHC	Universal Health Coverage
UHFPO	Upazila Health and Family Planning Officer
USAID	The United States Agency for International Development
WHO	World Health Organization

Executive Summary

The World Health Organization Network for Improving Quality of Care for Maternal, Newborn and Child Health (the Network), a consortium of Ministries of Health in 11 countries and their technical partners, works to improve the quality of care for maternal and newborn health (MNH). To achieve the Network's goal of halving maternal and newborn deaths and stillbirths in health facilities by 2022, countries and partners in the Network are improving quality of care in health facilities through four strategic objectives: leadership, action, learning, and accountability. The Network recognizes that private providers (e.g., non-government providers, for-profit businesses) are an important source of health care. The literature reveals that private providers (including unlicensed and uncertified providers) from low- and middle-income countries like Bangladesh were less likely to follow the standards of medical practice, have poorer patient outcomes, and lower efficiency. A lack of regulations and/or inconsistency in regulations weakens the quality of care (QoC) and patient safety.

In the context of low public sector capacity and growing healthcare demands in urban Bangladesh, private for-profit engagement is critical to achieve universal health coverage. The study explored the drivers and determinants of the current engagement and identified opportunities for involving the private sector to deliver quality MNH services. In addition to a review of grey and published literature, primary data was collected through 22 key informant interviews (KIIs) with representatives from the government and private sector at national, district and sub-district levels. Interviews were conducted both virtually and in person with participants representing policy/administration, service delivery and regulation level.

In Bangladesh, the private health sector is comprised of 1) private not-for-profit, 2) private for-profit and 3) informal providers. Professional representative bodies are also contributing. The Ministry of Health and Family Welfare (MoHFW) plays the stewardship role with the main two vertical streams: the Directorate General of Health Services (DGHS) and the Directorate General of Family Planning (DGFP). DGFP prioritized maternal and newborn health, including family planning method distribution. DGHS mainly provides general health and specialized health services, including MNH services. The Director Hospital and Clinic unit under DGHS deals with provision and renewal of licenses for the private health facilities and organizations. The Quality Improvement Secretariat (QIS) of the Health Economic Unit, led by DGHS, look after the quality of health service delivery, including in the private sector.

As per the DHIS2 as of Nov 29th, 2020, Bangladesh had 9,426 government-registered private for-profit health facilities. Almost one-fourth (21%) of these were in the Dhaka district, while the rest (79%) were outside Dhaka district. The Bangladesh Demographic and Health Survey (2017-18) shows that the proportion of ANC services from the private sector increased from 43% in 2011 to 63% in 2017, and the proportion of births delivered at private health facilities increased from 15% in 2011 to 32% in 2017. Thirty-six percent of women from the highest wealth quintiles in 2011 delivered at private facilities, which increased to 55% in 2017. In contrast, the proportion of women from the lowest wealth quintiles who delivered in a private facility grew from 3% (2011) to 14% (2017). The literature review found that National health policy encourages private sector providers to work with the public sector for the

management of the health sector in a coordinated manner. However, there was no approved, specific written policy to facilitate public-private collaboration for QoC and MNH at either policy or implementation level.

It was learnt from the interviews with study respondents that quality of obstetric care is not optimal in comparison with MOHFW standards. The private sector health facilities follow their own health care standards. There is lack of monitoring and regulating from the Quality Improvement Secretariat, MOHFW. It is critical to ensure that the private sector is accountable to the government for performing quality MNH care. The private facility should follow the standard facility readiness and standard operating procedures (SOP) recommended by MOHFW.

In Bangladesh, there are nationwide associations like the Bangladesh Medical Association, which is one of the biggest platforms for doctors registered with the Bangladesh Medical and Dental Council. The Obstetrical and Gynecological Society of Bangladesh, Bangladesh Pediatric Association, and Bangladesh Neonatal Forum are contributing at a policy level and delivering maternal health and newborn health services respectively. There is a competition between different private health sectors (PHSs), some of which face barriers in ensuring quality MNH services, such as limited transportation, lack of updated information about clinical management, and financial constraints. However, there was also acknowledgement that the private sector is filling gaps in the public sector.

It was found that there is a lack of accountability mechanisms, like client feedback collection, in most of the private hospitals. There was minimal standardization of measurement of patients' satisfaction. Despite substantial improvement in the national health management information system in Bangladesh, there was minimal information available on the private sector providers. Therefore, MoHFW cannot get a comprehensive view of the MNH service situation, including the contribution of the private health sector (PHS).

A standard set of protocols and an accreditation system should be in place for regulating (e.g., licensing, accreditation) and governing provision of quality MNH services. More policy research will be required to determine how the core weaknesses among private organizational environments can be addressed. Relevant service providers (e.g., doctors, midwives) from the PHS can be involved in capacity building on quality improvement (QI) and quality assurance (QA). Some of the private providers can offer clinical training and attachment with the local medical and nursing schools for quality maternal and newborn care. Private providers can recognize and measure patients' satisfaction, and the health ecosystem can boost their brand, providing a competitive edge in the market, reassuring patients, inspiring their staff, and ultimately helping to support further investment.

Private Sector respondents have recommended that they worked with MOHFW to improve their compliance with policies and standard operating procedures that are relevant to Maternal and Newborn Care. They further suggested that a framework can be maintained to motivate service providers of public sector, either by arranging incentives or a payment regime which is based on the service specification.

Furthermore, the government could also request certain private hospitals to make some hospital beds free of cost for patients or to charge less, in return for grants, thus improving access for Maternal and Newborn Care. Additionally, the Private health Sector representatives stated that the current administrative burdens for the private health sector are cumbersome and if these were to be reprioritized that some of this time could be dedicated to patients' care.

A referral network, including a list of need-based hospital emergency departments, is important, as is comprehensive preparation of a facility to deal with emergency support. The authority of the private health sector may keep some budget to support the poor and vulnerable people of the community to avoid any incidents. Any sorts of Incentives/ waiver from the government can be introduced on the basis of private investments in the provision of quality MNH services.

The government can propose and promote the culture of providing feedback to enhance the quality of MNH care. All private health facilities and organizations can be asked to create electronic health records and or HMIS like the public facilities, which would allow them to report regularly to the national DHIS2.

Strong regulatory and mediatory mechanisms are therefore recommended in Bangladesh about its growing private sector, in order to improve quality standards and ensure the accreditation of individuals and organizations.

1. Introduction

The World Health Organization (WHO) Network for Improving Quality of Care for Maternal, Newborn and Child Health (Quality of CareNetwork), a consortium of Ministries of Health in 11 countries and their technical partners, works to improve the quality of care for maternal and newborn health (MNH). To achieve the Network's goal of halving maternal and newborn deaths and stillbirths in health facilities by 2022 countries and partners in the Network are improving quality of care in health facilities through four strategic objectives: leadership, action, learning, and accountability (Adeniran, Likaka, et al. 2018, World Health Organization 2018).

While the Network's efforts to achieve this ambitious goal have largely focused on strengthening the public health sector, members of the Network recognize that private providers (e.g., non-government providers, for-profit businesses) are an important source of health care and have a role to play in improving quality of care (QoC). The private sector addresses an increasing volume of MNH care needs in countries in the Network. However, information about how to engage and sustain private sector contributions to deliver quality care in low- and middle-income countries was limited (Lattof SR, Maliqi B (2020). This gap must be addressed if the Network is to achieve its aims of reducing maternal and newborn deaths and stillbirths.

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

Definition of the private health sector

The private health sector is comprised of non-governmental health actors. These actors can be categorized by the levels at which they operate: multinational, national, or sub-national; and organizations, hospitals, clinics, or individuals. They can also be categorized by how they operate: providers involved in the direct delivery of health services (i.e., hospitals, clinics, formal and informal providers), associated industries supplying inputs (i.e., pharmaceutical industry, medical equipment industry), health research and training institutions, or payers (i.e., insurers). In lower-middle-income countries, informal and unqualified private providers may offer services as 'quacks,' traditional healers, or traditional birth attendants (Wadge, Roy et al. 2017).

Quality of care among private providers

QoC is fragmented and distributed inequitably between the public and private health sectors (SHOPS Project 2012). Analyses of healthcare in both government-run and private sector health facilities have found poor quality across multiple dimensions with little difference between public and private facilities (Basu, Andrews et al. 2012). While studies suggest that private providers deliver better service quality than public providers, technical quality in the private sector is as poor, if not poorer, than the public sector (Bhatia and Cleland 2004, Morgan, Ensor et al. 2016). For example, a mixed-methods study in rural Bangladesh revealed that private physicians scored higher in friendliness, respecting, informing,

and guiding than the public sector; however, neither sector scored optimally and both sectors would benefit from improvements in quality (Joarder, George et al. 2017). A systematic review in low- and 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, resulting partly from perverse incentives for unnecessary testing and treatment (Basu, Andrews et al. 2012).

Legislation and regulation of the private sector

Regulation is crucial throughout the health care system. A lack of regulations and/or inconsistency negatively affects QoC and patient safety. The regulatory functions depend not only on laws but also on having a proper organizational structure, work force, funding, governance structure, and sound compliance and enforcement mechanisms. Though in many areas there are laws, large gaps remain with regard to the compliance and enforcement of these legal instruments. This happens due to structural problems of existing regulatory bodies, which are compounded by weaknesses of governance structures (Kabir HM 2014). The Private Practice and Private Clinics and Laboratories (Regulation) Ordinance, 1982 governs the establishment of clinics and hospitals in the private sector.

Financing and infrastructure of the private sector

Patient payments and health insurance reimbursements make up the primary financing of the operational costs of the private sector. Hussain SA, Sullivan R. (2013) indicated that supply-side financing of health care services improved the access of poor households to essential health care services in Bangladesh. Here, out-of-pocket expenditures constitute 64% of total health expenditures (HEU/DI 2010). Furthermore, Sarker AR, Ali SMZ, Ahmed M, Chowdhury SMZI, Ali N (2022) showed that the average out-of-pocket expenditure (OOPE) of the people from the highest wealth quintile was 5.2% of their household income, and on the other hand, it was about 33% for the people from the lowest wealth quantiles. Such high out-of-pocket expenditures on health can lead to loss of productive assets (selling items to pay for medicines) and can threaten economic survival, especially in countries with high rates of catastrophic illnesses, such as Bangladesh (Health Care Financing Strategy 2012-2032).

Accountability

Accountability in the health sector is weak and limited by the inadequate reporting of health service indicators, such as QoC in both the public and private sectors. Quality data is key for accountability. The private sector offers little publicly available data on the quality and quantity of care it provides. There is an urgent need to integrate the private sector in national health system reporting, planning, and monitoring; and to incentivize the private sector to reliably collect and share these data in a timely manner (Saleh 2013).

2. Rationale of the study

The private sector plays a key role in delivering sexual and reproductive health services. The Sustainable Development Goal (SDG) 3 of reaching universal health coverage (UHC) by 2030 is challenging in pluralistic healthcare systems such as Bangladesh (Adams and Evans 2018). Here, the non-public or private health work force is an issue of particular concern. This includes both qualified and informal (often known as village doctors, unqualified/semi-qualified providers, or quacks) service providers.

Previous studies assumed that private providers deliver better service quality than public providers. Other literature revealed that private 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. A lack of regulations and/or inconsistency among regulations hamper quality of care and patient safety. According to the Bangladesh Health Facility Survey (2017), one-third of the private hospitals performed all nine signal functions for comprehensive emergency obstetric and newborn care (CEmONC) in the three months preceding the survey, though all facilities reported having conducted deliveries through Cesarean section. The same report also indicated that none of the private facilities surveyed had all 13 items[1] considered essential for providing normal delivery care services. In the context of low public sector capacity and growing healthcare demands in urban Bangladesh, private for-profit engagement is critical to achieve universal health coverage. To attain the SDG target, both the public and private health sectors need to invest in delivering quality services. An analytical study was required to identify possible pathways for engagement between the private and public sectors.

3. Research objectives

3.1. General objective

The study aims to explore the mechanisms for engaging the private sector in planning, delivering, and demonstrating accountability for quality MNH services in Bangladesh and establish the evidence-based mechanisms that ensure an active and meaningful engagement of the private sector for delivering on national plans for QoC, with a focus on MNH.

3.2. Specific objectives

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

3.3. Methodology

Study design

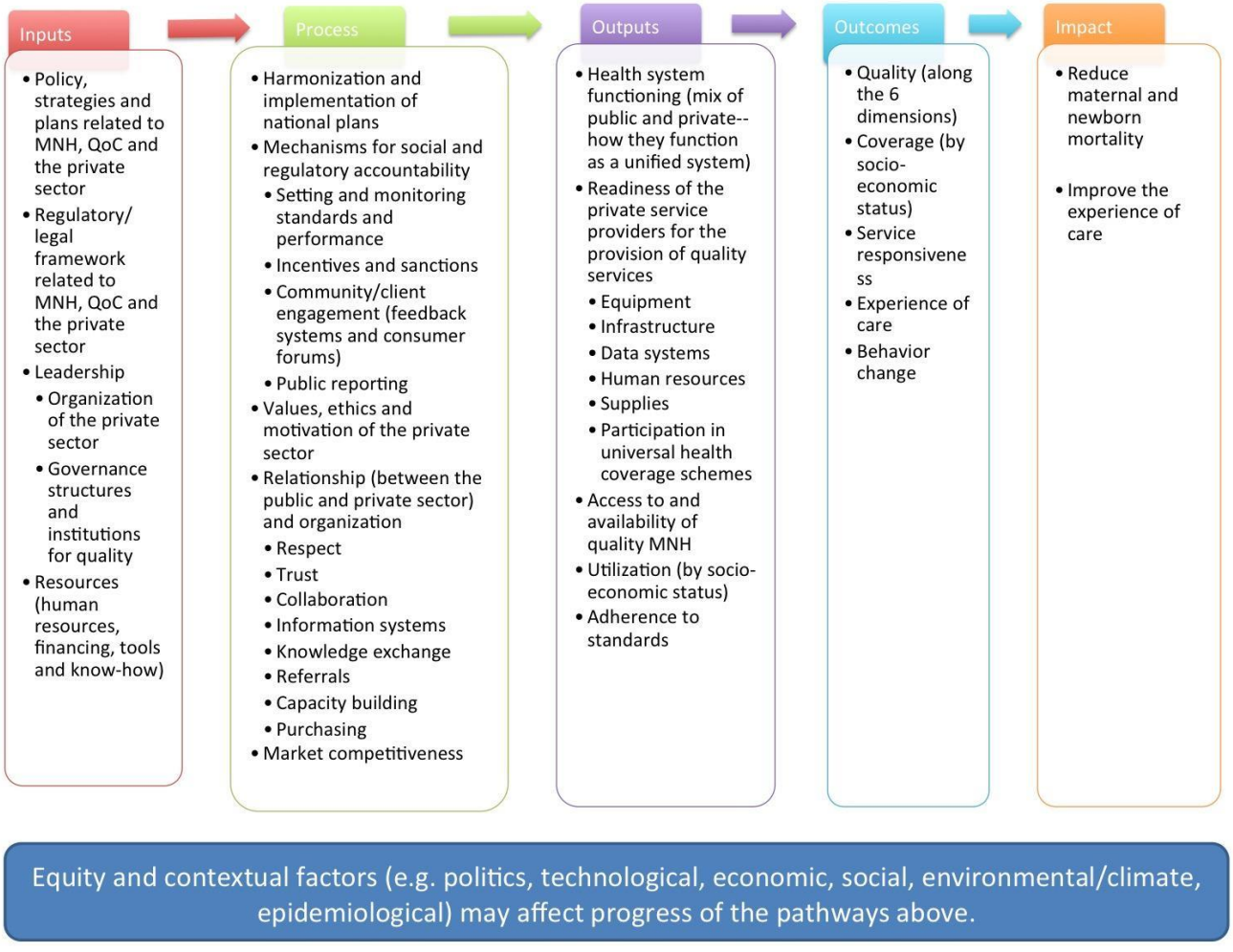
This was a mixed method study, involving both qualitative and quantitative methods. It also consisted of a literature review to complete a situational analysis on private sector engagement.

Logic model for mapping the private sector

[1] Items are (1) guideline on BEmONC or CEmONC (2) at least one staff ever trained in IMPAC at any time (3) examination light (4) delivery pack (5) suction apparatus (6) neonatal bag and mask (7) partograph (8) gloves (9) injectable uterotonic oxytocin (10) injectable antibiotic (11) magnesium sulfate (12) skin disinfectant (13) intravenous fluids with infusion set (ref: BHFS,2017)

Based on the relevant literature and input from colleagues at WHO, the global advisory working group developed a logic model (Figure 1). The model depicts key components of the private sector's involvement in delivering quality MNH services within the national health system. It was adapted from the evaluation framework for the scale-up for maternal and child survival (Bryce, Victora et al. 2011). The logic model illustrates that the private sector friendly policy, relevant regulatory framework for delivering quality services, and governance structure is necessary to engage the private sector. In the competitive market, the private health sector has to be ready in terms of technical capacity, resources and ensuring accountability. As a major portion of health services are covered by the private sector, the quality of services delivered, and patient's experiences of care, need to be considered to have the expected outcome. At the top and bottom of this model, we included 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 pathways.

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



Themes

Key thematic areas were mapped and aligned with the logic model (Figure 1). These were analyzed as follows, but were not limited to:

- National-level policies, strategies, and plans, regulatory and/or accreditation
- Quality of MNH service delivery, including preventive, promotion, and curative services; regulation; and values/ethics
- Market competitiveness and conditions
- Collaboration between the government and private sector and mechanisms for accountability
- Accountability and reporting

Study location

This study was part of a multi-country study. The study was not bound to a specific region or city as the scope of study was national policies and practices engaging the private health sector in Bangladesh. In addition to the national level, USAID's MaMoni Maternal and Newborn Care Strengthening Project (MNCSP) selected four districts (Dhaka, Manikganj, Madaripur & Noakhali) and three sub-districts, outside Dhaka to obtain more in-depth private sector engagement-related information.

Study population

The study population included individuals involved in the delivery of formal health services in the public and the private sectors in Bangladesh.

Inclusion/exclusion criteria

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

- have experience in and knowledge of service delivery of QoC and/or MNH in Bangladesh.
- are currently working in the public health sector and/or the private formal health sector in Bangladesh; and
- have been working in their current role for at least two years.

Individuals were excluded from participating if they:

- work in the informal private sector; or
- work on topics beyond service delivery (e.g., supply chain, education/training, insurance provision).

As per the Medical Practice and Private Clinics and Laboratories (Regulation) Ordinance, 1982, here we define the private sector in the following ways: "private clinic means clinic, hospital, or nursing home, by whatever name called, owned by any person, other than the Government, where patients are admitted and kept for treatment" (Bangladesh Ministry of Law, Justice and Parliamentary Affairs,2021).

Study duration

After achieving ethical clearance from Bangladesh Medical Research Council (BMRC), this study took about 12 months to complete (July 2020 to June 2021).

Methods of data collection

We utilized a mixed-method approach, integrating both qualitative and quantitative data throughout the data collection, analysis, and interpretation. It included both primary and secondary data collection.

Primary data was collected through key informant interviews (KII), using a semi-structured interview guide. This guide enabled pooling of the information gathered by different interviewers, while at the same time giving the interviewers flexibility to explore issues unique to respondents. The study tools were developed in English and then translated into Bengali. Most of the interviews were in Bengali. Almost all interviews lasted approximately 60 minutes and were audio-recorded with prior verbal consent. In a few cases, the participant did not consent to being audio-recorded. In those cases, the interview was conducted without the recording, but notes were taken and factored into the main thematic analysis. Most of the interviews were done in a virtual format using Skype, Zoom, or mobile phones, mainly due to COVID-19 pandemic. Later, all the recordings and written notes were translated and transcribed into English by experienced research assistants. Continuous supportive supervision from the study team was ensured for data quality.

Secondary data was extracted from grey and published literature reviews. Key terms used for web search included "private," "regulation," "quality," "policy," and "strategy." Both quantitative and qualitative data were collected on the private sector's size, scope, distribution, and QoC outcomes related to MNH in Bangladesh.

Sampling

We selected the sample for KIIs using a stratified purposive sampling approach that captured health sector (public or private), role (policy/administration, service delivery, regulation), and level (national, subnational, facility). This approach allowed us not only "symbolic representation," but it also illustrated the diversity within the population's boundaries (Ritchie, Lewis, et al. 2003). It also allowed forsome variation in individuals' roles and the level at which they operate (Patton 2002). We completed 22 KIIs out of 28 planned, due to the COVID-19 pandemic and the busy schedule of policy level respondents, particularly those involved in decision making in response to the pandemic. The sampling matrix depicted below (Table 1) shows the number and types of interviews conducted. Interviews were conducted on policy/administration, service delivery, and regulation issues, at national, subnational and facility levels.

Table 1: Qualitative sampling matrix

Health Sector	Role	Level	KII Sample	KII Sample
Public Health Sector	Policy / administration	National	3	5
		Sub-National	2	
	Service delivery	National	2	5
		Sub-National	1	
		Facility (Manager/Director)	2	
	Regulation	National	2	2
		Sub-National	0	
Private Health Sector	Policy / administration	National	0	1
		Sub-National	1	

	Service delivery	National	4	8
		Sub-National	2	
		Facility (Manager/Director)	2	
	Regulation	National	0	1
		Sub-National	1	
		Total	22	22

Data Analysis

Qualitative data from KIIs was analyzed using NVivo software and content analysis technique, with both inductive and deductive coding of themes. Deductive coding themes were informed by the logic model (see background section) and inductive coding themes were complemented by using manual content analysis using the questionnaire. They were organized under thematic and sub-thematic codes. All data regarding the perspectives of the respondents was summarized for this country case study. Country-specific literature was gathered for the systematic review using the same thematic tables prepared for content analysis.

Review and validation of the findings

For the review process of the study findings, we organized four consultative meetings: two at district level and another two at national level. In these consultative meetings, participants represented both public and private facilities and professional bodies. They validated the initial findings and provided their additional inputs.

4. Findings

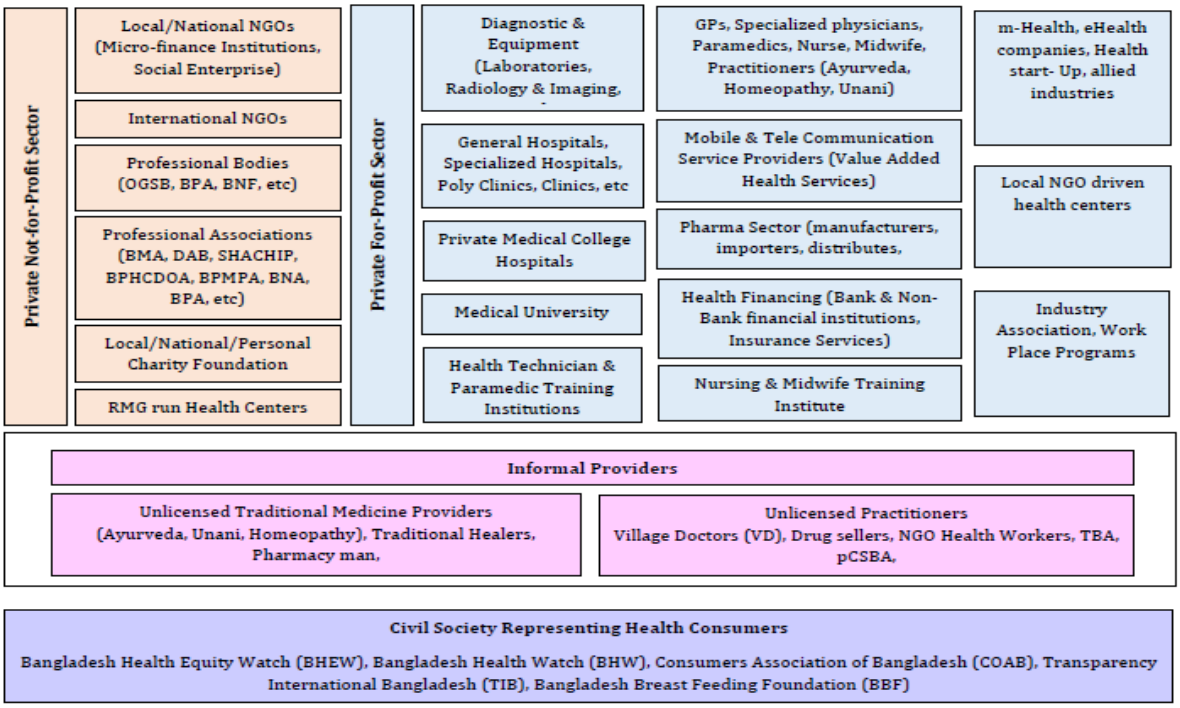
4.1. Overview of the health sector actors in Bangladesh

Drawing on the literature review, we describe below both sectors related to health services.

Private sector

The private health sector refers to all types of non-governmental health actors. These actors can be categorized into three major groups: private not-for-profit (PNFP), private for-profit (PFP), and informal providers (Figure 2). Services provided by civil society (non-governmental organizations [NGOs]) are included in the first two categories.

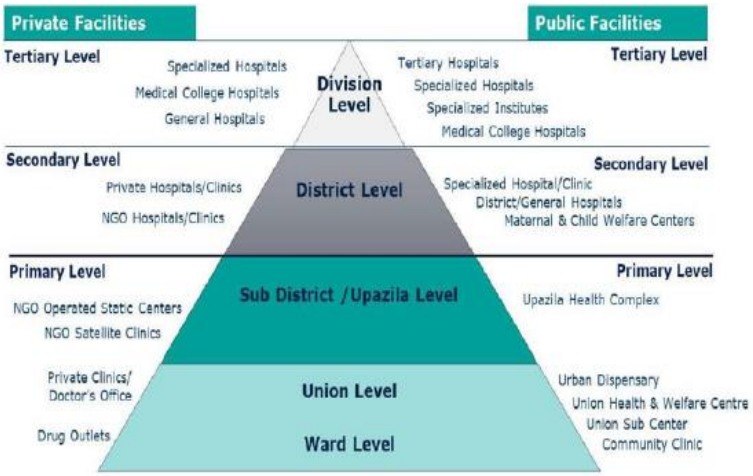
Figure 2: Segments of actors in the private health sector in Bangladesh (adapted from World Bank Private Health Sector Assessment)



As Figure 3 illustrates, the private health sector operates at all levels of care in Bangladesh and does complement the public sector in delivery of health services. Private health facilities range from:

- Primary level: private facilities include NGO static and satellite centers, PFP clinics, doctor's offices, and drug outlets
- Secondary level: PFP as well as PNFP NGO clinics and hospitals
- Tertiary level: PFP medical colleges, and specialized and general hospitals

Figure 3: World



Source: UNICO Report 2018. Ahmed et al. (2013), extract from the UNIDO report (http:// facilityregistry.org.dghs.gov.bd./index.php. Bangladesh Health Facility Survey (2014), Bangladesh Health System Review 2015 and Health Bulletin 2019

Tiers of health structure in Bangladesh (Source: Bank Private Health Sector Assessment.

Public health sector

Bangladesh's health sector comprises a substantial number of players, with the Ministry of Health and Family Welfare (MoHFW) playing a stewardship role. In the public sector, MoHFW acts with the help of implementing authorities (Figure 4). The two main vertical systems are: 1) Directorate General of Health Services (DGHS), and 2) Directorate General of Family Planning (DGFP). Each system maintains parallel administration and has functions from the central/national level to the community/ward level. Health facilities under DGHS and DGFP are also categorized by primary, secondary, and tertiary levels, depending on the location of facilities. DGFP prioritized MNH, including family planning method distribution. DGHS mainly provides general health and specialized health services, including MNH services.

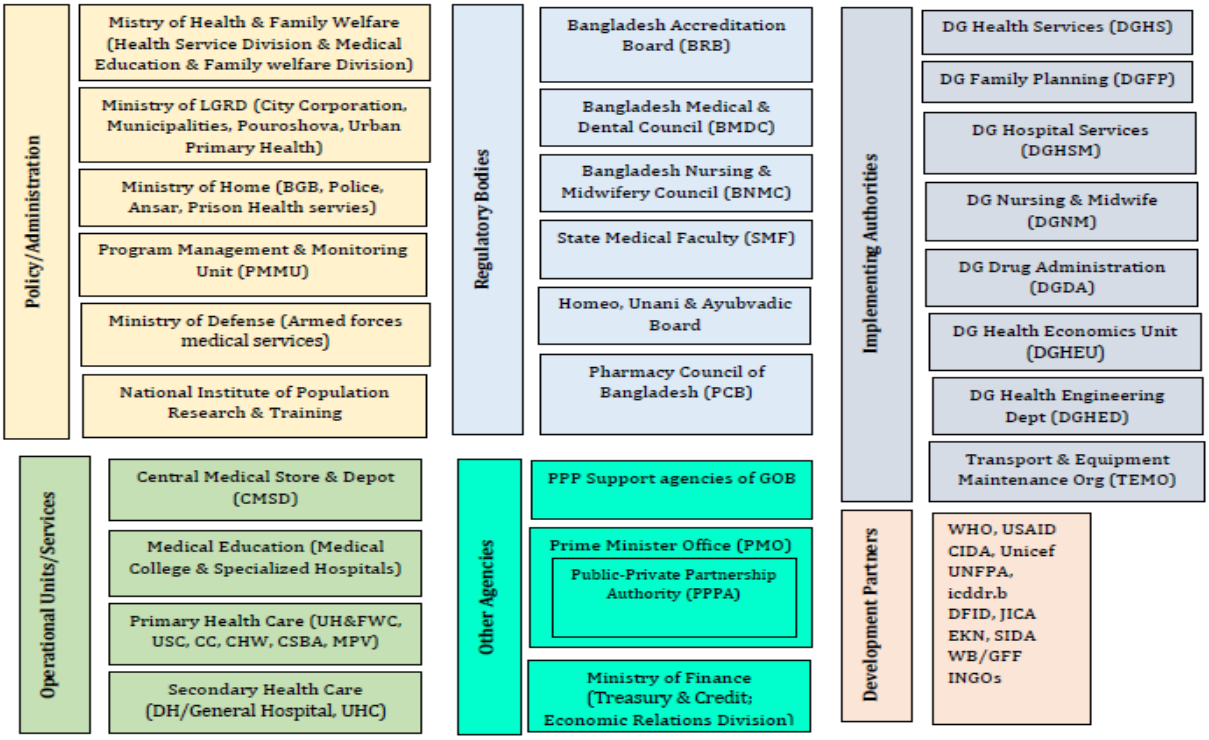
The Hospital Service Management (HSM) unit under DGHS has the mandate to ensure quality health service delivery, including in the private sector. Under DGHS, the HSM unit mainly deals with provision and renewal of licenses for the private health facilities and organizations in Bangladesh.

The Quality Improvement (QI) Secretariat (QIS) of the Health Economic Unit under DGHS looks after quality health service delivery. MoHFW has been implementing the 4th Health, Population, and Nutrition Sector Program (4th HPNSP). It has twenty-nine operational plans (OPs). One of them is on Maternal Neonatal Child and Adolescent Health (MNC&AH). Here, the importance of the development of a model for engagement of the private sector is highlighted.

These government structures are mainly based on rural and semi-urban areas. However, urban areas and city corporations deal with the health department of the Ministry of Local Government, Rural Development, and Co-operatives (MoLGRD&C).

Bangladesh has five regulatory bodies, as listed in Figure 4. Apart from those, professional bodies in MNH thematic areas are positioned and are contributing to policymaking, national guideline development, capacity building, and technical assistance. The Obstetrical and Gynecological Society of Bangladesh (OGSB), Bangladesh Pediatric Association (BPA), Bangladesh Breastfeeding Foundation (BBF) and The Bangladesh Neonatal Forum (BNF) are the key stakeholders (Figure 4). Additionally, there is another nationwide association, the Bangladesh Medical Association (BMA), which is one of the biggest platforms for doctors registered with the Bangladesh Medical and Dental Council (BMDC). The BMDC is a constitutional body that recognizes medical qualifications and registers all doctors who graduated from both public and private medical colleges to practice in Bangladesh.

Figure 4: Segments of actors in the public health sector of Bangladesh, adapted from Global Financial activity report the World Bank Group, March 2020.



4.2. Private sector engagement in maternal and newborn health services

Type, size, and scope of private sector MNH services

Among the private facilities, across the three categories, available in Bangladesh, most offer MNH services. At both the national and district levels, there are several maternity hospitals and clinics owned by groups of senior consultants. Furthermore, the NGO-run primary health care centers (PFNP) situated in urban and semi-urban areas are mainly for women and children. In the context of low public sector capacity and growing healthcare demands in urban Bangladesh, PFP engagement is critical to achieve universal health coverage.

Size and demand of the private health sector in Bangladesh

As shown in Table 2 below, as of November 2020, Bangladesh had 9,426 registered PFP facilities including hospitals, clinics, diagnostic centers, and blood banks. Out of these, almost one-fourth (21%) were in the Dhaka district, where the country's capital is located, while the rest (79%) were outside Dhaka district. While Dhaka district had about 700 hospitals and clinics, on average only 43 hospitals and clinics were present per district outside Dhaka.

This distribution is highly centralized. People from other districts had to travel to central Dhaka and other large cities to visit a private provider or facility because of perceived better-quality treatment and/or a lack of specialized services in their community (e.g. specialists, diagnostics). Also, rapid

population growth in megacity Dhaka influenced the general population to seek treatment in Dhaka. From interviews, participants shared that patient were also referred from other peripheral areas to Dhaka. However, this estimation and Table 2 only relate to PFP facilities, which are licensed and registered with DGHS. NGO-run primary maternal and child health care centers were excluded.

Table 2: Percent distribution of licensed private sector facilities/ organization from DGHS, MoHFW

Bangladesh	Hospital/Clinic N=3395	Diagnostic Center N=5946	Blood Bank N=85	Total N=9426
Percentage and (#) of private facilities in Dhaka District (Central) (# of district=1)	21%	20% n=1191	61% n=52	21% n=1,951
Percentage and (#) of private facilities outside Dhaka District (Peripheral) (# of district=63)	79%	80% n=4,755	39% N=33	79% n=7,475

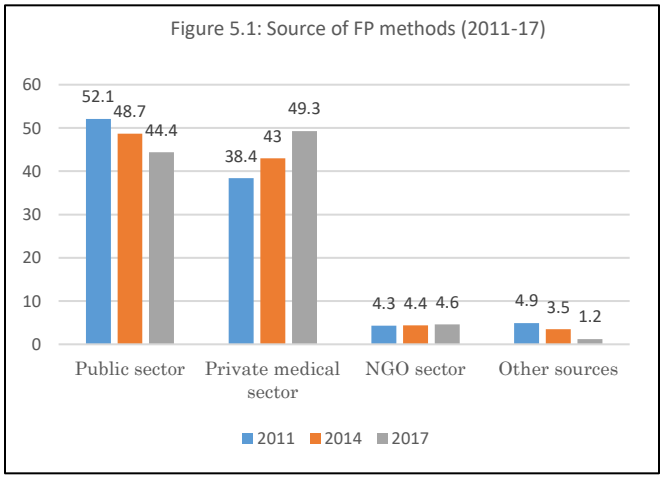
Ref: DGHS website: Retrieved from http://103.247.238.81/hsmdghs/registration/hsm_facility_show_public.php (November 29, 2020)

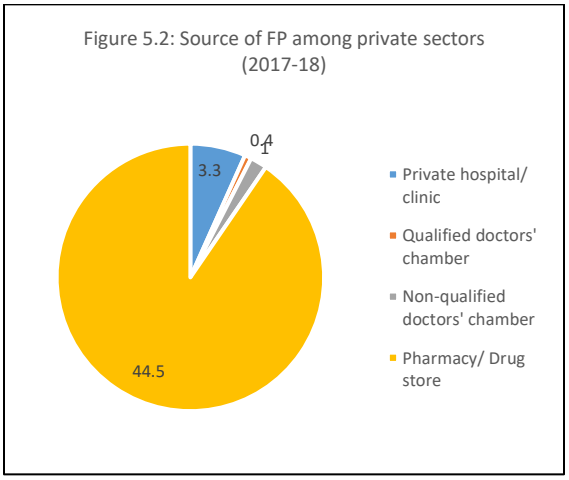
Market share of MNH care by the public and private health sectors

With the growing trend of urbanization and population growth, demand for services has been increasing and consumer demand is shifting toward the private health sector (Adams AM et al. 2019). Information on this shift for specific MNH and family planning services is provided in the following sections.

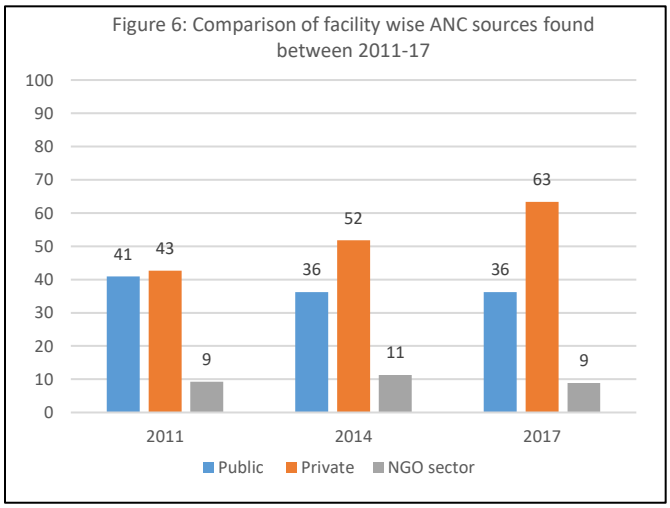
Family planning

According to BDHS (2017-18), about 62% of currently married women (15 to 49 years of age) were using a modern contraceptive method in Bangladesh. The same survey report showed that about half (49.3%) of the study participants received FP methods from the private sector. This is about a 10% increase over the 38.4% reported in BDHS 2011. Among different private sources of care, pharmacy/drug store was the main source (44 out of 49.3 percentage points) of FP methods for the women, accounting for almost 90% of total private sector-based sources (see Figure 5.1 & 5.2).





Antenatal care

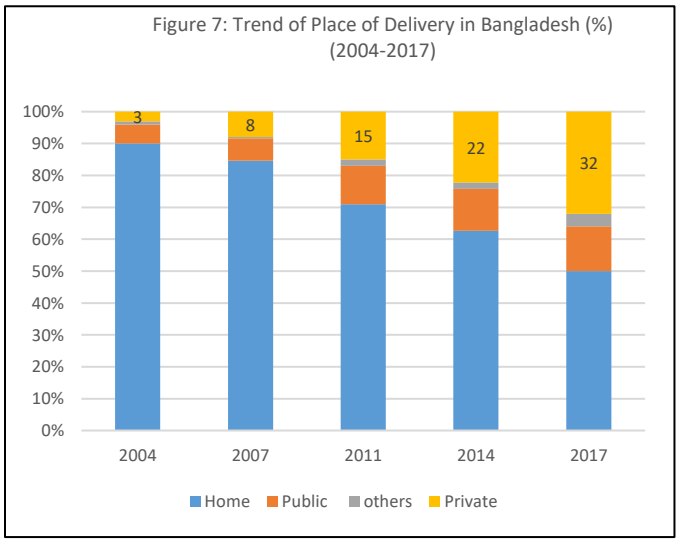


More than three-fourths (82%) of women with a birth in the three years preceding the survey received antenatal care (ANC) at least once from a medically trained provider. Almost half of the women (47%) had the recommended four or more ANC visits during their pregnancy (BDHS, 2017-18). The proportion of women with a live birth having four or more ANC visits increased in both urban and rural areas. This increase was from 34% (2011) to 59% (2017) in urban and from 26% (2011) to 47% (2017) in rural areas. Further analysis shows that greatest proportion of women received ANC during their most recent pregnancy from the private sector. This share increased from 43% in 2011 to 63% in 2017 (Figure 6). The proportion of women who received ANC from the public sector decreased from 41% in 2011 to 36% in 2017.

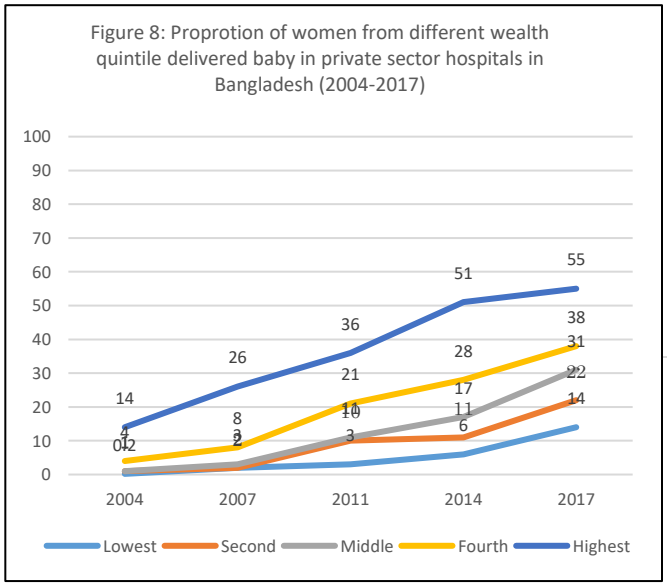
Institutional delivery

In Bangladesh, only 9% of births occurred at a health facility in 2004, while the rest were delivered at home. The facility-based delivery has increased to about 50% of births in the three years before the BDHS survey, 2017-18.

The private sector contributed to the increased rate of institutional deliveries. The proportion of births delivered at private health facilities increased from 3% in 2004 to 15% in 2011 and 32% in 2017 (Figure 7). Private sector delivery increased almost 10.7 folds, while public sector delivery improved 2.3 folds from 2004 to 2017.



Since 2004, the trend shows that a gradually increasing proportion of women from wealthier quantiles gave birth in private sector health facilities. This proportion grew from 14% (2004) to 55% (2017) among the women from highest wealth quantiles. In contrast, the proportion of women from the lowest wealth quintiles delivering in private facilities grew from 0.2% (2004) to 14% (2017) (Figure 8). Patients considered availability of drugs, cleanliness of the hospital, water supply and empathy from the nurses to prefer type of hospitals (Siddiqui N, Khandaker SA. (2007).



Bangladesh has made progress in reducing the gap between the poorest and richest women in

the use of facilities for delivery. In 2017, 26% of births to women in the lowest wealth quintile occurred in a health facility, compared with 78% of births in the highest wealth quintile. This translates to a ratio of about 1:3. The corresponding ratios were 1:6 in 2011, and 1:11 in 2004. To achieve equity in delivery in a health facility, the HPNSDP sets a ratio of less than 1:4 between women in the lowest and the highest quintiles (MOHFW 2011).

4.3. Available inputs for private sector engagement: enabling environment, organization, and resources

4.3.1 Key quality policies and strategies for the private health sector

Policy related to health service delivery is the key element. According to Kruk et al., (2018), several elements are needed to ensure quality services, including an established national quality policy and strategy, management capacity at all tiers of the health system, an up-to-date regulatory framework, mechanisms to hold public and private providers accountable, and a system to collect and learn how to continuously improve quality. Furthermore, the authors stressed the need for information in building governments' leadership and management skills to engage all stakeholders.

Bangladesh's national health policy encourages private sector entities to work with the public sector for the management of the health sector in a coordinated manner. This coordination mainly occurs during the establishment of a new private hospital and its license renewal. It can also be strengthened by developing a structured referral system. Documents on the national plan also emphasize quality services. The 4th HPNSP stressed the importance of delivery of quality services in the private sector for equitable health care coverage. It allows for the development of new approaches and partnerships with the private sector. The Policy and Strategy for Public-Private Partnership (PPP), 2010, mentioned the health sector as one of the eligible PPP projects, but this was not described in detail. There was a provision to establish partnership in the case of rural health services and hospitals under poverty alleviation initiatives. To accomplish that, any project needs to fulfill one or more eligible criteria, according to the International Standard Industrial Classification (ISIC), specified by the United Nations (GoB, 2010).

Regulation is also an important measure to be taken. In the Operational Plan for Hospital Service Management (2017-22), MoHFW highlighted strengthening the regulatory framework for private healthcare services and the accreditation system for private sector providers to improve the quality of patient care, by introducing the 5S Continuous Quality Improvement (CQI)-Total Quality Management (TQM) approach; the standard hospital operating manual; the risk management program; and comprehensive and monitoring and supportive supervision. The National Quality Improvement Committee (N-QIC) consists of relevant government departments, professional bodies, and development partner representatives. They support the harmonization and improvement of QoC for both clinical and managerial responsibilities of the health workforce. Representatives from NGOs and private hospitals can participate in the Divisional Quality Improvement Committees (Div-QIC) and District Quality Improvement Committees (D-QIC).

The government representatives mentioned that they provided loans to the small private organizations to offer health services. It was reported that the private sector was waived from taxes to import many instruments from abroad. The government representative also shared that such tax exemption would be applicable for the specialized private hospitals outside Dhaka district. The private sector had freedom on

some issues, as compared to the public sector. For example, they could buy any type of equipment easily. This indicated favorable policies for them to ensure quality services and is an instance of the private and public sectors working together to provide better health services. On the other hand, respondents from the public sector mentioned that as the private hospitals provide services to a large proportion of patients – in many cases critical ones – the government has to strictly monitor them in order to ensure the quality of MNH care. With a combined effort, Bangladesh can reduce maternal and neonatal mortality. In one KII, a private sector representative expressed that if the government collaborates by providing incentives or some opportunities, the private sector will agree to contribute to meet the national MNH goals following national health policies or strategies. She also claimed that while many talented individuals were interested in improving the system, there were obstacles within the health system. The private sector could cooperate with the government about having limitations in staff, logistics, and medicine in public sector hospitals.

Governance and leadership are critical for policy implementation. The government has established a network with both the public and the private sectors throughout the country, but, as highlighted in a KII, it was yet to function efficiently. The respondent also mentioned that all the public, private, and NGO entities are working individually, with minimal synchronization. In this regard, MoHFW should enforce its leading role to make all stakeholders contribute to the national health system. Furthermore, a private representative stated that the private health facilities did not have any community-linked structure that could reach more vulnerable women for MNH care. Current health structures and systems for the governance of QoC for MNH extend to the private sector. Senior professionals from the private sector indicated that the private sector could not complement the national health system without overcoming the bureaucratic complicacy. Therefore, a close partnership and collaboration between public and private hospitals is important for ensuring comprehensive MNH service coverage.

Other interviews indicated that a specific, approved written policy guideline to facilitate public-private collaboration for QoC and MNH is not available at either policy or implementation level. Respondents indicated that there was nothing specifically mentioned about such collaboration in the SOP for quality improvement. It is still in the dialogue stage.

> *". . . sometimes they come for surveillance with a magistrate or law enforcement agent like the Rapid Action Battalion (RAB) you know. There is more punishment than motivation. You know, rewards are more effective than punishments. We have not seen this kind of scenario yet."* -Medical specialist from a renowned private hospital

> *"During COVID pandemic there was an abundant stock of bleaching powder in the public hospital which a private hospital could not get. I asked the Directorate General to distribute us PPE, but he said there was no Government order. See in this crisis time if we get that help from the Government, then we could offer more services to help people and be more motivated to fight against Coronavirus."*- Senior management representative from district-based private Hospital and Diagnostic Centre.

A representative from the private sector did not receive any formal invitation to participate in training at the national or sub-national level. Only during a policy meeting was a major private hospital authority invited to participate. The MoHFW forms a committee when there was an incident. During hospital, blood bank, and laboratory license renewals, the government authority usually visits. After the inspection, it took a long time for the relevant authority to proceed with the licensing formalities. Private organizations have their structure and policy. It was acknowledged that many private hospitals

have medical doctors having international Standard and they have been providing quality health services. At the district level, a few examples of joint participation were seen.

> *"….. I have selected a government hospital and a private hospital in my district as a dedicated COVID hospital. They were agreed positively with this. When we asked them to give support, they agreed to give their logistic support also. During the COVID 19 situation, I brought emergency oxygen cylinders from the private hospital for our district hospital. Similarly, the private health sector will continue to cooperate with the public sector willingly. We need to serve people which so we can do together"*

There are few good examples of collaboration. Private respondents claimed success in achieving vaccination camp goals. The vaccination program has succeeded both for the public and private hospitals. As with the nationwide vaccination program, the private sector could partner with the government on maternal and child care issues. During the COVID-19 pandemic, they could continue providing maternal and newborn care support. Similarly, collaboration with the government's program is much needed for having special neonatal ICU and maternal special care services.

4.3.2 Quality mechanism

Regulatory mechanisms

Findings from the literature highlighted the need to adopt regulatory frameworks early before it became difficult to introduce in the growing private sector (Akhter A. 2011). Again, it was found that the due to not having strong regulatory and mediatory mechanisms create the grounds for decreased trust in the private sector in low-and middle-income countries (Joarder et al., 2017). But it is also true that the process of private sector engagement can be an ongoing process where there was a growing state of healthcare financing, and a weak regulatory framework (Adams AM et al. 2019). The national Health Care Financial Strategy report (2012) highlighted that the government should plan to build a national health benefit package meeting all sorts of legal and ethical perspective. Therefore, patients can take the benefit from the health service delivery aligned with standard treatment guidelines. HSM, DGHS is also responsible for the governance and stewardship of public and private sector hospitals. The QIS of DGHS's Health Economic Unit is to guide and oversee QI activities countrywide by monitoring quality-of-service delivery; developing and supporting in installation of relevant protocols, SOPs, and tools; and by ensuring attainment of National Health Care Standards. During the literature review, it was found that the relevant government department has limitations to bring all the points to the ground. There is scope to strengthen the legal and regulation framework, enhancing the capacity of the implementing agency in terms of monitoring and supportive supervision.

KII respondents from the private sector described a lack of a regulatory framework, institutional framework, or quality monitoring of services and facilities from the relevant department at field level. The establishment of private clinics across Bangladesh without any standard monitoring system was mentioned by respondents. As a result, a senior professional from a private hospital described unqualified medical service providers performing major surgery and a failure to deal with complicated cases. From the KIIs at the district level, it was noted that the government authority had various mechanisms to monitor the private sector. One mechanism is to send an inspection team to visit the private hospitals. During such visits, private facility authorities used to maintain all the requirement criteria like availability of relevant specialist medical personnel only during the inspection. The Private Health Sector (PHS) has to follow certain rules and regulations to secure a license to start a hospital. The

local authority made a checklist with the minimum criteria for licensing that they had to maintain, according to a particular format. They then sent it to the central authority to verify and to provide the approval to get the license. The PHS has to undergo a time-consuming process as well, which does not, however, include an assessment of availability of the necessary nationally endorsed technical guidance, including accreditation.

The government representative highlighted that further emphasis was given to the need for technical monitoring. Without this, the private hospitals can conduct delivery by unnecessary caesarean section without any medical indication. Many private hospitals had an obstetrics and gynaecology department without having specialized consultants. Medical doctors were unable to make critical decisions, resulting in poor QoC, leading to death or serious complications for either mothers or new borns. There is a need for the government to hold the private sector accountable for providing quality MNH services per national standards and guidelines. They also shared that due to not having any surveillance or monitoring visits from QIS, private health facilities were used to following their own healthcare standards. This results in inconsistent equipment lists and standard operating procedures (SOP) being followed by private facilities, which are not standardized with national SOPs. For example, in normal vaginal delivery, the equipment lists in the delivery room as per labor room protocol were not uniform. It was further suggested that PHS create a board or management body for decisions related to their internal hospital compliance, made up of expert senior clinicians.

Few leading private hospitals monitor clinical governance through a quality assurance committee that measures the quality of services monthly. In case of any reported maternal or neonatal deaths, there was a practice of doing further analysis to find out the reason behind the death and to improve the care to prevent further death. At the private facilities, most of the cases are not reported. Another committee that plays a very important role is the infection control committee, which measures infection control parameters every month. Besides hospital management, the clinicians were also engaged in monitoring regularly. Respondents from private facilities expressed their interest in improving the quality of their services with compliance even aligned with the international level. This would be an area to improve, along with alignment with the common standardized equipment list. Similarly, all health facilities, whether public or private, should be ready to offer quality antenatal, postnatal, or neonatal care. The government should take the initiative to streamline all facilities to ensure the quality of MNH care. There was a lack of initiative in this regard. Some respondents from the PHS complained that they did not receive invitations to participate and contribute to various national MNH events like safe motherhood day, breastfeeding day, family planning week, and pneumonia day, in which the government involved NGOs.

Ethics and values are a part of quality services. Without showing respect to each pregnant woman, it would be difficult to take a medical history from them and treat them accordingly. Achieving trust from a patient could save her and the baby's life. One respondent shared an incident:

> "*I had a patient for delivery when I was out of town because of my personal reason. The patient then requested the nurses to call me and requested to seek advice. As the pregnant women did all her ANC counselling to me and followed all the instructions given by me, ,she relied on me. Nurses waited for an hour for the normal vaginal delivery. This place of trust needs to be created in both sectors."*

On the other hand, a few respondents shared their experiences about incomplete consent forms before delivery and their consequences. During the time of delivery at midnight, consent was not taken properly at district or sub-district level private hospitals and clinics. This is one of the key elements of medical ethics that every facility should follow and maintain. They should recognize that ensuring the well-being of the mother raises her confidence level. By maintaining medical ethics, the private sector can strengthen ethical practices and cultural appropriateness in the delivery of quality MNH services.

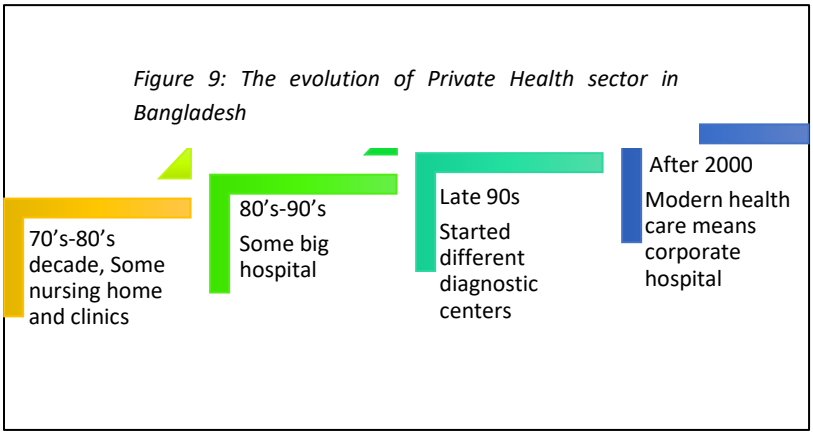
4.3.3 Public-private coordination and dialogue

A number of networks and associations are found in the private sector in Bangladesh, which are recognized by the government. These are:

- *Bangladesh Private Medical Practitioners Association (BPMPA).* A national association of General Physicians with more than 5,000 members. Membership requires a minimum of two years of experience in private practice.
- *Bangladesh Private Clinic Diagnostic Owners Association (BPCDOA)* is another association in the health sector recognized by the Bangladesh government.
- *Bangladesh Private Medical College Association (BPMCA)* was formed in health education. It was established with the approval of the Ministry of Commerce, the Government of the People's Republic of Bangladesh.

Initially, private clinics were established by senior medical clinicians, but later, the corporate world entered this sector, and many private hospitals are owned by businesspersons involved in multiple sectors. For these hospitals owned by a group of companies, the authority invested on their own land; built their own infrastructure; appointed architects for the equipment and design; and recruited doctors, nurses, operations staff, and paramedics. They did not have any government grants or donations. (Figure 9)

Figure 9: The evolution of Private Health sector in Bangladesh



The Obstetrical and Gynecological Society of Bangladesh (OGSB) is one of the national professional bodies for any medical graduates with higher specialization in Obstetrics & Gynecology having recognition from BMRC. Both private and public sector professionals can join. In collaboration with the government and many development partner organizations, they have been contributing not only to delivering MNH services, but also positioning themselves as contributors to policymaking regarding maternal health care. For newborn health, Bangladesh Neonatal Forum (BNF) has been working at national level since the late '90s. Neonatologists and pediatricians are members of this forum. They have many branches all over Bangladesh to improve neonatal care services. They arrange seminars in medical colleges and hospitals, and publish a journal on neonatal cases, complications, and management updates. In some cases, they offer scholarships for further study in neonatology. Both OGSB and BNF

arrange conferences to exchange knowledge and provide updated information from other parts of the world to Bangladesh.

An OGSB representative proposed a committee through public-private partnership, which can monitor the quality of health care services. This committee can support the respective monitoring wing of the MoHFW. The representative suggested to establish a model for quality maternal health, by resolving all the administrative and bureaucratic barriers of the government and its departments. The government can make a pathway for the private sector to come forward for effective participation in the national health system. Policymakers should accelerate this work. Furthermore, a KII participant from the private sector recommended using modern technology, if required, to hasten the process. As in other countries, they can use mobile apps instead of paper-based work for monitoring checklist installation, submission of visit reports, and the approval procedure. This could reduce official steps and time for the private hospitals to gain approval-related certification. An example of the administrative complexity of the government system was reflected by a private respondent:

> *"Magnesium sulfate is important to treat eclampsia. We ask for this for more than two years, but the government responds slow. We came to know that the production of magnesium sulfate injection has started. But it is not available in the pharmacy store and because of its slow selling, it became expired without any use. Eventually, the medical prescription of a doctor cannot be fulfilled by the seller to keep this injection to treat eclampsia patients, they don't want to keep this because of its expense and slow-selling process and to avoid compensation. This drug should be supplied to the hospital by the government only. Despite the wishes of the government, it took them two years to bring this drug. It is not acceptable if eclampsia patients, especially young mothers, died due to the unavailability of this drug."*

Many private hospitals did not follow all the government instructions regarding QoC maintenance and they did not work in an organized way. Private hospitals mainly follow their own ways. Participants from the PHS realized the importance of leadership, but there was a weakness in the functionality of their formed association. There should have a strong bridge between the government and the private sector. A representative from professional bodies pointed out:

> *"We don't have less talented people in our country, and I think their talent should be utilized properly. And we all are ready to work with the government if they ask. If the government can use efficiency properly then I don't think it is difficult to achieve SDG in time."*

4.3.4 Market conditions

Market conditions (resources) as reported by the private sector

Interviews with respondents from the private health sector found a competition between different private facilities. Resources are very important. Usually, a private hospital was established with the help of bank loans. Therefore, they aimed to return that money to the bank as soon as possible and get high profits. Respondents mentioned the diagnostic facilities, including ultrasonography, and about related charges. At the same time, they had to maintain a good relationship with all of their clients. The availability of skilled staff at different departments of the hospital and senior medical professionals

creates business competition. Additionally, customer relations and quick service delivery to pregnant women both in Outpatient and inpatient facilities influence positive marketing.

Business competition was also a concern at the district level. The private facilities located at district level can send the patients back if there is no opportunity to treat by themselves or if the providers find it risky to manage complicated cases. They preferred to avoid doing so, considering reputation concerns. Again, the shortage of specialist doctors at district level private hospitals was one of the key reasons. Private facility respondents from the district level identified that they charged fees for referral specially during accompanied referral, gave inadequate amounts of medicine, and asked for excess money from the patient. Some of them revealed that new private hospitals at the district or sub-district level appointed village doctors instead of qualified doctors to have more profit. Sometimes, these village doctors also received a commission from the hospital for referred cases. All these can ruin the quality of MNH care. A district-level hospital manager described the competition:

> *"Also, we offer patient's families to visit our hospital to get quality service at reasonable costs such as cesarean with medicine for $36 only and all the procedures will be safe for mother and new-born. But sometimes other clinics try to take these patients away by offering a lower cost than us, such as cesarean for $29."*

There is no national health insurance scheme in the public sector of Bangladesh, but there should be to prevent people from suffering. Many private facilities have scope to establish health insurance coverage schemes for the patients, but they did not show interest in providing quality MNH services at minimum cost. The focus was continuation of the business, attracting more patients, and creating more demand in society. Since their beginning, some private facilities faced barriers to ensure quality MNH services. These included, for example, limited transportation, lack of updated information about clinical management, and financial constraints.

There was no visible competition between the public and private sectors. The private sector does not have an extended team for the field like the public hospitals, so the private sector could not reach the patients at the community level. If they get the opportunity to work at the root level with the collaboration of the government, this could be helpful to promote private services. Furthermore, the public sector cannot manage the daily patient load they have, which could be solved by the private sector if there is a strong collaborative network. A district-level service provider highlighted that:

> *"Patients are more interested in the private sector than the public because the private sector has more sincerity than public and works with more manpower, instrumental support, and others. There is no sign of negligence."*

Private facilities are not properly utilized. During a particular season of the year, private sector representatives described an opportunity to cooperate with the government, if there is scope created. One of the private sector respondents proposed the following:

> *"There are 90,000 beds in the private sector at this moment. But sometimes 50% of these beds remain empty during Ramadan or winter season. If the Government can take initiative to subsidize their staff, they (Government employees) can avail most of the facilities from PHS. Their bed will be utilized; their recruitment will be utilized. On the other hand, a government employee will be benefited from low expenses. For example, in a caesarean section, the cost is around BDT 70,000 in a private hospital. But*

sometimes government employees can't afford it. If there is any insurance facility, they can pay only BDT 20,000 taka and the rest can be financed from the insurance package. We can work on this model on a trial basis and develop it further based on initial learning."

Usually, the private sector did not receive any financial support from the government. They had to finance everything on their own. Facilities had to arrange on-the-job training after hiring doctors, nurses, and paramedics. There is also some precedent for working jointly. Bangladesh Institute of Research and Rehabilitation in Diabetes, Endocrine and Metabolic Disorders (BIRDEM) hospital in Dhaka received financial support from the government. If they can obtain government support, they can then decide how they use it. While there was a lack of manpower in the public sector, there is a training center. Again, trained nurses and midwives from private facilities intended to shift to government jobs when declared. Thus, create a gap in the number of experienced health workforce in the private facilities which ultimately affect in delivering quality MNH care with the same spirit afterwards.

"We run a hospital of 350 beds with around 500 nurses. We trained them. In the last few years, the Government announced the recruitment of 5,000-6,000 nurses. So, the private sector helps to recruit trained manpower. Around 97% of the people who were trained from a private facility, selected in the public sector; this is our big challenge for us. We don't get quality manpower. We have to work with new people. So, more nurses need to be hired with the doctors as well. Because you know that in our country there is one doctor for every 10,000 people. And the ratio between nurse and doctor is supposed to be 3:1 where it is0.4:1 in reality. To overcome this, both the government and the private sector should take initiative. More medical colleges should have a nursing institute. Then we can overcome this crisis by three to five years."

Market conditions (resources) as reported by the public sector

In the current business world, a facility has to be well prepared to deliver quality MNH services to their clients. Facility readiness to provide MNH services was different in the two sectors. Of district and upazila public health facilities, 31% of were ready to provide ANC services per the WHO definition, but only 2% of private hospitals met the criteria (Bangladesh Health Facility Survey, 2017). The same report also emphasized that only one-third of the private hospitals could perform all nine signal functions of comprehensive emergency obstetric and newborn care (CEmONC) during the past three months of the survey period, whereas almost half of the district level public health structures could.

According to government representatives, there was no specific competition between the public and private health sectors, but there were still visible differences. Manpower, capacity building, essential medicines, logistic and equipment, and cost of services made the two sectors diverse. In the case of general services, the public hospital had preparation with financial and technical support from international development partner organizations, which was absent for private sector hospitals. Both the sectors have their own limitations, and they are acknowledged accordingly. The public sector was not as cordial as the private sector. The government took on many projects, spending a huge amount of budget, appointing project directors and a workforce, and arranging meeting sessions. However, results were not up to the expected level. Less focus on the health sector itself may be one of the key reasons. It was recognized that the private sector had been helping to fill gaps in the public sector by covering a good number of pregnant women, as the public health structure could not provide services efficiently with limited resources. The private sector developed the first positive impression on patients with nice

decoration, neatness, and cleanliness. They also maintained it systematically. There was a lack of such a welcoming environment in the public sector, and the public sector could learn from the private providers. A representative from the public sector regrets not having such an offer to attract more patients but showed their eagerness to change the situation.

> *"It's not only for what I have as a good financial backup, but also we want to ensure the proper service, time, opportunity, neat and cleanness, and many other issues . In public hospitals, we need more seats, services in a widespread way, but we can't be able to fulfill these. That's why the private sector supports us in parallel."*

The contribution of the private sector was acknowledged widely.

> *"We are grateful to the private sector. Cause it wouldn't be possible to reduce maternal and neonatal mortality except for the vital cooperation of the private sector with the government. In a word, the private sector strengthens the strategies taken by the government." -Member of a professional body*

However, it was pointed out that most of the deliveries by cesarean section were performed in a private hospital. Additionally, study respondents reminded that the government had given the opportunity to the private authority to provide health care to this huge portion of people. Regarding technical staff concerns, there is only one post for a gynecologist in the district hospital. Due to limitations in facility readiness for delivery care, she might be demotivated to offer and utilize her expertise in the public facility. On the other hand, the same person was earning money by providing services through private clinics in the same area. Here, besides financial issues, if she could have a better working environment with adequate facilities, even during emergency case management, then she could spend more time in the public facility.

> *"I should advise the patients as it is a universal decision. But he/she has every right to choose where he/she wants to go; either a public or private hospital, nobody can say it's a wrong decision"* -a gynecologist from sub-district level

It was further stated that the government should look into the maintenance of standards and service fees of the private hospitals in exchange of offering quality care as well. Without this, a unified health system for MNH care would not be effective and people would not get benefit out of it.

4.3.5 Private health sector accountability

Feedback mechanism

The accountability mechanism is one of the vital components of quality MNH. This should be in place at the site of health service delivery. It was found that there is a lack of an accountability mechanism (e.g., client feedback collection) in most of the private hospitals. Respondents highlighted that the hospital authorities were less likely to check the complaint notes, even when there were any. Furthermore, there was minimal standardization of measurement of patients' satisfaction. Patients' priorities or perspectives can also sometimes hamper service delivery with available resources. However, the country's health system must be respectful to the cultures or customs of individuals. Both management and clinicians have to give value to the cultural norms of an individual country. Usually, both the private and public sector facilities should care about this, but not all facilities consistently have the provision to

ensure all patients' satisfaction. A grading system can be implemented. For private sector facilities, consumers' rights and laws were important. Some study participants from both sectors highlighted the importance of having some system regarding to capture the client's feedback.

> *"Of course, it's very necessary to take patients' feedback. We have a complain-box in our hospital and the patients submit their notes here. I have a plan that if we can provide them a form with some questions and answer options. So, we can know their opinion and our lacks."* –Private sector representative

Another participant stated:

> *"Patients are like a mirror of a hospital. When a patient goes to the hospital to take treatment, he/she is so sensitive to his/her satisfaction or dissatisfaction. So, if the authority takes it seriously and takes steps whatever they can, it would be fruitful."*

The absence of an accountability mechanism led to many incidents. Respondents mentioned that it was a moral duty for the head of a private facility or organization to install this system to be transparent with their clients. They could lead the process so all the staff would be bound to follow. Then, when the government visited the private sector facility, the accountability would not only be on paper but also in their regular services.

> *"We have a quality improvement team, who visits all time here. We collect the patients' feedback by a form. Also, we take the suggestion, lacking the service they take. After then we identify the comments and try to solve those issues by the quality assurance team." -a representative from the government hospital*

> *"We have complained about the box here. Firstly, if there are complaints, they can give them in writing or verbally to the chairman. Secondly, for reporting, we have some experts who are also a partner of this hospital . . . There are separate waiting rooms, washing rooms in our hospital for the patients. We accept complaints from the patient and discuss those with management and staff. We instruct staff to take the necessary steps so that patients do not complain." -authority of a PHS from sub-district level*

There were some opposite examples as well, where health facility and its service providers showed their responsibilities to a patient during an emergency. Another experience was shared by a medical officer at the district level:

> *"Almost five to six years ago, I could not find the head of the baby while doing ultrasonography of referred pregnant women. But I could see the head outside through the vagina of that woman. Staying in the ultrasound room, I started to take preparation to deliver the baby without any delay. After the cord-cutting, the baby was not breathing and crying. The 20 bedded hospital had nothing. Then I carried the baby with a help of local transport leaving his parents to another private hospital. Though I did not do any operation at his private hospital, the owner came forward to help us and to save the baby by arranging an oxygen cylinder and other necessary logistics available. With all these, the baby survived on that day. Parents had no speech to acknowledge my dedication and expressed their extreme happiness to see their newborn baby. This was a*

memorable day in my medical career. I felt happy to contribute and use my training on Helping Baby's Breath (HBB)."

Reporting

In Bangladesh, there has been a lot of improvement in the National Health Management Information System (HMIS). However, there was minimal information on the private sector. Not all PHCs submit their periodic reports to the national platform: DHIS2. This is a missed opportunity to visualize their contribution. Though a few private hospitals at district level report back to the civil surgeon (CS) office, these data are ultimately not being entered into the DHIS2. Some of the private authorities did not want to disclose their overperformance due to fear of harassment. There is a guideline for development partner and NGO collaboration for QI, regarding technical support for data analysis and sending performance review findings in a designed format periodically (three months). These are based on observation with the service providers and exit interviews with clients. This is not applicable to the private hospitals and clinics.

Due to this situation, MoHFW cannot get a comprehensive picture of MNH services, and the contribution of the PHS could not be fully visualized. There should be a properly structured format for this sector. The government should collect their information by either increasing human resources or appointing a focal point for the PHS. A professional body representative shared their experiences:

"/ . . . we are working on family planning for a long time with a private hospital but there is no information in MIS. There is no bilateral support as well. So, we don't get the exact view there. Moreover, the antenatal care we give in the private clinic they are not counted as well. There are many talented officers who can work on this. Maybe they are working in an optimized situation but still by the proper structure it can be increased."

A private sector respondent opined that the government did not provide any incentives for reporting for the private sector, but within the government system, there was a mechanism to discuss and share performance data between national and sub-national levels every week through teleconference. Due to digitalization, many improvements could be possible to make the data available and updated altogether.

Gynecologists from the public sector expressed that the private facilities could not gather or store enough information when needed and noted an urgency to keep updated on this issue. They believed that any hospital was able to report any time on MNH services, including delivery care. The main requirement was to have information about patients' admission, death, and how they recovered if any complication. From the sub-district level, PHS representatives pointed out that they provided a report to the Upazila Health and Family Planning Officer (UHFPO) monthly, particularly about the number of cesareans and normal vaginal deliveries.

The private sector expected that the government would cooperate with the private sector for the improvement of MNH care. Otherwise, they did not show interest to share data and information with the government. At the district level, there was relatively closer formal and informal collaboration between the two sectors. Here, local level government authorities visited the private facilities, but there was no formal communication from the central level to seek support.

Public health authorities urged that there was a need to understand reporting, but the private hospital usually did not show interest to disclose their reports. One of the reasons might be that they are carrying out many operations without indication. Therefore, private facilities should undergo monitoring

to ensure they understand the importance of quality services. Respondents also pointed out that there was an opportunity to enrich national achievements if they had quality recording and reporting of services. If the presence of accountability can be ensured in the PHS in a structured way, and private providers are engaged in the national health MIS system, the government will have played a stewardship role properly. This would also facilitate planning and bilateral cooperation. For example, the PHS has been providing family planning services for a long time, but there is no updated information in HMIS. Similarly, for antenatal care, a significant proportion of pregnant women from both urban and semi-urban areas visit private clinics. These remain outside of total country-level calculations. Therefore, no scope was created for bilateral support.

4.3.6 Results from the consultation meeting

National and district level consultative meetings validated the initial findings that emerged from the literature review and KII results (Figure 10). They also contributed to the findings and generated recommendations on strategic ways to engage the private sector. A summary of the identified challenges, with ranked prioritization, is shown below in Table 3. Here, ranking from 1-6 represented as from Highest to least priority.

Figure 10: Consultative meeting at national and district level

Table 3: Prioritization of the identified challenges

Overall policy environment	Ranking
Specific approved written policy to facilitate public-private collaboration for QoC and MNH is not	1

available both at policy and implementation level. Collaboration is in the dialogue stage like QI committee.	
Maternal SOP/ National Newborn Health Program (NNHP) toolkit is not uniformly used in all private sector for quality MNH care.	2
Private health facilities could not complement the national health system at their optimal level because of the administrative /operational complicacy.	3
Functional health insurance scheme is not in place for the patients.	4

Quality regulatory framework and enforcement	
Some private facilities have limited facility of transportation, information lack of updated information about clinical management, and finally, the financial constraints to ensure quality MNH services	1
Private facilities have to arrange on the job training after hiring doctors, nurses, and paramedics.	2
Specialized HR shortage in some private hospital to deal emergency cases	3
Have weakness in the functionality of the private sector formed association	4
There was minimal standardization of measurement of patients' satisfaction in private hospitals/clinics	5
Minimal synchronization in some service delivery among the private sector	6

Market conditions	
Minimal competition between private hospitals to improve quality of services delivery	1
Usually, a private hospital is established with the help of bank loans; Therefore, they aimed to return that money to the bank as soon as possible and get high profit	2
Private facilities have to finance everything by their own, less likely to get any financial support from the government	3
There is shortage of specialist doctors at district level private hospitals that force them to refer patients to other hospitals	4
Ownership of private hospitals is shifting from medical professional to corporate businessmen having involvement in multiple sectors	5

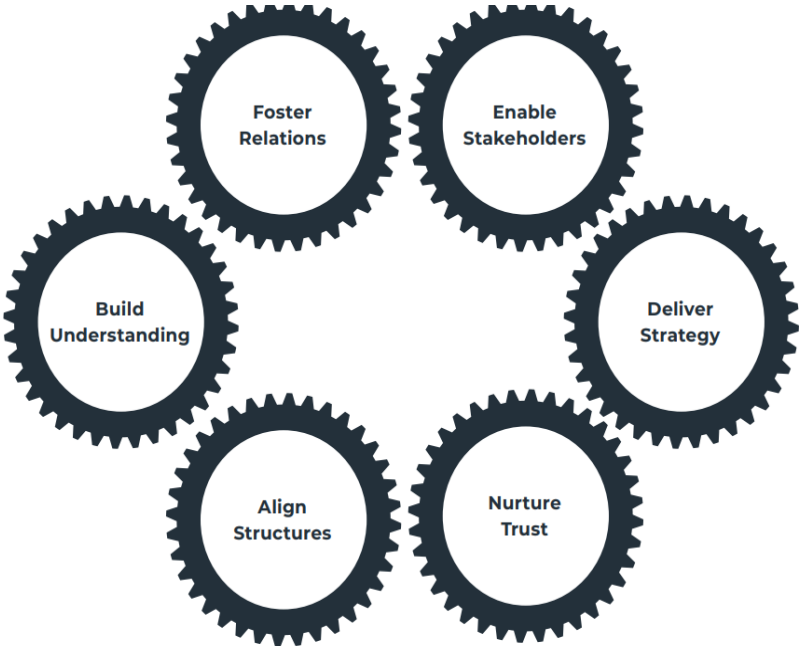
Private health **sector engagement**	
Most of the private hospitals/ clinics usually do not report to DHIS2 resulting in a missed opportunity to visualize their contribution	1
After getting training from a private facility, HR (Nurses, Midwives) get offered in the public sector following Public Service Commission (PSC) exam - skill transfer	2
Medical professionals from Private health sector are less involved in national level MNH training	3
There is no mechanism to provide any GoB incentives to the private sector for delivering services	4

After the priority exercise, participants shared recommendations based on the current situation. We incorporate their suggestions below with the interview results in relevant sections.

5. Recommendations

The recommendations below are organized according to the WHO strategic framework that illustrates components of governance behavior (Figure 10). A mixed health system, comprised of both public and private sectors, can achieve good governance behavior for universal health coverage with the following components included (Fig 10).

Figure 10: Components of governance behavior (taken from WHO report,2020)



○ 5.1 Enable stakeholders

It is critical to ensure that the actors have agreed to their roles and have the capacity to do their jobs, and to ensure that others do theirs. At the same time, the government has to have enough capacity to play a regulatory role and engage the private sector effectively. Strong regulatory and mediatory mechanisms are therefore recommended in Bangladesh.

- *A standard set of protocols and an accreditation system should be in place in regulating (e.g. licensing, accreditation, credentialing) and governing its provision of quality MNH services*. Otherwise, different hospitals would offer different services which might cause increased morbidity and mortality. The accreditation standard development is in process, but it was delayed due to the priority shifting for COVID-19 pandemic.

- *There is a need to change legislation regarding restriction of dual practice by medical professionals.* By being involved in the private sector, they can earn more money. As a result, they cannot give their full attention to the public sector. It should be reorganized. In Bangladesh, senior medical professionals of the government hospitals could not do any private practice during office hours, but after office hours they were allowed to do so, including surgeries at their own hospital or clinics. It would be useful to update the legislation and to share with all professionals.

- *In general, more policy research will be required* to determine how the core weaknesses among private organizational environments, including quality control, and real data sharing can be addressed as a means of accountability and transparency. It is also important to create evidence on how to improve government capacity to govern the private sector.

- *The two-way communication system can motivate both sectors* to increase the coverage in terms of the provision of quality MNH services. Collaboration can be established if the government can take initiatives to fill the gaps in private hospitals, especially for equipment and logistical support. The government can invite medical professionals (e.g. doctors, midwives) to the training where they can be receive and be oriented on the national level treatment protocol and maternal and newborn SOP . Newly appointed doctors in the private hospitals can receive necessary clinical sessions organized by the medical association under supervision of the relevant national body.

- *Some of the private providers can offer clinical training and attachment with the local medical and nursing schools*. They can build more human resources for the clinical services, specialized in quality MNH. This can result in a balanced ratio for the overburdened hospital and contribute to the ecosystem of the number of healthcare professionals. Such an effort can improve the national health system and meet the public demand for quality health care.

- *Private providers themselves can recognize measurable patient satisfaction and the health ecosystem* can boost their brand, giving a competitive edge in the market, reassuring patients, inspiring their staff, and ultimately helping to support further investment. A framework can be used to uphold the motivation of the service providers, either by arranging incentives or a payment regime on service specification. This can regulate the health system mainly at a peripheral level, where a large portion of service providers are practicing while either unqualified or underqualified (Wadge et al., 2017).

- *The MoHFW can arrange grants to establish a private hospital if anyone shows interest*. The private sector works with its own funding, without government financial help. One respondent shared that the Ministry of Social Welfare took initiatives and requested some private hospitals to make some seats free of cost for patients or to take less charge, in return for grants. This system may still exist in few private medical college hospitals, but it has to be monitored to determine its effectiveness. The private health sector is offering MNH services by maintaining their standard. Land is very expensive. If it is easier to buy land, a significant portion of the financing will be saved, which can be put toward improving quality health care, by allocating for machinery and modern technology to save mothers and newborns. Government grants can help ensure high-quality MNH care. The first condition will be following all the relevant national guidelines of quality MNH care. It can be a model for Bangladesh and other low- and middle-income countries. Simultaneously, government departments can take pride in it.

- *Establishing a referral network including hospital emergency is important*. An area-wise directory of all relevant hospitals and clinics can be established. The environment for a need-based referral system is yet to be matured or formalized in Bangladesh. Patients are often referred at the last moment when there is no possibility to save his/her life. The referral system is necessary because not all preparation is available in all hospitals and in remote areas. A private hospital should know the comprehensive list of facilities where all types of MNH management are possible. Study participants from the district level mentioned the scarcity of ambulance services and relevant

expenses. This was one of the barriers to creating an effective referral mechanism in the country. Hence, the number of the ambulance should be increased for the benefit of the patients.

> *"I don't think that any private hospital exists in Bangladesh where the public hospital can refer patients because they don't have that kind of infrastructure. Private hospitals refer patients to public hospitals. But Public Hospitals don't refer a critical patient to a private hospital."*

They claimed:

> *". . . Actually, there is corruption. Moreover, if there are 50,000 people behind 500 bedded government hospitals, then there will be a big competition, so patients come here to avoid this situation."*

There were also some bottlenecks on the way to collaboration:

> *". . . relationship is actually for policing. What we know till now is that the Government will not help much. If we make any mistake, then they will be there to identify it."*

○ 5.2 Nurture trust

The government can create an environment to establish mutual trust among the actors and encourage working together; otherwise, it will be difficult to establish effective collaboration. Both sectors can have a memorandum of understanding (MoU) to support each other. In the mixed health system, all the relevant actors should have an accountable system.

- *A certification system for the health facilities can be developed, based on examples from other countries and keeping alignment with nationally approved technical protocol/ guideline*. A third party can be engaged to facilitate the licensing formalities, reducing existing complex mechanisms.

- *Every service provider and facility have to be prepared for an emergency or critical mothers or newborns.* Every facility should have immediate neonatal care management preparation. The Bangladesh Health Facility Survey (2017) showed that only 40% of the private hospitals having normal delivery had 7.1% chlorhexidine solution. Without having comprehensive preparation, it will be incomplete management. It is necessary to ensure sufficient facility readiness in both sectors. This may require fostering a culture of seeking emergency support from other facilities where a specialist is present. An effective referral system can play an important role in reducing maternal mortality.

- *More training on medical counseling will be required for the doctors and midwives* on QI quality assurance (QA), organized by DGHS, MoHFW. This approach can help to develop a motivated and skilled workforce. Poor patients in the hospital, especially at the district or sub-district level, face challenges because they are not financially able to afford the cost of treatment. In order to manage unexpected cases in hospitals, the authority from the private health sectors may keep some budget for the poor and vulnerable people of the community. At the same time, management should also look for the providers' side, as they suffer from frustration for many reasons. In this regard, good

work should be rewarded, such as raising the grade, which can further motivate others. Supervisors should nominate them for relevant training to improve skills and knowledge for better performance.

- *The health system should be patient-friendly, and the medical education system should also be people-friendly,* so that future doctors and nurses can work with a service attitude. Most of the future doctors and nurses are not fully aware of the country's infrastructure and the country's health needs. In the medical education system, orientation on the health system and MNH coverage can be integrated, so they are updated with public health information before entering the profession. This can enhance the capacity of the health workforce, which can contribute more for the country.

- *Incentives can be introduced for private investments* in the provision of quality MNH services. The government can easily organize a reward function announcing and publishing the best performing private hospital in quality MNH care every year. A standard marker can be set to determine the best performer. Besides, best doctors/clinicians from both the public and private sector separately can be awarded. The cost will not be significant, and it can improve the perception of the QoC among district-level private facilities, as they assume financial support from the government can improve service quality.

- *Knowledge exchange practices – A learning health system* with the partnership of all the health actors, including the PHS, can be established. Stakeholders can share their experiences and knowledge during the national seminar, observation of a national event, and international conferences held in our country. In the same events, some presentations can be given jointly by both government representatives and private facilities. More workshops, seminars, and training can be arranged from the government, where medical service providers and managers from the local level private hospital can participate and contribute. They would learn and increase their technical capacity.

5.3 Foster relations

A platform of collaboration can be built where all the actors can play their role efficiently and openly with a common objective: high quality MNH care in Bangladesh.

- *Personal communication between doctors from a public hospital and private facility* influences the referral and management of mothers with medical complications and newborn with respiratory problems. Moreover, the financial status of the patients guided to identify referred facility having comprehensive MNH care. Shifting towards decentralization was highlighted so that the health system could save many lives from the way to the hospital.

- *Professional bodies at various levels can be more active and engaged* in facilitating training, organizing knowledge sharing events, and conducting policy review. The government can invite the professional bodies to provide support in mentoring, technical supervision, and protocol compliance regarding quality of MNH care.

5.4 Build understanding

A common understanding on the importance of health governance is necessary. It will promote ownership and commitment towards quality of services delivered from each end.

- *There should be a properly structured reporting format* and data audit system *for this sector*. The government should collect their service information by either increasing manpower or giving access to DHIS2 for data entry. The data can be organized per the department of service delivery from a hospital (e.g., OPD, IPD, admission, OT), complication, referral, and mortality with causes. The government can also initiate having an (MoU) with the private hospitals and clinics. Within the public sector, there are many talented officers who can work to make a bridge between the two sectors. They may need to take steps so that PHS will be interested in providing service-related data and information into the national HMIS. A common dashboard can visualize the performance of both sectors.

- *As part of eligibility for annual renewal of the license, all the private health facilities and organizations can be asked to complete electronic health data reporting* per the mandatory schedule. This is also directed in the OP of Health Information System and e-Health (HIS & e-H). In this document, the establishment of a PPP was recommended to improve the infrastructure and capacity to deal with the health MIS.

- *All the activities done by private hospitals and clinics can be brought into the audit* to make them accountable to provide quality services. This can illuminate opportunities and gaps about the quality of services. Gathering feedback from the patients in Bangladesh was not culturally sensitive and the outcome of feedback was not clear, leading to a lack of interest in giving feedback before discharge from the hospital. We can promote the culture of providing feedback to improve the quality of MNH care. An awareness program can be designed to develop such a culture.

6. Conclusion

With a view to achieve Universal Health Coverage (UHC) and the SDG goals, a comprehensive strategy for the private health sector engagement should be in place. The Bangladesh Strategic Investment Plan is also aligned with the goal of achieving UHC, highlighting every citizen's right to quality healthcare without incurring economic hardship. The government has to engage PHS because of their significant contribution to MNH service coverage. Equity in and access to high-quality evidence based health care has to be ensured for all especially the vulnerable and underprivileged population. Success is most likely when the private sector works together with the public sector, within a strong and transparent regulatory setting. In this regard, shealth governance should be strengthened, development of operational procedures can be developed and executed and finally utilization for the high-quality health workforce need to be ensured.

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