World Health Organization

Engaging the private sector in delivering quality maternal, newborn and child health services

A step-by-step workbook to inform analysis and policy dialogue

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Contents

Acknowledgements iv

Introduction 1

Step 1 Get organized – core concepts 5

Step 2 Prioritize MNCH problem(s) and describe public–private mix for services 9

Step 3 Collect data on policies, governance tools and behaviours relating to the MNCH problem 11

Step 4 Analyse and summarize data 13

Step 5 Develop draft recommendations and a background report 15

Step 6 Validate findings and recommendations through a multi-stakeholder consultation, and develop an implementation plan 17

References 19

Annex 1. Glossary 21

Annex 2. Suggested facilitated process supported by a technical team 22

Annex 3. Worksheets 23

Annex 4. Guide for key informant interviews 48

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Introduction

To accelerate progress to reach the Sustainable Development Goals (SDGs) for ending preventable maternal, newborn and child deaths, it is critical that health systems invest not only in increasing coverage of interventions, but also in quality, and ensuring that quality is sustainable at adequate scale. Private health care is one of the fastest growing segments of the health-care system, and private providers (i.e. individuals and organizations that are neither owned nor directly controlled by governments and being for-profit and not-for-profit, formal and informal, domestic and international) are an important source of health care.

The purpose of this workbook is to assist ministries of health, health managers and practitioners in engaging with the private sector on delivery of quality maternal, newborn and child health (MNCH) services in lower- and middle-income countries (LMICs). The workbook suggests for countries to take an iterative approach, and the steps are supported by various guiding tools for the process. It is not intended to be prescriptive, as the processes should be adapted to suit the needs of the country where it is being used.

The audience for the workbook is those who are involved with organizing and implementing processes for engaging the private sector in delivery of quality MNCH services.

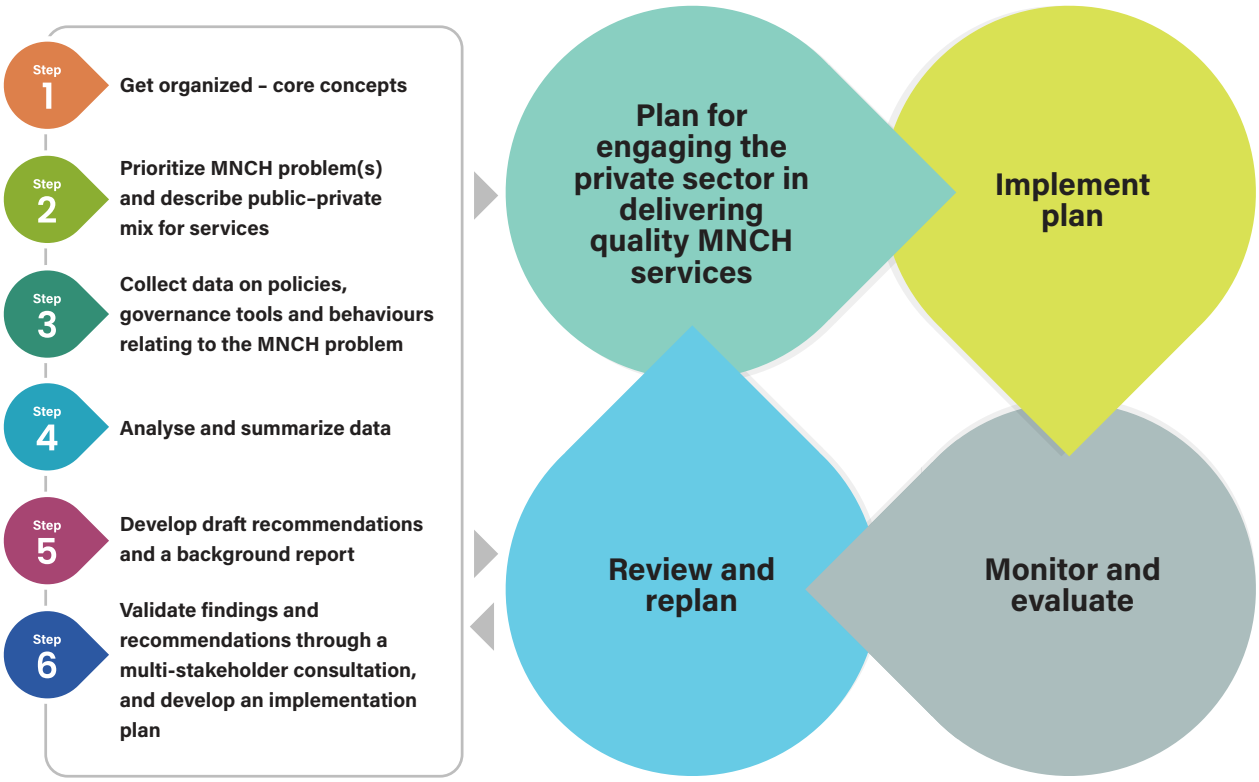
The workbook is to be used together with the worksheets. It may further be used in conjunction with a facilitated process, supported by a technical team with regular consultations depending on country needs.

Approach to workbook development

The contents are informed by the lessons learnt during the implementation of the analysis and multi-stakeholders policy dialogue on the private sector's involvement in delivering quality of care (QoC) for MNCH conducted in Ghana and Nigeria, the strategy report of the WHO Advisory Group on the Governance of the Private Sector for Universal Health Coverage, "Engaging the private health service delivery sector through governance in mixed health systems", the work of the "Managing Markets for Health", and other publications produced by WHO and partners.

Fig. 1. Overview of the process

Fig. 2. Engaging the private sector – a continuing process



The outcome of the process would be a plan for taking forward the recommendations for engaging the private sector in delivering quality MNCH services. This plan should be monitored and followed up.

Step 1. Get organized – core concepts

Objectives: The objectives of this step are for the Ministry of Health (MoH): (i) to decide to engage and/or strengthen the private sector in delivering MNCH services; (ii) to form a technical working group (TWG) that can help take the process forward; and finally (iii) to agree on the approach, including main concepts, for engaging the private sector.

Outcomes: A functioning TWG, an agreement on the approach and concepts and an overview and plan for the process.

Worksheets: Introduction and Glossary

Often, efforts have focused on strengthening the public health sector without addressing the role and contribution of the private sector. However, the engagement of the private sector is critical for progress towards ending preventable maternal, newborn and child deaths. The starting point for the process is an expression of the government's commitment to improving QoC in the public and private sectors and to engaging local implementation partners.

Get organized

Each country will decide how to best manage the process, but it has proven useful to establish a TWG, led by a senior strategic lead in the MoH and supported by a local consultant with experience in the private sector. If a country-level multi-stakeholder group or mechanism already exists, that may be the starting point for initiating and furthering the process. In summary:

1. Identify a senior strategic lead in the MoH (director level)
2. Recruit a local consultant with experience in the private sector
3. Establish a national multi-stakeholder TWG to advise on the process, including:
   - National experts with experience in the private sector
   - MoH official(s)
   - For-profit private sector representative(s)
   - Not-for-profit private sector representative(s)
   - WHO and other partners.

The TWG will

- plan, oversee the process and steps and ensure follow-up of recommendations; and
- engage other partners and stakeholders in various segments of the process as part of the TWG or on a more ad hoc basis, i.e. professional organizations, academia, developing partners, civil society, etc.

The MoH assisted by the local consultant will prepare for and collect data, draft reports, meetings, etc.

In order to initiate the process and for the further work, it is important to understand and agree on a few core concepts and definitions.

Core concepts

This section starts with an understanding of the need to govern the private sector within health systems. It introduces core concepts used in the MNCH workbook and the accompanying Excel diagnostic tool. It provides a brief summary of the governance behaviours and provides links to additional resources and a glossary of terms.

Most countries have health systems, where a mix of public and private entities deliver health-related goods and services. Health systems are defined as "the ensemble of all public and private organizations, institutions, and resources mandated to improve, maintain or restore health" *(1).* An important challenge in governing health systems relates to the diversity of characteristics and interests of health entities. This is especially challenging when it comes to the private sector in health. The private sector in health is less bounded than the public sector and is *"generally large, poorly documented, and very heterogeneous" (2).* It consists of both formal and informal entities ranging from drug shops to specialized hospitals, comprising both for-profit and non-profit entities, both domestic and foreign. Digital health and self-care interventions may also be categorized as part of the private sector in health.

In many lower- and middle-income countries (LMICs) the private sector in health contributes a large and growing proportion of health-care services. Such contribution is estimated to be in the range 40–62% and varies across WHO regions *(3).* This level of health-care provision underscores the importance of ensuring that formal private entities (including pharmacies) are integrated into overall health systems. It also suggests that informal private health-care entities cannot be ignored by governments if health systems are to deliver equity in service use, quality and financial protection.

The goals and priorities of health systems need to be shaped, shared and ultimately implemented across all health entities, including the private sector in health. Inclusive health policy therefore sets out the rationale for private sector engagement and respective roles for different types of private sector entities, including the means through which this will be achieved. Public sector roles should also be calibrated relative to those of the private sector in health. This is in recognition that increasingly ministries of health are more involved in strategic planning, target setting, and monitoring of the component parts of the health sector and less involved in direct service provision. Despite this, few ministries of health have reassessed their own structures, staffing and operations, particularly in relation to overall information and liaison functions with multiple entities, including the private sector in health.

An explicit health policy can achieve several things: it defines a vision for the future; it outlines priorities and the expected roles of different groups; and it builds consensus and informs people *(4)*. Policy tools include the rules, regulations, guidelines, and administrative norms that governments use to translate national laws and policies into programmes and services. Fig. 3 provides an example of policy objectives related to MNCH.

Fig. 3. Examples of policy objectives related to MNCH

The **governance behaviours** were conceptualized as part of the WHO strategy "Engaging the private health service delivery sector through governance in mixed health systems" *(5).* Launched in 2020, this strategy contributes a specific focus on the private sector as part of health systems governance and systems strengthening. The government sets the lead as steward of all health system entities, both public and private.

The governance behaviours are fundamentally a **socio-ecological approach**. They build from an understanding of health systems as "everybody's business" and governance as a dynamic process through which governments engage public, private and civic health actors to achieve public health policy and improve health system performance. They do not prescribe norms and values to behaviours, as these should be contextually determined. Furthermore, they recognize that behaviour change is not a quick fix but a series of connected actions that should be approached consistently.

Deliver strategy and **enable stakeholders** focus on broader institutional arrangements for health system performance; these include health priorities and strategic direction, articulation of the principles and values of the health system and the underlying policy and regulatory framework.

Align structures considers the organization of the health system to deliver on health priorities, principles and values. This focuses on the mix of public–private entities, the division of roles and activities among entities, and the integration of entities within the health system.

Build understanding and **foster relations** consider system and interactive processes using information and engagement as levers for improving institutional and organizational (structural) performance.

Nurture trust considers how well this is done, in terms of the quality of integrative engagement, how power and responsibilities are exercised, and the centrality of people, principles and values to sectoral roles and interactions.

A behavioural approach to governance practice recognizes that change is not a quick fix but a series of connected actions that should be approached consistently. The government sets the lead as steward of all health entities, public, private and civic.

Resources

The WHO's Country Connector on Private Sector in Health has been recently launched with the aim to share experiences across countries, connect countries to the resources, tools and guidance needed for stronger health system governance and better public policy toward the private sector in health (https://www.ccpsh.org/).

Engaging the private health service delivery sector through governance in mixed health systems *(5).*

Private sector landscape in mixed health systems *(6).*

The Governance Behaviours: A socio-ecological approach to governing the private sector in health *(7)*.

Governance of the private sector in health: A public health policy framework approach *(8).*

How to develop inclusive national health policy for the private sector in health *(9)*.

Governance of the private sector in health: Entry points in the policy cycle and learning from practice *(10)*.

Governance of the private sector in health: Insights from policy analysis *(11)*.

Step 2. Prioritize MNCH problem(s) and describe public–private mix for services

Objectives: The objective of this step is to focus the process on important MNCH issues, so that outcomes and recommendations are specific and actionable. This is done by: (i) prioritizing the MNCH problem(s) to be addressed; (ii) describing the public–private mix for services supporting them; and (iii) mapping the relevant stakeholders.

Outcomes: Identification of the most important MNCH problem(s), for which engaging the private sector would be important for improving availability, accessibility, acceptability and quality of MNCH services.

Worksheets: 1. MNCH problem analysis; 2. Public–private mix analysis; and 3. Stakeholder analysis (Annex 3)

Prioritize MNCH problem(s) to be addressed

The reasons for prioritizing the MNCH problems(s) at this point are: (i) the process will focus on engaging the private sector in health specifically for improving availability, accessibility, acceptability and quality of MNCH services; and (ii) experience has shown that if problems are formulated too broadly, recommendations become equally broad and non-specific.

The MNCH problem prioritized and further analysed should be services and/or products critical for improving MNCH and for which engaging with the private sector would improve outcomes. The MNCH problem identified may be specific to geographical locations and/or populations. To help prioritizing the MNCH problem you may:

1. Describe overall status of MNCH

   You may start reviewing the overall status of MNCH. What are specific problems of concern in each of the areas or a combination? Which services are critical to improve health outcomes of concern by improving availability, accessibility, acceptability and quality?

2. Identify services and/or products critical to improve the health outcomes of concern

   For each of the areas (MNCH or a combination), identify the services and/or products critical to improve the health outcomes of concern. You may identify as many as you want.

3. Prioritize the MNCH problem

   To help prioritizing the MNCH problem for further analysis, apply the following criteria using the worksheet:

- *Relevance:* What is the nature of the problem selected? Who does it affect? How does the problem affect this group?
- *Opportunity:* Does private provision of services play an important role and/or are there opportunities for improving access, quality and financial protection by engaging private provision? What is the opportunity to improve the priority problem? Has something changed to create an opportunity to address the priority health problem?
- *Feasibility:* Is it feasible to improve the priority health problem? Is the proposed intervention feasible? What are key enablers of change (i.e. technical, financial, political)?

4. Summarize the analysis into a problem statement based on opportunity, relevance and feasibility in the worksheet.

Analyse public–private mix of the services

Key considerations include the range of MNCH products and services the private sector delivers, the quality of those outputs (e.g. their safety, appropriateness, efficacy and so on), and their prices (which are often paid by patients "out of pocket"). We need to understand how aligned it is with MNCH service objectives such as improved quality, access and utilization. The private provision of MNCH services should be considered in relation to the public provision as the market may be responding – or trying to respond – to failures, weaknesses or gaps in the public provision.

To help understand the public–private mix for MNCH services supporting the problem you may consider the following aspects:

- *MNCH services*: What is the core health service(s)/goods of interest?
- *Performance*: What are the problems in the public–private mix for health service delivery in terms of the principles of universal health coverage (UHC): access?, quality?, costs? or a combination?
- *Demand*: What segment of the population is affected?
- *Supply*: Who are the suppliers (public and private) of the core health service/good of interest? What do they do?

Enter the problem statement for the prioritized MNCH problem in the worksheet "Problem analysis" and fill in information on the questions as above. Finally, summarize key issues and key stakeholders in the public–private mix for service delivery in the "Public–private mix analysis" worksheet.

Map and analyse stakeholders

Mapping and analysing stakeholders is done to ensure that all relevant stakeholders are included in the process and analysis, and eventually in the recommendations in respect to their roles and responsibilities. When analysing the public–private mix of the services, you have already identified some of the stakeholders (public and private suppliers of the health services). There are however others which are important such as management entities, professional entities, funding entities and oversight entities. What are they supposed to do and what do they do in practice? Enter the stakeholders, public and private, and their functions in the worksheet "Stakeholder analysis". This may also help to identify key informants to interview when collecting data and information – step 3.

Step 3. Collect data on policies, governance tools and behaviours relating to the MNCH problem

Objectives: The objective of this step is to collect data, based on a plan that defines data needs and sources relevant to the prioritized MNCH problem(s) to be addressed in step 2, which identifies data collection tools and includes key stakeholders.

Outcomes: A set of data in the following domains: (i) status of policies that have implications for the MNCH problem; (ii) status of policy tools relevant for the MNCH problem; and (iii) status of the governance behaviours which have implications for the MNCH problem.

Worksheets: 4. Policy analysis; 5. Policy tools analysis; and 6. Governance behaviours analysis (Annex 3)

In step 2 you have identified the key MNCH problem(s) to be addressed, the public–private mix for MNCH services that affect as well as a stakeholder mapping/analysis. In step 3, you will develop a data collection plan that

- defines data needs and sources;
- identifies data collection tools (i.e. document reviews, key informant interviews, etc.); and
- maps a process to involve key stakeholders in data collection.

What are the data needs?

This workbook suggests three domains of data on private sector engagement in addition to the analysis in the previous steps:

- Policies that have implications for the MNCH problem
- Governance tools relevant for the MNCH problem
- Governance behaviours which have implications for the MNCH problem.

Review the worksheets "Policy analysis", "Tools analysis" and "Governance behaviors analysis" (Annex 3) and identify which data are relevant for the MNCH problem in the specific country context. Based on the data need, decide which are the sources of information. In some cases, it may just include document reviews, but in other cases, documents may not provide the full information.

Throughout the process, the collection of data and information (as well as in the further analysis) on the MNCH problem should include: the provision of services, policies and the governance behaviours and tools applied, include also information on the gender context and inequalities. Do inequities exist between women and men in the MNCH problems,

access to services and in the governance behaviours and tools applied? Are these inequities between men and women different across different population subgroups? Are there subgroups that bear a disproportionate burden of the health problem?

Identify the need for additional data and data collection tools

Information on the actual implementation, effects (intended and not intended), acceptability, information sharing, etc. of policies and governance tools and behaviours may often require interviews with those involved directly, both among public and private actors – key informants.

Key informant interviews will require a planned process identifying which key informants to be interviewed (look at the stakeholder mapping/analysis) and development of an interview guide with questions. Key informant interviews should be simple with the main purpose of validating collected information and provide additional information of degree of implementation, barriers and solutions.

Develop and carry out the data collection plan

Based on the above, make and carry out a plan for data collection and key informant interviews including timelines and responsible person(s).

Resources

Research Protocol. Mechanisms for engaging the private sector in planning, delivering and demonstrating accountability for quality maternal and newborn health services: Evidence from Ghana *(12)*.

Guide for key informant interviews (Annex 4).

Regulation of private primary care – a country assessment guide *(13).*

A tool for strengthening gender-sensitive national HIV and sexual and reproductive health (SRH) monitoring and evaluation systems *(14)*.

Step 4. Analyse and summarize data

Objectives: The objectives of this step are to summarize and analyse the data collected in the previous steps.

Outcomes: A summary of the analyses of all dimensions of the public–private mix for services in relation to the MNCH problem.

Worksheets: 4. Policy analysis; 5. Policy tools analysis; 6. Governance behaviours analysis and 7. Summary (Annex 3)

In this step, you will analyse and summarize the data collected in the previous steps for the identified MNCH problem in relation to private sector engagement.

Enter the data collected in step 3 in the worksheets "Policy analysis", "Tools analysis" and "Governance behaviors analysis" (Annex 3).

For Policy analysis: Enter policies relevant to the MNCH problem and public–private mix of services. Analyse them with regards to the implementation status. Summarize the analysis.

For Tools analysis: Complete the table for the most relevant governance tools for the delivery of MNCH services in relation to the problem. Rank up to five of the tools most critical to the problem. Summarize the selected tools and gaps.

For Governance behaviors analysis: For each of the six governance behaviours, analyse them using the questions in the worksheet and score them using the drop-down menu. Summarize gaps for each of the behaviours in relation to the MNCH problem.

The summaries from the MNCH problem analysis, Service delivery analysis, Policy analysis, Tools analysis and Governance behaviours analysis automatically populate the worksheet "Summary". It acts as an executive summary for the analyses of all the dimensions of the public–private mix for services in relation to the MNCH problem.

Step 5. Develop draft recommendations and a background report

Objectives: The objectives of this step are to develop draft actionable recommendations and prepare a preliminary report.

Outcomes: A preliminary report with draft recommendations that are discussed and validated by key public and private actors/stakeholders involved with the provision of MNCH services.

Worksheets: 8. Recommendations as well as previous worksheets that may form the basis for the preliminary report (Annex 3).

Developing actionable recommendations

Based on the data and information collected, the analysis and summaries, recommendations for each domain (service delivery, policies, governance tools and behaviours) should be made. The recommendations should be actionable and answer: (i) what change is needed?; (ii) institution/person responsible for implementation – what change is needed?; (iii) who should pay?; (iv) gender context and inequalities – what change is needed?; and (v) role of government and the private sector in facilitating change.

Solutions vs. recommendations

Solutions help to address and overcome the causes of the most important problems.

Recommendations are the specific actions that need to be taken to achieve these solutions to problems.

Recognize that it may not always be possible to identify feasible solutions to a problem. If additional data are required, note these data needs and include them as a recommendation for further action. If problems cannot be immediately solved, then a recommendation may be to allocate responsibility for working on the problem in the longer term.

The recommendations should provide details on how the solutions identified may be implemented. The recommendations should be specific, action-oriented, feasible and realistic to incorporate into a plan for implementation.

Developing a preliminary report

The preliminary report will be the background document for the multi-stakeholder workshop for step 6: organize multi-stakeholder consultation, deliver and engage stakeholders. The report should include a description of the steps, methodology, data, analysis and recommendations. A possible outline is described below.

Suggested outline of a preliminary report

- Introduction
- Objectives of the report
- Methodology
  - Steps
  - Data collection (secondary and primary data)
- Findings
- Analysis
- Recommendations
- References

Step 6. Validate findings and recommendations through a multi-stakeholder consultation, and develop an implementation plan

Objectives: The objectives of this step are to jointly review and validate findings and recommendations of the preliminary report through a multi-stakeholder consultation and, based on this, develop an implementation plan.

Outcomes: A validated report with findings and recommendations to be presented at relevant policy levels and more widely, as well as an implementation plan.

Worksheets: All (Annex 3)

A multi-stakeholder consultation is intended to engage public and private sector entities and their representatives to share information and intelligence, to deliberate on the diagnosis of common challenges, and to elicit new ideas for resolving them.

The objectives of conducting a multi-stakeholder workshop in collaboration with stakeholders are:

- to jointly review and validate the findings and recommendations of the preliminary report;
- to identify opportunities for further engaging the private sector in working within the national health system to deliver quality MNCH services;
- to propose models and a plan for effective engagement of the private sector within the national health system for implementing quality MNCH services; and
- to propose models for the implementation and monitoring of the plan.

Participants in the workshop should include key public and private actors/stakeholders involved with the provision of MNCH services.

For additional information, including sample agenda for virtual and face-to-face workshop, report format, etc. – *see under resources.*

The outcomes of the process, including the multi-stakeholder workshop should be presented at relevant government levels as well as shared widely. It is important to note that the engagement of the private sector in delivering quality MNCH services is a continuous process that should be monitored and evaluated.

The benefits of such an approach include the following:

- Inclusion of the private sector may lead to more realistic policies by recognizing private sector's competencies, perspectives and constraints.

- It helps the private sector in health to develop a better understanding of the government's policy intent and fosters private sector buy-in, increasing the likelihood that the private sector will put the policy reforms into practice.
- It helps the government anticipate resistance and avoid bottlenecks in implementation through constant communication during a policy process.
- For the private sector it may create a more predictable business environment by establishing policies, regulations and health plans through a participatory and transparent process.
- Frequent and consistent communication and information sharing with the private sector enables governments to be better prepared for conflicts and troubleshoot problems as they arise.
- Getting to know each other through frequent interactions and open communication nurtures relationships – a core ingredient to achieve any policy reform or programme objective.

Resources

Engaging the private sector in delivering quality maternal and newborn health services – A guide for policy dialogue (https://www.qualityofcarenetwork.org/sites/default/files/2021-06/Guide%20for%20policy%20dialogue%20version%201.0.pdf *(15).*

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Annex 1. Glossary

Civic sector includes populations (e.g. lay people), communities and civil society.

Health governance involves ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system-design and accountability.

Health policy includes the decisions, plans and actions that are undertaken to achieve specific health-care goals within a society. Ideally this includes the rationale for private sector engagement and respective roles for the different types of private sector entities. Terminology may vary, e.g. national health strategy, plan or policy.

Health policy framework is the management of policies as an integrated whole rather than a collection of parts (e.g. separate policies).

Health reform is a significant, purposeful effort to improve the performance of the health-care system.

Health systems embody the people, institutions and resources, arranged together following policies established by a government to improve the health of the population it serves.

Policy tools are the rules, regulations, guidelines and administrative norms that governments use to translate national laws and policies into programmes and services.

Private sector in health consists of both formal and informal entities ranging from drug shops to specialized hospitals, comprising both for-profit and non-profit entities, both domestic and foreign. Digital health and self-care interventions may also be categorized as part of the private sector in health.

Private sector entities refer to individuals, groups or organizations that have an interest in the organization and delivery of health services and products.

Private sector organizations include recognized networks, groups, associations, syndicates or federations of private sector entities. These may be organized geographically, by level of care, by profession or service.

Public–private dialogue is a structured mechanism that brings together a range of public, private and civic entities to collectively identify, prioritize, implement, and measure policy reforms and actions.

Public–private mix refers to the mixed provision of health-care services and products through public, private and civic sectors.

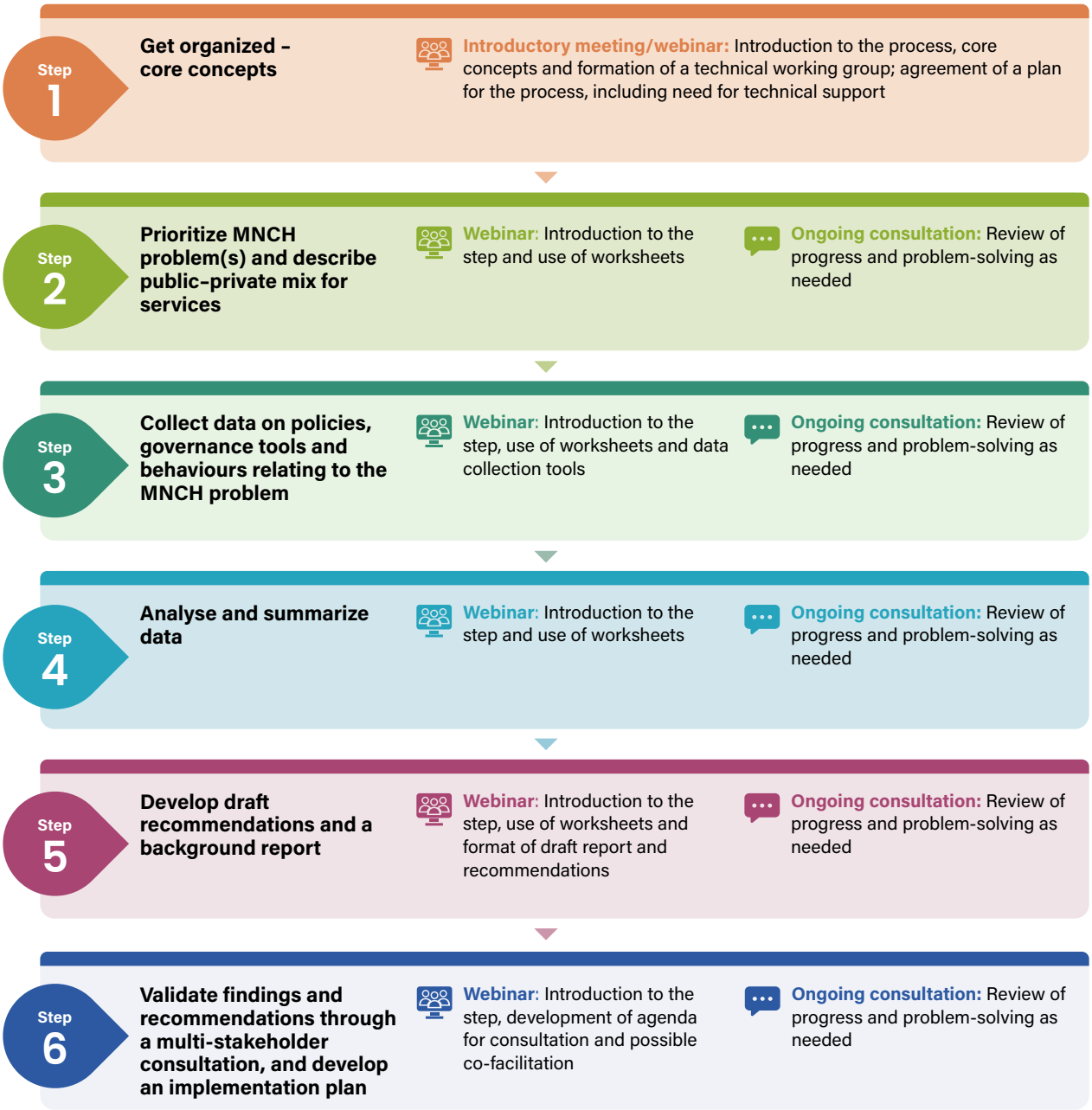
Stakeholder analysis is a systematic way of analysing the relevant entities inside and outside the government who might influence policy and its implementation.

Stewardship refers to how government actors take the responsibility for the health system and the well-being of the population, fulfil health system functions, assure equity, and coordinate interaction with the government and the civic and private sectors.

Structures entail the arrangement and organization of interrelated entities within a system.

Annex 2. Suggested facilitated process supported by a technical team

The workbook on "Engaging the private sector in delivering quality maternal, newborn and child health services" including worksheets may be used in conjunction with a facilitated process, supported by a technical team with regular consultation depending on country needs. Given below is an outline of a possible sequence of exchanges between the ministry of health/technical working group and a WHO technical team with experience in the processes.



Annex 3. Worksheets

Introduction

These worksheets refer to and can be used together with the Workbook "Engaging the private sector in delivering quality maternal, newborn and child health services". The sheets follow the steps outlined in the Workbook. The sheets include examples of data and information to be collected and can be modified according to the specific situation in a country. Using and filling in the worksheets may help keeping key information in one place during the process and it may help in generating a report. Please note that it may be useful to use the Excel version of the worksheets as it auto-generates the report at the end if the blue cells are completed as part of each worksheet.

1. MNCH problem analysis

Instructions:

Define the key MNCH problems in your country context.

Focus on MNCH problems in which the private sector plays an important, not peripheral role.

Problems should be at the outcome level, e.g. Availability, Access, Acceptability, Quality (AAAQ).

Prioritize the MNCH problem by considering both relevance and feasibility.

Summarize analysis into a problem statement based on relevance and feasibility.

Prioritize the most relevant problem based on feasiblility and relevance to the MNCH outcome area.

Write the prioritized problem statement in the blue box.

MNCH focal areas	Define MNCH problem in your country at the outcome level (AAAQ)	Relevance of private sector engagement in addressing the problem		Feasibility	Problem prioritization	
		Do private providers play a role in delivering services for this problem?	What AAAQ aspect(s) will improve by engaging private providers?	Is it technically, financially, and operationally feasible to improve the priority MNCH problem through private sector engagement?	Summarize analysis into a problem statement based on relevance and feasibility	Prioritize the problems
Maternal						
Newborn						
Child						
Combination/ other						
MNCH problem statement						

2. Public-private mix analysis

Instructions:

Use the problem statement from worksheet 1 as the basis for analysing the public–private mix (PPM).

Consider the mix of entities providing the services (and their distribution), the scope and consistency of services provided, the population affected and their location and the quality of information available for the analysis.

Summarize key issues in the blue box.

Problem statement (from worksheet 1)	**Demand: What segment of the population is affected? Geographical variation?**	**Supply: What are the key supply issues within the public-private mix?**	**Information: What are data and information sources for this analysis? What are the data gaps?**	**Summarize key issues in the PPM for service delivery**

3. Stakeholder analysis

Instructions:

The stakeholder analysis is a role analysis of public and private sector entities.

Select the most important stakeholders in relation to the MNCH problem and consider both what they are supposed to do and what they do in practice.

Choose one of the selected/prioritized stakeholders from the list provided and add any that are missing to the relevant entity categories.

Summarize stakeholder gaps in the blue box, and also in the blue box below the table.

Entities/ stakeholders relevant to the MNCH problem and public–private mix of services	**Public entities (formal)**	**What are they supposed to do?** (please add precise title of entity)	**What do they do in practice?**	**Private entities (formal and informal, for-profit, not-for-profit)**	**What are they supposed to do?**	**What do they do in practice?**	**Stakeholder gaps**
Health service entities	☐ Tertiary: teaching and referral hospitals ☐ Secondary: district hospitals, health centres and maternity homes ☐ Primary: health dispensaries/clinics, community health workers, outreach sites ☐ Digital: telemedicine, mHealth, Monitoring and compliance units (inspection, supervision) ☐ Other (specify):			☐ Tertiary: teaching and referral hospitals ☐ Secondary: smaller hospitals, large/group-owned clinics and maternity homes ☐ Primary: general practitioners, allopathic doctors, indigenous providers, traditional birth attendants, community health workers ☐ Digital: telemedicine, mHealth ☐ Other (specify):			

Entities/ stakeholders relevant to the MNCH problem and public–private mix of services	**Public entities (formal)**	**What are they supposed to do?** (please add precise title of entity)	**What do they do in practice?**	**Private entities (formal and informal, for-profit, not-for-profit)**	**What are they supposed to do?**	**What do they do in practice?**	**Stakeholder gaps**
Management entities	☐ National health departments (programmes, planning, financing, quality) ☐ National health information departments/systems Subnational health departments (devolved management, service delivery) ☐ Regulation and standards departments PPP units ☐ Other (specify):			☐ NGO programmes ☐ Umbrella organizations (e.g. federations, faith-based bureaus) ☐ Networks, platforms (may be virtual) ☐ Other industry representative groups ☐ Other (specify):			
Professional entities	☐ Training institutes ☐ Councils (doctors, nurses, clinical officers, pharmacists) ☐ Research institutes ☐ Other (specify):			☐ Training institutes ☐ Associations (doctors, nurses, clinical officers, pharmacists) ☐ Technical agencies ☐ Research institutes ☐ Other (specify):			

Entities/ stakeholders relevant to the MNCH problem and public–private mix of services	**Public entities (formal)**	**What are they supposed to do?** (please add precise title of entity)	**What do they do in practice?**	**Private entities (formal and informal, for-profit, not-for-profit)**	**What are they supposed to do?**	**What do they do in practice?**	**Stakeholder gaps**
Funding entities	☐ Ministry of finance ☐ National health insurance agency ☐ Ministry of health budget holders ☐ Management agent (vouchers, RBF) ☐ Subnational health budget holders ☐ Other (specify):			☐ Private health insurance agencies ☐ Micro-insurance/credit agencies ☐ Domestic financing (donations, CSR) ☐ Bilateral and multilateral donors ☐ Foundations ☐ Global health programmes ☐ Digital finance ☐ Other (specify):			
Health product entities	☐ National medical stores ☐ Regulatory boards ☐ Other (specify):			☐ Medical stores/pooled procurement ☐ Pharmacies, drug shops ☐ Social marketing, e-pharma organizations ☐ Manufacturers ☐ First-line buyers ☐ Distributors ☐ Others (please specify):			

Entities/ stakeholders relevant to the MNCH problem and public–private mix of services	**Public entities (formal)**	**What are they supposed to do?** (please add precise title of entity)	**What do they do in practice?**	**Private entities (formal and informal, for-profit, not-for-profit)**	**What are they supposed to do?**	**What do they do in practice?**	**Stakeholder gaps**
Other entities with a role in health	☐ Ministry of education ☐ Ministry of women's affairs, youth, disability ☐ Office of the President ☐ Public services commission ☐ Intergovernmental bodies ☐ Local government National planning authority ☐ Other (specify):			☐ Traditional leaders ☐ Community development committees ☐ Other (specify):			
Oversight entities	☐ Office of the President ☐ Parliament (legislation) ☐ Oversight/redressal (parliamentary, judicial, Ombud's offices) ☐ Formal (boards, committees, working groups) ☐ Other (specify):			☐ Patient/consumer groups ☐ Press and media ☐ Research institutes ☐ Civil society organizations ☐ Unions ☐ Other (specify):			

Entities/ stakeholders relevant to the MNCH problem and public–private mix of services	**Public entities (formal)**	**What are they supposed to do?** (please add precise title of entity)	**What do they do in practice?**	**Private entities (formal and informal, for-profit, not-for-profit)**	**What are they supposed to do?**	**What do they do in practice?**	**Stakeholder gaps**
Others							
Stakeholder gaps (summarize the key stakeholder/ role gaps)							

4. Policy analysis

Instructions:

Identify the most important policies in relation to the MNCH problem.

Analyse selected policies using the prompts.

Summarize the analysis of selected policies in the blue box.

Policies relevant to the MNCH problem and public–private mix of services	Effectiveness: What effects does the policy have on the MNCH problem and public–private mix of services?	Unintended effects: Are there unintended effects of this policy?	Equity: What are the effects of the policy on different population groups?	Cost: What is the financial cost of this policy?	Feasibility: Is the policy technically feasible?	Acceptability: Do the relevant policy stakeholders view the policy as acceptable?	Summarize all the key policy issues for the selected MNCH problem
ex. Strategy for public–private partnerships							
ex. Health-specific plans and policies							

5. Policy tools analysis

Instructions:

Complete the table for the most relevant policy instruments (tools) for the delivery of MNCH services and in relation to the problem.

Rank up to five of the tools most critical to the problem (change often requires use of more than one tool and change in one tool is likely to have an effect on other tools).

Summarize the selected tools and gaps in the blue box below the table.

Tools of governance (add/ modify tools relevant to your context)		Tool in place? (Y/N)	Tool under development? (Y/N)	Tool consistently implemented/ enforced? (Y/N)	Tool reference (e.g. name of tool)	Responsible entity	Tool gap (example)	Rank up to five tools critical to the MNCH problem
Regulation	Legislation (facility licensure)							
	Legislation (pharmaceutical licensure)							
	Regulations (clinical entry requirements, provider certification)							
	Regulations (pharmaceutical entry requirements, provider certification)							
	Regulations (MNCH pricing)							
	Regulations (MNCH quality)							
	Accreditation (MNCH service standards)							
	Monitoring and compliance (inspection, supervision)							
	Monitoring and compliance (judicial, parliamentary oversight)							
	Self-regulation (individual/peer benchmarking)							
	Other (specify)							

Tools of governance (add/ modify tools relevant to your context)		Tool in place? (Y/N)	Tool under development? (Y/N)	Tool consistently implemented/ enforced? (Y/N)	Tool reference (e.g. name of tool)	Responsible entity	Tool gap (example)	Rank up to five tools critical to the MNCH problem
Financing	MNCH benefits package (e.g. national health insurance)							
	MNCH benefits package (e.g. results-based financing that includes the private sector)							
	MNCH benefits package (e.g. vouchers that include the private sector)							
	MNCH subsidy (e.g. FBO block grants, concessions, rebates)							
	MNCH in-kind (e.g. staff secondments, goods, training)							
	MNCH infrastructure (subsidized credit/loan, and guarantees)							
	MNCH contracting (clinical, support, outsourcing)							
	Duty or tax exemptions							
	Other (specify)							

Tools of governance (add/ modify tools relevant to your context)		Tool in place? (Y/N)	Tool under development? (Y/N)	Tool consistently implemented/ enforced? (Y/N)	Tool reference (e.g. name of tool)	Responsible entity	Tool gap (example)	Rank up to five tools critical to the MNCH problem
Information (suppliers)	Professional codes of conduct							
	Government–supplier communication system (government websites, chatbots, help desks)							
	Health information system (routine, vital statistics, notifiable events)							
	Formal consultation (government reviews, commissions, etc.)							
	Formal petition (sectoral advocacy/ policy briefs, etc.)							
	Other (specify)							

Tools of governance (add/ modify tools relevant to your context)		**Tool in place? (Y/N)**	**Tool under development? (Y/N)**	**Tool consistently implemented/ enforced? (Y/N)**	**Tool reference (e.g. name of tool)**	**Responsible entity**	**Tool gap (example)**	**Rank up to five tools critical to the MNCH problem**
Information (patient/ civic)	Public redressal mechanisms (e.g. Ombud's offices)							
	Social accountability tools (such as scorecards, satisfaction surveys)							
	Public interest litigation							
	Public complaint (formal)							
	Service and patient rights' charters (formal)							
	Patient/civic communication systems (websites, chatbots, help desks)							
	Other (specify):							
Tool analysis:								

6. Governance behaviours analysis

Instructions:

Answer the questions using the four-point rubric.

Select one rubric that best reflects your country content.

Summarize key behavioural gaps in the blue box.

Deliver strategy	Rubric	Behavioural gap
Does national health policy/strategy include the private health sector?	☐ Private sector is not mentioned in national health policy ☐ Private sector is included in national health policy but vaguely referenced ☐ Private sector is included in national health policy with some specificity on entities and roles ☐ Private sector is included in national health policy with clear identification of entities and roles ☐ Do not know	**Deliver strategy:**
Is national health policy/strategy used to guide the private sector towards public health goals?	☐ National health policy is not used to guide the private sector ☐ Limited use of national health policy (not reflected in operational plans) ☐ Moderate use of national health policy (reflected in operational plans but limited implementation) ☐ Demonstrated use of national health policy (operationalized plan/roadmap and tools) ☐ Do not know	

Is there an inclusive process for national health policy review? (e.g. formal review as part of the policy cycle)	☐ No policy review ☐ Policy review (public sector only) ☐ Policy review (selective participation of private and civil society) ☐ Policy review is inclusive of private sector entities and civil society ☐ Do not know	
Are there defined national health policy monitoring mechanisms in place that include the private sector?	☐ No monitoring mechanism ☐ Monitoring mechanism defined, but no evidence of use ☐ Monitoring mechanism used in a limited way (e.g. at time of policy review, or only by the public sector) ☐ Monitoring mechanism used consistently ☐ Do not know	
Align structures	**Rubric**	**Behavioural gap**
Are private sector entities integrated into health system organizational arrangements? (formal, informal health actors, as well as digital self-care models of care, etc.)	☐ No evidence of integration ☐ Limited integration (e.g. larger urban entities) ☐ Moderate integration (e.g. a base of large, medium and small providers) ☐ Full integration of private entities in the health system ☐ Do not know	**Align structures:**
Do private sector entities deliver a defined essential health-care package?	☐ No essential benefits package ☐ Essential benefits package defined but not used to align/engage the private sector ☐ Essential benefits package defined and partially delivered by private sector entities ☐ Essential benefits package is fully aligned and delivered by private sector entities ☐ Do not know	
Are systems used to align public and private providers? (e.g. referral, quality assurance, supervision, etc.)	☐ No systems used ☐ Systems used on an ad hoc basis ☐ Systems used but coverage is limited ☐ Systems used across a range of public and private entities ☐ Do not know	

Build understanding	Rubric	Behavioural gap
Are private sector entities included in national health information systems (HIS)?	☐ No private sector reporting in HIS ☐ Limited private sector reporting in HIS (e.g. larger facilities, faith-based facilities) ☐ Moderate private sector reporting in HIS (e.g. wider spectrum of entities) ☐ Universal reporting by private sector entities (e.g. meets WHO threshold of 80%) ☐ Do not know	**Build understanding:**
How confident are health actors in using private sector data from national HIS? (e.g. completeness, timeliness, quality, and consistency of information)	☐ No confidence in private sector data ☐ Limited confidence in private sector data ☐ Moderate confidence in private sector data (efforts in place to improve quality) ☐ Confidence in private sector data (e.g. routine data quality review/ assurance) ☐ Do not know	
Are other sources of private sector data/ information available and used? (e.g. surveys, assessments, research)	☐ No other data sources available ☐ Other sources available but not recognized/used ☐ Other data sources partially recognized/used ☐ Evidence of triangulation of information sources and their use ☐ Do not know	
Foster relations	**Rubric**	**Behavioural gap**
Is the private sector organized for public sector engagement?	☐ No private sector organization ☐ Limited private sector organization (e.g. parts of the private sector) ☐ Moderate private sector organization (wider membership) ☐ Organized private sector (wide and active membership) ☐ Do not know	**Foster relations:**

Is the public sector organized for private sector engagement?	☐ No public sector organization (for PSE) ☐ Limited public sector organization for PSE (e.g. limited resources, role and reach) ☐ Moderate public sector organization (e.g. investment in resources, roles and reach) ☐ Public sector organization for PSE (e.g. established/adequate resources, roles and reach) ☐ Do not know	
Are there public–private coordination platforms?	☐ No coordination platform ☐ Coordination platform(s) available but not formalized/used ☐ Coordination platforms formalized and used on an ad hoc basis ☐ Coordination platform(s) formalized and consistently used ☐ Do not know	
Enable stakeholders	**Rubric**	**Behavioural gap**
What regulations are in place for the private sector? (e.g. licensure, accreditation, etc.)	☐ No regulations in place ☐ Limited regulations in place ☐ Regulations in place but some gaps ☐ Comprehensive regulatory framework ☐ Do not know	**Enable stakeholders:**
Do public financing arrangements include the private sector? (e.g. grants, in-kind, contracting, social health insurance, etc.)	☐ No public financing of the private sector ☐ Limited public financing options (e.g. training, access to commodities, etc.) ☐ Wider availability of public financing instruments but not widely used (e.g. grants or contracts to specific entities only) ☐ Public financing instruments available and cover a range of private sector entities ☐ Do not know	

Is there adequate public sector capacity to ensure compliance with regulations and rules?	☐ No capacity to monitor or enforce ☐ Limited capacity to monitor/enforce (e.g. ad hoc, selective) ☐ Moderate capacity to monitor/enforce (e.g. procedures in place but not fully implemented) ☐ Monitoring and compliance systems fully implemented ☐ Do not know	
Nurture trust	**Rubric**	**Behavioural gap**
How central are patient/civic interests to private sector engagement?	☐ Patient/civic interests not mentioned as part of PSE ☐ Patient/civic interests mentioned broadly as part of PSE ☐ Patient/civic interests with some specificity as part of PSE (e.g. some analysis of gaps) ☐ Patient/civic interests specified as part of PSE (e.g. analysis considers gender, diversity, equity) ☐ Do not know	**Nurture trust:**
Do measures exist to manage competing and conflictive sectoral interests?	☐ No measures in place ☐ Measures in place but not used for mitigation ☐ Measures in place but require pressure to prompt mitigation (e.g. via media or civic intervention) ☐ Measures in place and used to mitigate and manage interests ☐ Do not know	
What is the role of brokers/champions in sectoral engagement?	☐ No broker/champion ☐ Broker/champion used on an ad hoc basis with limited effect ☐ Brokers/champions used more routinely to facilitate engagement ☐ Brokers/champions consistently engaged to facilitate engagement and build trust across sectoral entities ☐ Do not know	

Is there any sharing of resources, capacities, skills for establishing trust between sectors?	☐ No sharing of resources, capacities, skills ☐ Ad hoc sharing of resources, capacities, skills ☐ Externally driven sharing of resources, capacities and skills ☐ Cooperative models of sharing of resources, capacities and skills ☐ Do not know	

7. Summary

Instructions:

The summary analysis is pulled from the blue boxes in the worksheets. It acts as an executive summary for the various analyses and proposed solution.

	MNCH problem statement (worksheet 1)	
MNCH problem analysis		
	MNCH service delivery (worksheet 2)	
Public–private mix analysis		
	MNCH stakeholders (worksheet 3)	
Stakeholder analysis		

What change is needed (MNCH solution)

	MNCH policies (worksheet 4)	
Policy analysis		
	MNCH policy tools (instruments) (worksheet 5)	
Policy tools analysis		

	Governance behaviours (worksheet 6)	
Governance behaviours analysis	Deliver strategy:	
	Align structures:	
	Build understanding:	
	Foster relations:	
	Enable stakeholders:	
	Nurture trust:	

8. Recommendations

Instructions:

Develop a vision statement that responds to the selected MNCH problem. Use this as a basis for considering the changes needed in each of the domains: service delivery, policy, tools and behaviours.

Formulate recommendations in the blue boxes.

Problem statement	
Service delivery	

Domains	**What change is needed (MNCH solution)?**	**What resources are needed?**		**Responsible (government, private sector and others) for implementing change**	**Timeline**	**Recommendations**
		Resources	**Source**			
Policy						
Tools (instruments)						
Behaviours						

Annex 4. Guide for key informant interviews

Introduction

Information on implementation, effects (intended and not intended), acceptability, information sharing, etc. of policies and related tools and behaviours in relation to engaging the private sector in delivering quality maternal, newborn and child health (MNCH) services may often require interviews with those involved directly, both among public and private actors – key informants.

Key informant interviews will require a planned process of identifying which key informants to be interviewed (look at the stakeholder mapping/analysis) and development of an interview guide with questions. Key informant interviews should be simple with the main purpose of validating the collected information and provide additional information on the degree of implementation, barriers and solutions.

The purpose of this guide is to provide an outline of possible questions for key informants following the steps and analytical framework suggested in the "Workbook for engaging the private sector in delivering quality maternal, newborn and child health services" and related worksheets. The questions may be modified and adapted to the specific context.

Who are the key informants?

The key informants are individuals and/or representatives of entities relevant to the MNCH problem and public–private mix of services from both the private and public sectors. They may come from different areas of work and entities, including:

- **Health service entities** – i.e. primary, secondary, tertiary health facilities;
- **Management entities** – i.e. national health departments (programmes, planning, financing, quality), national health information departments/systems, subnational health departments, regulation and standards departments, NGO programmes, umbrella organizations (e.g. federations, faith-based bureaus), industry representative groups;
- **Professional entities** – i.e. training institutes, councils and associations (doctors, nurses, clinical officers, pharmacists), research institutes;
- **Funding entities** – i.e. ministry of finance, national health insurance agency, ministry of health and subnational budget holders, private health insurance agencies, bilateral and multilateral donors, foundations, global health programmes;
- **Health product entities** – i.e. national medical stores, regulatory boards, medical stores/pooled procurement, pharmacies, drug shops, manufacturers, distributors;
- **Oversight entities** – i.e. office of the president, parliament (legislation), oversight/redressal (parliamentary, judicial, ombud's offices), formal (boards, committees, working groups), traditional leaders, community development committees; and
- **Other entities with a role in health** – i.e. ministry of education, ministry of women's affairs, youth, disability, public services commission, local government, national planning authority, patient–consumer groups, press and media, research institutes.

How to select the key informants?

The selection of key informants depends on the stakeholders relevant to the MNCH problem(s) that has been prioritized and the public–private mix of services. The stakeholder analysis (worksheet 3) will help in providing an overview of the most important stakeholders and their roles.

When choosing who to interview among the stakeholders identified, you may use the "purposive sampling technique", meaning that you/the technical working group use your knowledge about the stakeholders and the specific context to identify those key informants who may be able to provide the most valuable insights and information. Depending on the context you may want to ensure information from different geographical locations (i.e. urban/rural), different population groups, different levels of the health system, etc.

Key informant interviews should ideally be conducted after the initial document review, allowing for the key informants to validate, comment on implementation and provide additional information.

The following topic guide is generic for all key informants, but emphasis on the questions may vary depending on the knowledge and functions of the key informant. The questions follow the sequence of questions in the worksheets.

Interview guide for key informants

Key informant and position:

Date:

Interviewer:

Introduction: Introduce yourself, explain briefly the purpose of the interview, the prioritized MNCH problem including public–private mix of services and the process.

Questions regarding service delivery:

- Do private providers play a role in delivering services for the MNCH problem? If yes, what role do they play?
- What aspect(s) of service delivery would potentially be improved by engaging private providers? [probe: in relation to availability, access, acceptability and quality]
- Is it feasible to improve the priority MNCH problem through private sector engagement? [probe: technically, financially, and operationally]
- What segment of the population is affected by the problem? [probe: rural/urban, socioeconomic, age, etc.]
- What are the key supply and demand-side issues within the public–private mix?

Questions regarding policies:

Review together with the key informant the most relevant policies related to the provision of quality MNCH services (i.e. national health strategic and operational policies) identified in worksheet 4. Policy analysis and ask:

- Are you aware of other relevant policies?

For each of the policies:

- What effects does the policy have on the MNCH problem and public–private mix of services?
- Are there unintended effects of the policy?
- What are the effects of the policy on different population groups?
- Do the relevant policy stakeholders view the policy as acceptable and feasible?

Questions regarding policy tools:

Review together with the key informant the policy tools already identified in worksheet 5. Policy tools analysis and focus on areas where there may be divergent views. Ask for each of the tools:

- Do you agree with the initial findings and identified gaps?
- Are you aware of other important policy tools being implemented or under development?
- Of these, what are the most critical policy tools to address the MNCH problem?
- What would need to happen to make the identified policy tools more effective?

Questions regarding governance behaviours:

Review together with the key informant the initial findings of worksheet 6. Governance behaviour analysis and focus on areas where views may be divergent. Ask for each of the behaviours:

- Do you agree with the initial findings and identified gaps?
- Do you have additional comments to the governance behaviours?

Concluding questions:

- Generally speaking, what should be done differently on engaging the private sector in delivering quality MNCH services to attain the necessary impact on MNCH care outcomes?
- Is there anything else you think that I should know about the private sector delivery of quality MNCH care services?
- Is there anyone else you would recommend that I speak with about this assessment?
- Do you have any questions for me/us?

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