Engaging the Private Sector in High Quality Neonatal and Child Health Care

Private Sector Engagement Subgroup

May 20, 2021
Child Health Task Force Today

- 1500+ members
- 50+ countries
- 300+ organizations

Working together in 10 subgroups

Focused on 5 themes of work

- Coordination
- Advocacy
- Support Countries
- Learning
- Knowledge Management
Today’s Webinar

- Key lessons from the Nepal experience engaging the private sector
- Quality interventions that include and go beyond training
- Practical steps for implementers and governments

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Global Recommendations from a Demonstration in Nepal

May 20, 2021

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Global Context

- The private health sector is a **key source of ANC, NN, and CH services worldwide**
- SHOPS Plus Scoping Review (2018) demonstrated a **paucity of evidence exploring the scale and quality of these services**
- Highly contextual:
  - In some settings, **private POC possess advanced technologies, expert HRH, and can promote advanced outcomes**
  - In other settings, **private POC are constrained by health system challenges, not engaged by government, unknown QoC and outcomes**
- To inform systematic global approaches, **we needed to more deeply explore contextual factors** aiding or restricting private QoC in a particular setting
In any given context...

Why should the PHS be engaged?

• Current NN and CH mortality rates suggest a need for service extension
• Current caregiver health seeking demonstrates private sector use
• Anecdotal evidence suggests inadequate referral patterns / options

Why haven’t they been engaged to date?

• Hesitation among public sector health officials
• Lack of successful examples and no clarity on ‘how’

What would be needed to scale NN/CH services in the PHS?

• Clarify levels of registration, certification, and approval for NN/CH service delivery
• Assess and increase NN/CH clinical knowledge and QoC interventions
• Clarify interaction between private and public POC
Nepal’s Karnali Province

- SSBH mapping (2018) and MCSP PSBI report (2018) suggested widespread use of private health outlets for NN/CH care seeking

- Years of private sector dialogue; GON still lacking evidence of successful engagement

- Effort needed to demonstrate a successful partnership for QoC in Nepal’s private health sector

- SHOPS Plus/SSBH Joint Demonstration Initiative

  - Locate and engage a group of private health entities in catchment areas of public sector’s Surkhet Provincial Hospital (SPH)

  - Landscape their service offering and QoC needs

  - Advance private-public interaction to jointly advance clinical and operational engagement
Narrowing in on private QoC

• Universe of possible QA, QI, and CQI supervision strategies

• Given foundational status of Nepal’s PSE narrowed in on issues of critical and equal importance to all cadres:
  1. Increase private provider access to quality clinical standards and guidelines
  2. Clarify current private referral tendencies and advance joint private-public patient handling and referral procedures
  3. Strengthen streamlined processes and materials for private reporting into NN/CH service statistics
Karnali Province: Municipality Focus

- Catchment area of public sector’s Surkhet Provincial Hospital
- Broad range of private facility and provider types
- Proximal, semi-proximal, and remote referring sites
- Municipality leadership supportive of private sector engagement

1. Barahtal Municipality
2. Birendranagar Municipality
3. Narayan Municipality
Locating a private cohort

- 39 facilities met the following selection criteria:
  - Reported to be ‘formal’; operating with some form of licensure and not known to be operating ‘informally/illegally’
  - Reported/demonstrated volume of NN/CH clients (more than 5 per month)
  - At least one certified health provider (preferably two) and a relatively even mix of health provider cadres (doctors, nurses/midwives, AHWs)
  - Located within the geographic referral catchment area of Surkhet Provincial Hospital.
  - Were (at least initially) acknowledged by government as priority/acceptable private facilities for NN/CH engagement
Levels of private facilities engaged

Higher level

Polyclinic
- Registered on the basis of prevailing law and **providing more than five health services** such as outpatient service, laboratory service, immunization service, family planning service, physiotherapy service, radio imaging service etc.

Hospital and Nursing Home
- Hospital and nursing homes are not different in providing health services, they **provide inpatient services in addition to the services provided at polyclinic level**

Lower level

Medical Hall/ Pharmacy
- Facility that dispenses drugs as authorized by Department of Drug Administration (DDA). **Provides no clinical services**

Clinic
- Registered on the basis of prevailing law; **providing less than five health services** such as outpatient service, laboratory service, immunization service, family planning service, physiotherapy service, radio imaging service etc.
Assessing QA/QI Profiles of Facilities

- Improving the enabling environment
- Improving knowledge and clinical capacity
- Continuously strengthening practice
- Building financial and business management capacity

Promoting Sustainability
Facility profiles: Foundational legal and regulatory issues

Is this considered a health facility?

- Majority of higher-level facilities registered with an appropriate government health body
- Only *some* lower-level health related businesses registered with either their municipality (n=8, 38%) and/or DDA (n=10, 48%)

Is it a legal business?

- 97% are registered with the tax authorities and have a PAN number; 46% are registered with the Office of Cottage and Small Industry; 74% hold multiple business registrations

Are there aggregating or umbrella bodies?

- Association membership is common (76%); lead provider or owner was registered with the Nepal Health Professionals Council (72%)
- Higher-level facilities (67%) are members of NCDA; lower-level providers are members of CMA (57%)
Private HRH and knowledge: Assessing existing capacities for NN/CH QoC

Private Staffing Levels:

• Urban concentration of staff in Birendranagar
• Majority of high-level private staff are P/T; includes ‘visiting’ specialists, surgeons, and pediatricians (often dual-practicing)
• The most prominent cadres include AHWs (n=68, 24%), lab techs (n=59, 20%); higher-level have ~13 staff; lower-level have ~3 staff

Private NN/CH Knowledge:

• Less than 25% of facilities reported anyone who had received any of the relevant NN/CH trainings; usually just one person
• For any individual NN/CH topic, 12% or fewer reported staff with training
• Pre-qualification for CB-IMNCI or other training is a key challenge; relying on their old ‘certification’ training
Limited access to and low rates of provider alignment with guidelines

- For 13 conditions, we assessed whether facilities claiming to offer NN and CH services reported protocols in alignment with CB-IMNCI and FB-IMNCI guidelines

- For NN care:
  - The **highest rate of alignment was for acute respiratory distress (ARD)**, (40%, 2 of 5 facilities)
  - **One-third of facilities** offering care for jaundice, localized infections and diarrhea were **aligned with guidelines**
  - **A majority of facilities** offering per-term neonatal care, for omphalitis, neonatal emergencies, PSBI, and seizure **indicated an off-guidance treatment** (50%-77%, n varies by condition see table)
Limited access to and low rates of provider alignment with guidelines

For CH care:

- There were varied rates of alignment with guidelines.
- A majority of facilities offering parasitic infection, anemia, and ARI care were aligned with guidelines (64%-74%, varies by condition).
- A third of facilities offering diarrhea, dysentery, and TB care were in alignment with guidelines (varies by condition).
- There were no conditions in which a majority of facilities indicated an off-guidance treatment.
Private POC are available, but there is limited NN/CH service availability

- Higher- and lower-level facilities are regularly operating, however there is very limited dedicated NN/CH service space:
  - Only 3, higher-level facilities in Birendranagar reported any space that is dedicated for NN/CH clients
  - Only one facility reported any dedicated beds for neonates (1 bed) or children (10 beds)
  - No facilities reported that they provide 10% free beds in their facilities
  - Higher-level facilities see ~738 clients/month; ~39 NN (5%) and ~160 CH (22%). Less than 25% are referred in.

- Lower-level facilities see ~397 clients/mnth; ~12 NN (3%) and ~83 CH (21%). Less than 29% are referred in
Some NN Related Service Availability, but Limited Emergency Care

• Similar levels of neonatal service availability at lower- and higher-level (with a few exceptions)
• More than 50% of all facilities treat: ARI, jaundice, diarrhea, omphalitis, and local infections, and FUO
• Remote facilities do offer: ARI, jaundice, diarrhea, and fever, chlorhexidine cord care
• Few facilities (<20%) treat or intake neonatal emergencies
• Reasons are lack of demand for the service; lack of staff awareness; hesitation among clinicians
Better CH coverage, but obvious gaps?

- Similar levels of child service availability at higher and lower level
- Few facilities (<20%) treat malaria, TB, HIV/AIDS, hypoglycemia
- Remote facilities do offer: diarrhea, ARI, fever, dysentery, parasitic and local infections
- No facilities assessed reported providing any vaccines
- **Reasons are lack of demand, not approved by MOH to deliver, or low provider confidence**

**Possible remote service gap**
Proximity matters: NN and CH clients are being immediately referred

• Half (20/39) of the facilities assessed are located less than 30 minutes from SPH by public transport; nearly all (16/39) of the higher-level facilities were within 30-60 minutes of SPH.

• Most (17/21) of the lower level-facilities assessed are not close to SPH (30+ min by public transport); Narayan demonstrates most high-risk referrals to SPH.

• The private facilities most likely to have capacity to scale their NN/CH service package are the ones closest to SPH, and least likely to do so.

• The lack of remote facility service delivery options is a core challenge.

• For each NN condition assessed, a majority facilities (>87%) refer neonatal patients elsewhere.

• For each CH condition assessed, a majority of facilities refer elsewhere.
Informal referral processes are in use, but can be improved

- Most facilities (79%) **provide patients counseling** prior to referring them.

- Most **higher-level facilities** (72%) and one third of lower-level facilities (32%) **send an informal note or form** with NN or CH referrals.

- **No facilities use a government referral form**, 4 facilities (10%) use a facility-specific referral form, and 19 facilities (49%) send a handwritten note.

- **Few facilities (15%) communicate with the receiving facility** or confirm the referral is complete. Higher level are *slightly* more likely than lower level to do so.

- Most facilities (84%) **have access to an ambulance** (on- or off-site), but few facilities (41%) use an ambulance to transport referrals.

- The average **off-site ambulance cost is NPR 1,653 (~$13 USD)**; average cost in Narayan NPR 5000 (~$42 USD).
The practice environment: Are the facilities suitable for QoC?

Higher-level Facilities

- **Water**: Almost all facilities (n=16, 89%) have regular access
- **Handwashing**: Almost all facilities (n=15, 83%) have handwashing for staff and clients
- **Electricity**: All facilities (n=18, 100%) have regular access
- **Working phone**: Almost all facilities (n=17, 94%) have a working phone
- **Computer**: Half of facilities (n=9, 50%) have access to a computer

Lower-level Facilities

- **Water**: Half of facilities (n=11, 52%) have no access (**basic access issues**) (confirm piped water)
- **Handwashing (area)**: Many facilities (n=9, 43%) lack any handwashing capacity
- **Electricity**: Most facilities (n=15, 71%) have access
- **Working phone**: Most facilities (n=15, 71%) do not have a working phone
- **Computer**: No (n=0) facilities have access to a computer
The practice environment: Major gaps in equipment availability

• Facilities were assessed for availability of 52 different essential equipment/supplies against a pre-defined standard amount.

• On average, higher-level facilities were up to standard on only 13 items:
  – Digital thermometer, IV set, IV cannula, lockable cupboard, stethoscope, fetoscope, oxygen cylinder, flowmeter, nebulizer, sterile gloves, refrigerator, syringe, autoclave

• On average, lower-level facilities were up to standard on 3 items:
  – Digital thermometer, IV set, IV cannula (24Gx, 26Gx)
Management and operations: Information management

- Most higher-level facilities (72%) keep paper records
- Most higher-level facilities (61%) already report some service statistics monthly to the government (via HMIS).
- No lower-level facilities keep records
- Only 30% of facilities (n=12, all higher-level) have data privacy measures in place, most of these (n=11) do so by keeping data in a protected place (i.e. a locked cabinet)
- A majority of higher- and lower level facilities (n=24, 61%) have received government inspection or follow-up supervision at some stage (mainly from DDA or Public Health Office)
- Few (18%) have received other forms of information or services mentorship or support
Management and operations: Diagnostic management and processing

• We assessed the availability of 16 diagnostic services

• All higher-level (n=18) facilities collect diagnostic samples, and over two-thirds provide the majority of the services assessed

• A little over one third (38%) of lower-level facilities collect specimens on site

• Most higher-level facilities (89%) do on- and off-site specimen processing (2 facilities process all samples on site).

• Of the lower-level facilities that handle diagnostic specimens (n=8), most (n=6) utilize off-site processing.

• Facilities send specimens for off-site processing to a number of different private and public labs in and outside of Surkhet
Management and operations: Pharmaceuticals management

- All facilities reported that they buy their drug stocks from private sector suppliers
  - 95% can order their **drugs on credit with their supplier**; 90% get their **drugs delivered** and average delivery time is 1.7 days (range is 1-5 days)

- Facilities identified 30 unique suppliers (all in Surkhet) from which they source their drugs.
  - The most cited sources include Nabin Drug House (n=18, 46%), Synergy Pharmacy (n=13, 33%), and Kalika Medicine Distributors (n=9, 23%)

- Almost all facilities (97%) monitor the expiry dates on their drug stocks.

- Most (72%) higher-level facilities have a direct DDA supervision and reporting mechanism in place
Emerging Conclusions: Nepal and Global Knowledge Advancement
Improving the enabling environment

Improving knowledge and clinical capacity

Continuously strengthening practice

Building financial and business management capacity

Promoting Sustainability
Improving the enabling environment

- Engage public and private stakeholders of all types early in the process
- Clarify ‘who’ various private facilities/providers are in context, ‘where’ they are, ‘what’ services they are providing and are allowed to provide, ‘when’ they have been engaging with government and are supposed to, and ‘why’ any of these issues have not already been addressed
- Determine early on which private health facilities and providers the local health authorities (at district or council level) are willing to engage with
- Engage private providers and facility owners early on in order to openly determine which private health facilities are willing to engage, and more importantly, which ones are not and why
- Clarify what to do with ‘grey area’ private health facilities operating as peripheral points of contact with the health system
Improving knowledge and capacity

• IPs can finance initial ‘**private invite trainings**’ where public sector providers and trainers are invited to participate.

• Utilize **government trainers for private sector focused trainings** (as has been done for services such as immunization) as part of strategic disease program scale-up.

• **Train private sector ‘master trainers’** in government SOPs and curricula so they can increase private training opportunities without additional burden on existing government training capacities.

• **Increase knowledge among ‘grey area’ POC** with the health system

• **Ensure post-training follow-up (PTFU) is included** in the training program from the outset
Continuously strengthen the practice environment

- Acknowledge from the outset that private QoC requires inputs and attention well beyond facility certifications and provider knowledge.

- Explore opportunities for private sector health facilities and/or networks to jointly invest in essential equipment for neonatal and child health equipment.

- Explore ways for government and/or donors to invest in private sector equipment placement.

- As part of PTFU explore ways in Government is comfortable with (and has the capacity to) support private health facilities with supportive supervision longer-term.
Strengthen private management capacities

- Assess ways in which private sector facilities are referring neonatal and child health clients to other points of care in context
- **Explore short-form referral options** and other ways to **streamline and expedite referrals from private POC to receiving facilities.**
- Discuss with Governments how to **streamline and simplify the private reporting options** for neonatal and child health service statistics
- **Invest in longitudinal tracking** of NN and CH referrals and outcomes
Update! 2021

- January 2021, USAID’S SSBH and Nepal Public Health Service Office (PHSO) Birendranagar conducted two batches of CB-IMNCI) training for public and private health providers

- Total of 38 health providers (21 public health providers and 17 private health providers) participated in the six-day training

- Investment in longitudinal monitoring of patient outcomes in discussion with SSBH

- Government has agreed to work with SSBH to develop streamlined reporting and referral procedures

- Still work to be done in clarifying the ‘grey area’ peripheral points of contact

- This success in conducting a joint private-public training in Karnali province is a critical first step forward in fostering stronger public-private linkages and alliances for high quality neonatal and child health services in Nepal
Questions and Further Information

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Subgroup information, recordings and presentations from previous webinars are available on the subgroup page of the Child Health Task Force website: www.childhealthtaskforce.org/subgroups/private-sector

*The recording and presentations from this webinar will be available on this page later today

Become a member of the Child Health Task Force: www.childhealthtaskforce.org/subscribe

Check out the Task Force Child Health & COVID-19 web page for additional resources!

Suggestions for improvement or additional resources are welcome. Please email childhealthtaskforce@jsi.com.