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

Private Sector Engagement Subgroup

May 20, 2021

Child Health Task Force Today

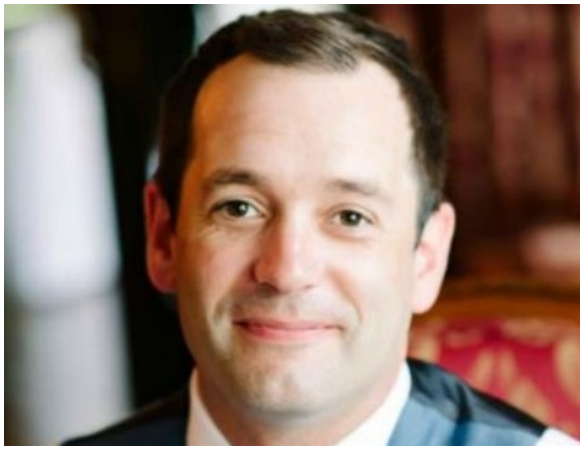
1500+ members *from* **50+** countries **300+** organizations

Working together in **10** subgroups

Focused on **5** themes of work

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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SHOPS PLUS

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

Global Recommendations from a Demonstration in Nepal

May 20, 2021

USAID
FROM THE AMERICAN PEOPLE

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

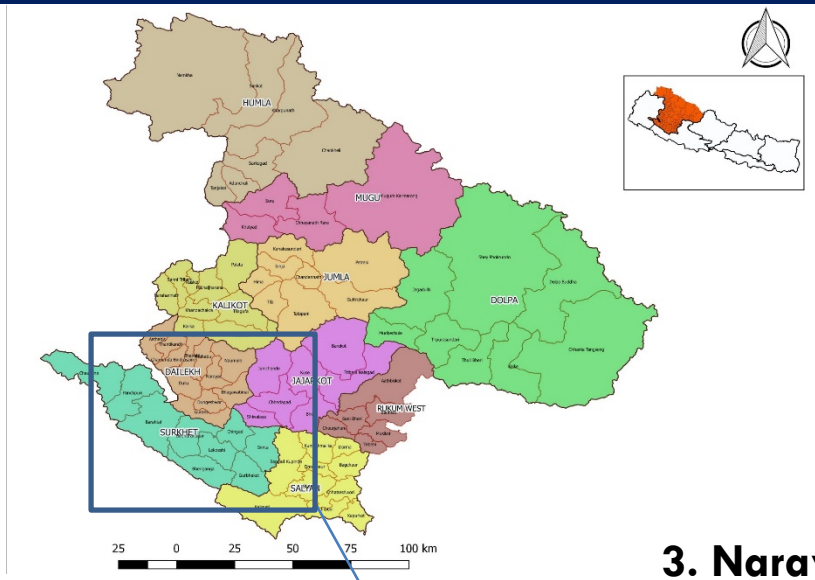
- SSBH mapping (2018) and MCSP PSBI report (2018) suggested widespread use of private health outlets for NN/CH care seeking
- Years of private sector dialogue; GON still lacking evidence of successful engagement
- Effort needed to demonstrate a successful partnership for QoC in Nepal's private health 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



3. Narayan Municipality

1. Barahtal Municipality

2. Birendranagar Municipality

- 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

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 out-patient 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

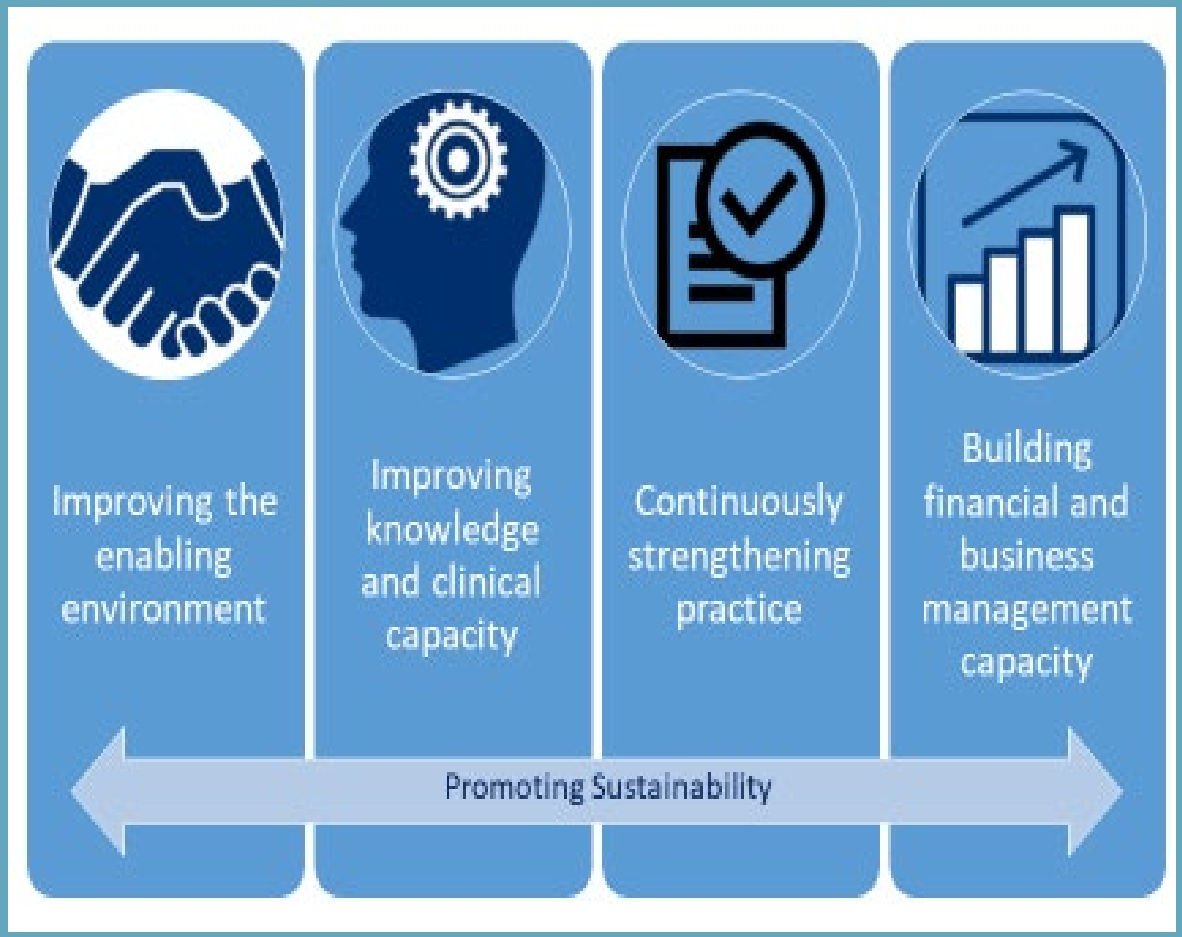
Medical Hall/ Pharmacy

- 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 out-patient service, laboratory service, immunization service, family planning service, physiotherapy service, radio imaging service etc.

Assessing QA/QI Profiles of Facilities



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

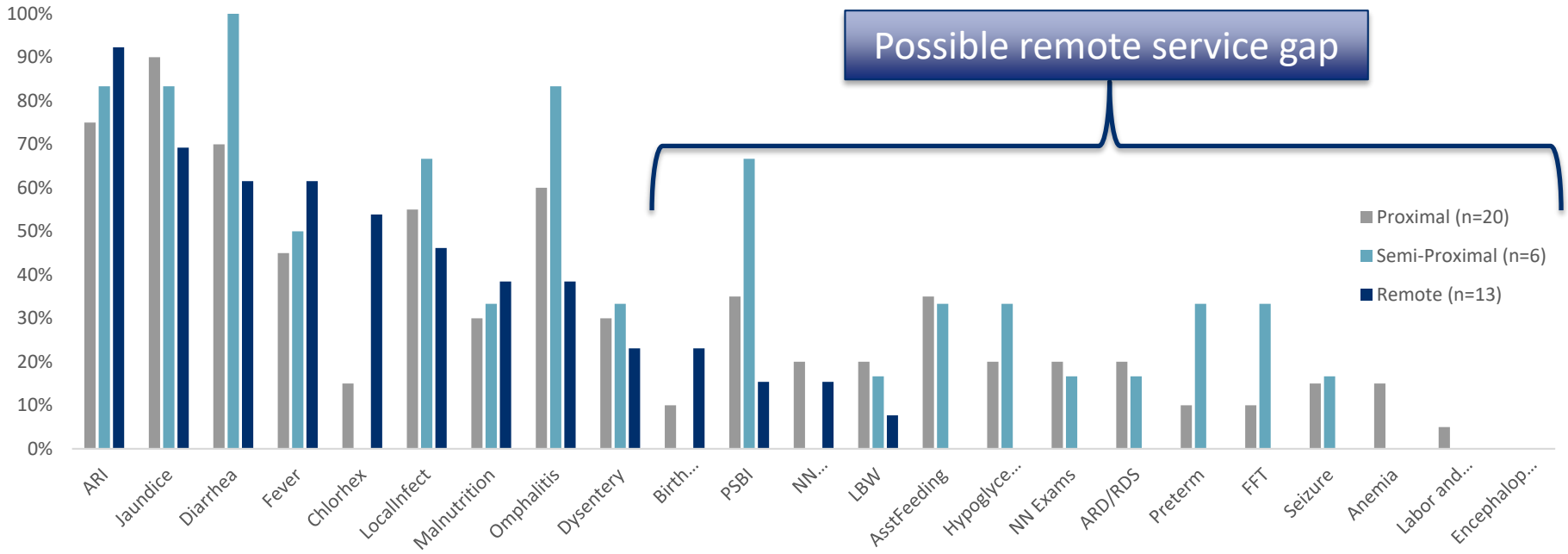
- For CH care:
  - There were **varied rates of alignment with guidelines**
  - A **majority of facilities offering parasitic infection, anemia, and ARI care were aligned with guidelines** (64%-74%, varies by condition)
  - A third of facilities offering diarrhea, dysentery, and TB care were **in alignment 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

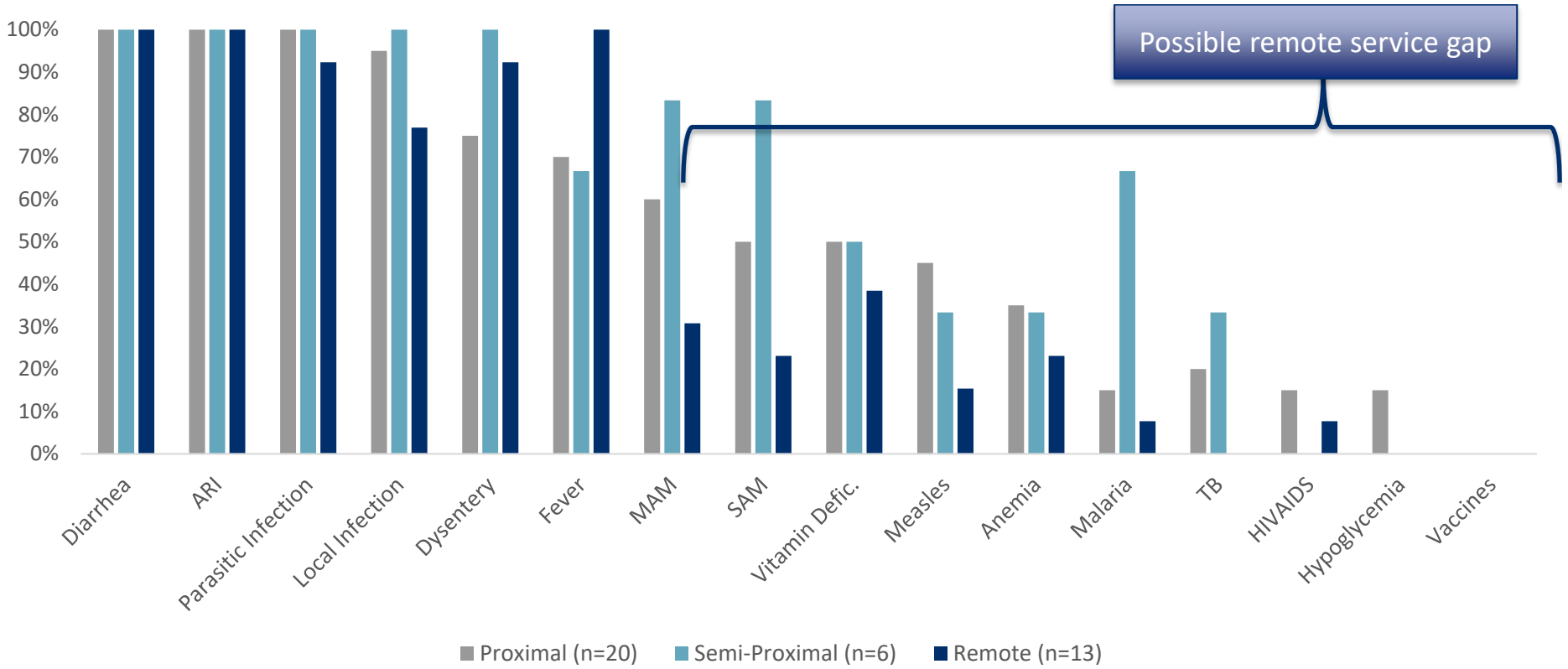
Some NN Related Service Availability, but Limited Emergency Care

- 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**



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**

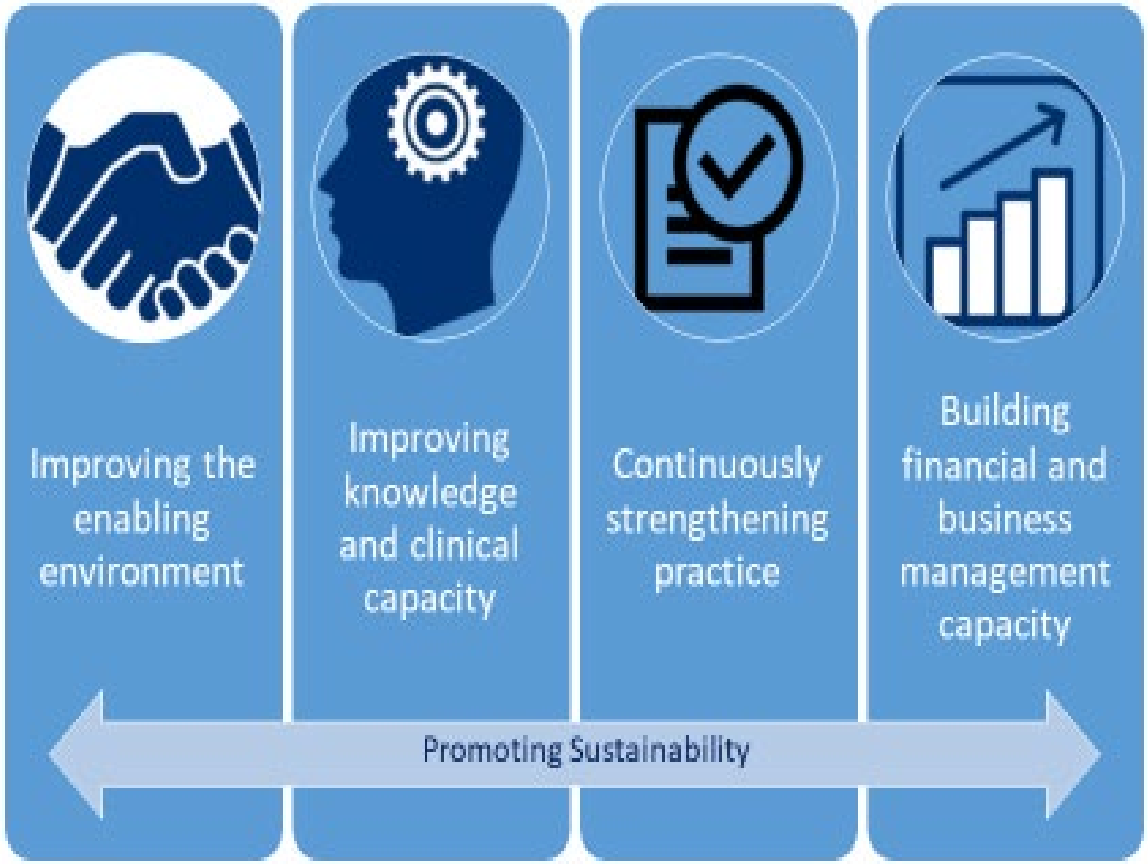
Management and operations: Diagnostic management and processing

- 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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Resources

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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*

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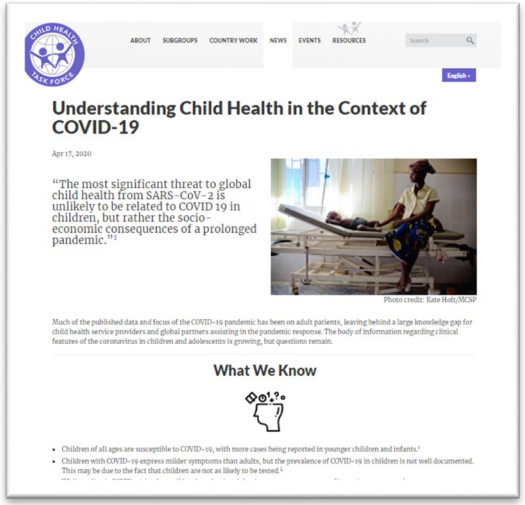

Check out the Task Force Child Health & COVID-19 web page for additional resources!

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