



UN Secretary-General's Independent Accountability Panel: Call for Evidence 2018

Submission by the Maternal Healthcare Markets Evaluation Team
London School of Hygiene and Tropical Medicine (LSHTM)

The [Maternal Healthcare Markets Evaluation Team](#) (MET) at LSHTM conducts multidisciplinary research on the role of the public and private health sectors in delivering healthcare for women, children and adolescents. We aim to inform efforts to widen access and improve the quality of care for all women by evaluating the ways in which care is accessed and delivered through the public and private sectors. Our work has implications locally, nationally and globally as governments and key stakeholders around the world consider how to integrate private providers into their strategies for achieving universal health coverage. MET is funded by [MSD for Mothers](#) (MfM) – a 10-year, \$500 million initiative focused on improving the quality of maternal healthcare women receive at a health facility during childbirth, and on increasing access to family planning.

Our submission of evidence to the UN Secretary-General's Independent Accountability Panel is organised under three themes. The first theme includes studies that have evaluated different models of engaging with the private health sector, notably social franchising and supply chain interventions. Under the second theme, we highlight studies that have used Demographic and Health Surveys (DHS) to provide insights into the patterns, transitions and choices women in low- and middle-income countries make in accessing reproductive and maternal healthcare services. The third theme examines the operation and performance of the private sector in delivering maternal healthcare.

We highlight each research output relevant to this call for evidence and provide a short summary of the findings. We would be more than happy to discuss any aspect of our submission in more detail should the Independent Accountability Panel have further questions.

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Engaging with the private sector: social franchising and supply chain management

The MET project has conducted external evaluations of three maternal health social franchise programmes funded by MfM in India and Uganda and a supply chain management intervention funded by MfM in Senegal. There was an impact evaluation of the Matrika social franchising model in Uttar Pradesh, and case studies involving rich quantitative and qualitative descriptions of programme functioning for all three social franchise programmes. The evaluation of the family planning supply chain intervention in Senegal is on-going. Published outputs to date are

- Tougher et al (2017). Effect of a multifaceted social franchising model on quality and coverage of maternal, newborn, and reproductive health-care services in Uttar Pradesh, India: a quasi-experimental study. *Lancet Global Health*. <https://www.ncbi.nlm.nih.gov/pubmed/29275135>

This paper evaluated a multi-faceted social franchising programme that established a network of private providers and strengthened the skills of both public and private sector clinicians in Uttar Pradesh, India. Findings show that the programme was not effective in improving the quality and coverage of maternal health services at the population level.

- Penn-Kekana et al (2018) *Process evaluation of a multi-faceted social franchising model to improve maternal health: evidence from a multi-methods study in Uttar Pradesh, India*. *Implementation Science*, in press

This companion paper to the Tougher et al impact evaluation reports results from a process evaluation with the aim of explaining the impact findings. Drawing on both quantitative and qualitative data, we used a theory of change to identify issues related to implementation, mechanisms and context which limited programme effectiveness.

- Haemmerli et al (2018). *How equitable is social franchising? Case studies of three maternal healthcare franchises in Uganda and India*. *Health Policy and Planning*. <https://doi.org/10.1093/heapol/czx192>

This paper studied three maternal health social franchises in Uganda, Rajasthan and Uttar Pradesh and found that antenatal and delivery users were concentrated in higher wealth quintiles. However, the content of care received at social franchise visits did not vary by socio-economic status. While most social franchises acknowledge they will not reach the very poorest, the tension between targeting poorer groups and financial sustainability remains a challenge for this type of intervention.

- Key lessons for collecting M&E data across private sector healthcare projects: Experiences from a collaboration between MSD for Mothers, LSHTM and implementing partners in India and Uganda

In this short report we share lessons from a multi-institutional collaboration to collect routine M&E data on a set of harmonised indicators from private sector maternal healthcare programmes in India and Uganda. In attempting to collect a harmonised set of indicators across these projects, the team aimed to minimise duplication of efforts and unnecessary burden of work, and facilitate comparability across projects, making data more relevant and meaningful for aggregation at a higher level. Many challenges were experienced along the way, and in this report we share our lessons learned from the experience. This report is still being finalized and can be forwarded once it is available.

- Cavallaro et al (2016). *Taking stock: protocol for evaluating a family planning supply chain intervention in Senegal*. Reproductive Health. <https://www.ncbi.nlm.nih.gov/pubmed/27098965>

This paper presents the study protocol of the evaluation of a supply chain intervention using performance-based contracting for contraceptive distribution that was introduced throughout Senegal between 2012 and 2015. Preliminary results were presented at the 18th Reproductive Health Supplies Coalition Meeting in Brussels, 20-22 March 2018, and the full findings from the evaluation will be available late-2018.

Secondary data analysis for generating new evidence (SAGE)

MET researchers use DHS to gain insights into the patterns, transitions and choices women in LMICs make in accessing reproductive and maternal healthcare services. The SAGE team have assembled and standardised a main dataset comprised of DHSs from 61 countries, containing the experiences of 2 million women between 1986-2016, on antenatal, delivery, postnatal and family planning provision. The dataset is uniquely suited to answering questions about the sources of reproductive and maternal health services across LMICs across time. The dataset assembled through the SAGE project is the only global cross-country and across-time standardised DHS data on antenatal, delivery, postnatal and family planning provision. The SAGE team would be please to discuss any specific analyses that might be useful for the purposes of this consultation with the IAP.

Published outputs to date, organised into three work streams, comprise:

Five papers in the series: "Who cares for women? Towards a greater understanding of reproductive and maternal healthcare markets" (Tropical Medicine & International Health, 2014-5).

- Campbell et al (2016). *Family planning, antenatal and delivery care: cross-sectional survey evidence on levels of coverage and inequalities by public and private sector in 57 low- and middle-income countries*. Tropical Medicine and International Health. <https://www.ncbi.nlm.nih.gov/pubmed/26892335>

This is the overview paper for the series and assessed the role of the private sector in providing family planning, ANC and delivery care in LMICs using DHS for 57 countries (2000–2013). Data from 865,547 women aged 15–49, representing a total of 3 billion people were analysed. The private-sector share among users of family planning services was 37–39% across regions (overall mean: 37%; median across countries: 41%). The private-sector market share among users of ANC was 13–61% across regions (overall mean: 44%; median across countries: 15%). The private-sector share among appropriate deliveries was 9–56% across regions (overall mean: 40%; median across countries: 14%). For all three healthcare services, women in the richest wealth quintile used private services more than the poorest.

- Powell-Jackson et al (2014). *The role of the private sector in the provision of antenatal care: a study of Demographic and Health Surveys from 46 low- and middle-income countries*. Tropical Medicine and International Health. <https://www.ncbi.nlm.nih.gov/pubmed/25358532>

In this paper we examined the role of the private sector in the provision of antenatal care (ANC) across 46 LMICs using DHS data. Across all countries, the main source of ANC was public (54%), followed by private commercial (36%) and home (5%), but there were large variations by region. There were no differences in quality of care between public and private commercial providers, while the private not-for-profit sector showed highest quality of care.

- Benova et al (2015). *Role of the private sector in childbirth care: cross-sectional survey evidence from 57 low- and middle-income countries using Demographic and Health Surveys*. Tropical Medicine and International Health. <https://www.ncbi.nlm.nih.gov/pubmed/26412496>

This paper examined the role of the private sector in providing delivery care and compared the equity and quality of the sectors using the most recent DHS (2000–2013) for 57 LMICs. One-fifth of all deliveries occurred in the private sector, ranging from 9% to 46% across the four LMIC regions. In every region, caesarean section rate was higher in the private compared to public sector.

- Campbell et al (2015). *Who, What, Where: an analysis of private sector family planning provision in 57 low- and middle-income countries*. Tropical Medicine and International Health. <https://www.ncbi.nlm.nih.gov/pubmed/26412363>

This paper examined the sector of contraceptive method provision, by women's socio-economic position, in 57 LMICs, finding that the private sector share of the family planning market was 37–39% of users across the regions. Private retailers played a more important role in sub-Saharan Africa (14%) than in other regions (3–5%). NGOs and FBOs served a small percentage. Privileged women (richest wealth quintile, urban residents or secondary-/tertiary-level education) used private sector services more than the less privileged. Contraceptive method types with higher requirements (medical skills) for provision were less likely to be acquired from the private sector, while short-acting methods were more likely.

- Footman et al (2015). *Using multi-country household surveys to understand who provides reproductive and maternal health services in low- and middle-income countries: a critical appraisal of the Demographic and Health Surveys*. Tropical Medicine and International Health. <https://www.ncbi.nlm.nih.gov/pubmed/25641212>

This last paper in the series examined the challenges encountered using DHS data for the purpose of assessing the types of providers being used by women in LMICs for reproductive and maternal health care. Within the 57 surveys reviewed, we identified 141 unique provider types of family planning, 50 of delivery care, and 79 of antenatal care. More systematic and standardised collection of data would aid cross-country comparisons of utilisation of different provider types, including understanding the complexity of private care provision.

In the second work stream, we assessed the role of the private sector in provision of reproductive/maternal care to adolescents, focussing on sub-Saharan Africa. This resulted in three published papers.

- Owolabi et al (2017). *Comparing the use and content of antenatal care in adolescent and older first-time mothers in 13 countries of West Africa: a cross-sectional analysis of Demographic and Health Surveys*. *Lancet Child and Adolescent Health*. [http://dx.doi.org/10.1016/S2352-4642\(17\)30025-1](http://dx.doi.org/10.1016/S2352-4642(17)30025-1)

We used DHS data to compare the use, timing, source, and components of antenatal care between adolescent and older first-time mothers in 13 West African countries. Although a large percentage of West African adolescents used some antenatal care for their first birth, they sought care later, made fewer visits during pregnancy, and received fewer components of care than older first-time mothers. Although most women received antenatal care in the public sector, in nine of the 13 countries, the proportion of women that used the private sector was higher in older mothers.

- Dennis et al (2017). *Pathways to increased coverage: an analysis of time trends in contraceptive need and use among adolescents and young women in Kenya, Rwanda, Tanzania, and Uganda*. Reproductive Health. <https://www.ncbi.nlm.nih.gov/pubmed/29041936>

This paper described changes over time in contraceptive need, use, and sources of care among young women in four East African countries (Kenya, Rwanda, Tanzania, and Uganda) using DHS data. Met need for contraception among women aged 15–24 years increased over time, ranging from a 20% increase in Tanzania to more than a 5-fold increase in Rwanda. More than half of young women in Tanzania and Uganda receive contraceptives from the private sector; however, while the private sector played an important role in meeting the growing contraceptive needs among young women in Tanzania, increased use of public sector services drove expanded access in Kenya, Rwanda, and Uganda.

- Radovich et al (2017). *Who Meets the Contraceptive Needs of Young Women in Sub-Saharan Africa?* Journal of Adolescent Health. <https://www.ncbi.nlm.nih.gov/pubmed/29249445>

We examined the first source of adolescents' current modern contraceptive method using the most recent DHS since 2000 for 33 sub-Saharan African countries. We found that the public and private sectors were both important sources of family planning, young women (15–24) used more short-term methods obtained from limited-capacity, private providers, compared with older women. The use of long-term methods among young women was low, but among those users, more than 85% reported a public sector source.

The third work stream looked at various themes of content of care and pathways through care, comparing public and private sectors in LMICs, resulting in four papers and one report.

- Campbell et al (2016). *Length of Stay After Childbirth in 92 Countries and Associated Factors in 30 Low- and Middle-Income Countries: Compilation of Reported Data and a Cross-sectional Analysis from Nationally Representative Surveys*. PLOS Medicine. <https://www.ncbi.nlm.nih.gov/pubmed/26954561>

We described length of stay (LOS) after facility delivery in 92 countries. In 30 LMICs with DHS data on LOS, we used multivariable logistic regression to examine the factors associated with stays that were "too short" (<24 h for vaginal deliveries and <72 h for caesarean-section deliveries). We found that LOS after childbirth was very variable between countries and substantial proportions of women stay too short to receive adequate postnatal care. In adjusted analysis, the association of LOS which was "too short" with provider sector was not significant among vaginal births, while among caesarean-section births, private-sector births were 50% more likely to be too short (<72 h) than public-sector births ($p < 0.001$).

- Benova et al (2017). *Should I stay or should I go?: consistency and switching of delivery locations among new mothers in 39 Sub-Saharan African and South/Southeast Asian countries*. Health Policy and Planning. <https://www.ncbi.nlm.nih.gov/pubmed/28981668>

We assessed the extent and determinants of switching delivery location (home – facility and among facility: public/private) between women's first and second deliveries using DHS from 39 LMICs in sub-Saharan Africa and South/Southeast Asia. Majority of women consistently used the same delivery location for their first two deliveries and the probabilities of switching varied widely across included countries. In both regions, the most common switching pattern among women who delivered their first birth in a public facility was to have the second at home. Among women who had their first delivery in a private facility, the most common switching pattern in Sub-Saharan

Africa was to switch to a public facility, whereas in South/Southeast Asia women were most likely to switch to home locations.

- Oakley et al (2017). *Early breastfeeding practices: Descriptive analysis of recent Demographic and Health Surveys*. Maternal and Child Nutrition. [10.1111/mcn.12535](https://doi.org/10.1111/mcn.12535)

This study described early breastfeeding practices (initiation within 1 hour of birth, no prelacteal feeding, and a combination of both—“optimal” early breastfeeding) according to childbirth location in 57 LMICs using DHS collected between 2000 and 2013. Overall, 39% of children were breastfed within 1 hour of birth (region range 31–60%), 49% received no prelacteal feeding (41–65%), and 28% benefited from optimal early breastfeeding (21–46%). Among facility births, breastfeeding practices were more favourable among those taking place in the public sector compared to private sector in all four regions.

- Wong et al (2018) *Why not? Understanding the spatial clustering of private facility-based delivery and financial reasons for homebirths in Nigeria*. BMC Health Services Research. <https://doi.org/10.1186/s12913-018-3225-4>

In this paper we presented a novel analytical approach to examine the relationship between women’s reasons for homebirth and community-level, health-seeking surroundings. We assessed the extent to which cost or finance acts as a barrier for facility-based childbirth across geographic areas with varying levels of private provision of childbirth services in Nigeria. Geographic clusters of low private facility-based delivery were primarily located in the north, and the Bayelsa and Cross River States. Financial barriers were associated with high private facility-based delivery at the cluster level – each 10% increase in private facility-based delivery was associated with an increase of 2% in non-users of facility-based delivery citing cost as a reason for homebirth. In summary, in communities where private facility-based delivery is common, we found that women who stayed at home for childbirth might have had mild increased difficulties in gaining effective access to *public* care, or face an overriding preference to use private services, among other potential factors.

- Benova et al (2017). *The Landscape of Cesarean Section in Sub-Saharan Africa and South and Southeast Asia*. Published Report. https://fistulacare.org/wp-fcp/wp-content/uploads/2015/10/LSHTML-report_Nov-8_final_for-web.pdf

This report assessed the landscape of caesarean sections in LMICs using DHS in 34 countries in Sub-Saharan Africa and 10 in South and Southeast Asia between 2002 and 2016. We found that national-level caesarean section rates ranged widely, from 1.5% of births in Chad to 33.8% in the Maldives and births occurring in health facilities ranged from 12.1% in Ethiopia to 97.2% in the Maldives. In most of these 44 countries, caesarean section rates in non-public facilities were higher than in public facilities.

Operation and performance of the private sector in delivering maternal healthcare

The MET project has also conducted research to study the operation and performance of private maternal healthcare providers in India.

- Sharma et al (2017). *Quality of routine essential care during childbirth: clinical observations of uncomplicated births in Uttar Pradesh, India*. Bulletin of the WHO. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5463813/>

This paper assesses the quality of essential care during normal labour and childbirth in maternity facilities in Uttar Pradesh to provide context to the evaluation of social franchising. Using clinical

observations, the study found that the quality of care was poor across the board, in both private and public facilities. Obstetric, neonatal and overall care at birth was slightly better in the private facilities than in the public ones.

- Goodman et al (2017). *The Nature of Competition faced by Private Providers of Maternal Health Services in Uttar Pradesh, India*. Final Report. Available on the [MET website](#)

Anticipating and interpreting the effects of interventions involving private providers requires an understanding of the nature of competition in these markets. This study in 6 districts of Uttar Pradesh State, India investigated (i) the market structure for maternal healthcare, in terms of number and types of providers, their characteristics and market shares; and (ii) private provider competitive strategies in relation to price setting, non-price competition, integration and collaboration. The findings are used to explore the implications for accessibility and quality of maternal healthcare, and for the design of policies and interventions related to the private sector.

- Lange et al (2017). *The role of unqualified health workers in private sector maternity services in India*.

Following on from our work on social franchises we carried out ethnographic work exploring the activities and status of unqualified and qualified health workers in four private sector facilities in Rajasthan and Uttar Pradesh. Key findings include that unqualified staff deliver babies; both qualified and unqualified staff perform unnecessary medical procedures for profit and experience tensions and dissatisfaction due to a lack of employment rights. This work is in the process of being written up but was presented at the Human Resources for Health Conference in Dublin in November 2017.

Our work with social franchises highlighted how the private sector used community health workers for their outreach work and growing their client base. We have been doing detailed follow up work with community health workers in Rajasthan exploring their relationship with the private sector and how private sector incentives influence their work with women and families. This work is in the process of being written up.