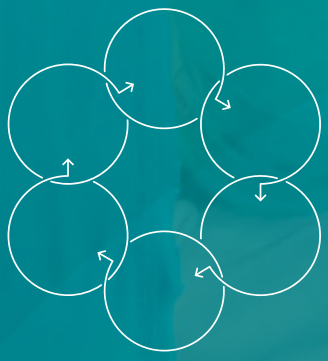

Engagement with the private sector in health for the COVID-19 response

A comparative synthesis of country experiences in the Eastern Mediterranean Region

World Health Organization

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Conflict of Interest

The authors certify that they have NO affiliations with or involvement in any organization or entity with any financial interest (such as honoraria; educational grants; participation in speakers' bureaus; membership, employment, consultancies, stock ownership, or other equity interest; and expert testimony or patent-licensing arrangements), or non-financial interest (such as personal or professional relationships, affiliations, knowledge or beliefs) in the subject matter or materials discussed in this document.

Abstract

This document provides comparative synthesis of country experience on private sector engagement as part of the COVID-19 response in the Eastern Mediterranean region (EMR), with a specific focus on health service delivery. The intention of this comparative analysis is to distil behaviours and derive lessons between countries to strengthen governance of national health systems, inclusive of the private sector in health. The study methodology included a literature review of articles published between January 2020 and March 2022 supplemented by key informant interviews with government, academic, development partner and private sector representatives. The comparative synthesis highlights a range of practice in response to COVID-19. Practice built upon available institutional arrangements, organisational structures, mechanisms for coordination and information exchange. The degree to which this was effective varied and is reflective of the attributes of EMR contexts to manage change and secure essential public health functions. The World Health Organization (WHO) seeks to support Member States with a practice-based and action-oriented approach to governance of the private sector in health, one that is grounded in context.

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Key messages

- There is need to review, update and align legal provisions and institutional arrangements to ensure these guide emergency preparedness and response, inclusive of the private and civic sectors.
- There is need for a functional public health review to address role alignment across sectors and organisational structures to ensure that intersectoral models of care and referral pathways are reinforced and utilised.
- Use of available fiscal space and existing financing arrangements can facilitate access to emergency care, and should be coupled with establishing the fair cost and monitoring pricing for emergency services in the private sector.
- There is need to review and enhance the capture of private sector data in national health information systems, its aggregation and use, and optimisation at national and sub-national level.
- As the COVID-19 response was initially public sector driven/led, this also limited coordination, as the role of the private sector was not adequately anticipated. To rectify this, there is need to address fragmentation within the private sector in health and improve intersectoral and interorganizational coordination.
- There is need to align health systems and sectors around inclusive and equitable emergency preparedness and response, to build trust across sectors and define a policy agenda that matches public health interests.

Introduction

The COVID-19 pandemic demonstrated that efforts to advance Universal Health Coverage (UHC) and respond to health crises are reliant on a whole-of-society approach. Leveraging the private sector for healthcare service delivery is a key component to achieve UHC and health security, to ensure that health-related services and goods are accessible and of high-quality for all people, regardless of where they seek care, and to effectively respond to health emergencies like COVID-19, harnessing all health actors.

This study provides comparative analysis on private sector engagement for COVID-19 response in the Eastern Mediterranean region (EMR) with a specific focus on private sector health service delivery. The intention of this study is to distil behaviours and derive lessons to strengthen governance of health systems, inclusive of the private sector in health.

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Background

The Eastern Mediterranean Region (EMR) context is both unique and complex. The region includes 22 countries with a combined population of approximately 679 million people. Countries represent a range of socio- economic conditions, with six countries classified as high income, four as upper-middle income, seven as lower-middle income, and five low-income *(1)*. Nine of the countries in the region are considered fragile *(2)*, defined as countries affected by conflict, emerging from conflict, or otherwise lacking the will or capacity to implement pro-poor policies *(3)*. Crises have exacerbated inequities within society and the health system, with more than 62 million people considered in "dire need of access to quality health care" *(4)*. Contained within these figures are significant numbers of transient, displaced and refugee populations.

Health systems within the EMR are pluralist and often devolved, and include a range of public, private, and civic entities and administrative bodies. Over time, there has been a significant increase in the role and number of private sector entities. In Tunisia, the capacity of private clinics has increased by 36% between 2014-2017 *(5)*. In Oman, the number of private sector hospital beds quadrupled between 2005 and 2017, compared to a 10% increase in the public sector *(6).* In Saudi Arabia, the total number of private hospitals rose from 145 to 164 between 2015 and 2019 *(7)*. Moreover, a 2021 assessment estimated that the for-profit private health sector was sought for the provision of 53% of inpatient services and 66% of outpatient services in the Region *(8)*. However, this growth was not part of a health sector planning or a pre-defined strategy. Accordingly private providers have typically *"replicate rather than remedy the skewed patterns of public health services, with a bias towards richer quintiles in urban centres" (7)*.

This has resulted in de facto privatisation of the health sector with an ability to pay the basis for access to healthcare in many contexts *(8)*. According to a global monitoring report, just over half of the EMR population have access to basic health services *(9)*. These are characterized by an overreliance on hospital-based, curative care; given this, several EMR countries are in the process of strengthening primary care systems *(10)* as part of health system reforms.

Within the EMR, similar to other contexts, COVID-19 exacerbated pre-existing weaknesses within health systems. These included inadequate and inequitable levels of health financing, fragmented and inflexible service delivery, limited and inefficiently distributed human and physical resources, and weak surveillance and health information systems *(10)*. COVID-19 has further provided an opportunity to reposition health and preparedness within regional and national agendas, and drive cooperation and a shared sense of responsibility, within and across countries *(11)*. This study is intended to support this drive.

Methodology

The study methodology was comprised of two phases. In phase one, a quick desk review was conducted where the WHO COVID-19 Database and Google Scholar were searched for articles published between January 2020 and March 2022. Articles in English were included that discussed a combination of key concepts, including COVID-19 response/preparedness, private health sector, governance, regulation, and public health policy, filtered by selected EMR countries (Iraq, Iran (Islamic Republic of), Lebanon and Egypt). Additional background articles relevant to the EMR context at the time of the pandemic were also included in the review. Since our focus was on EMR and selected country cases, we excluded articles that focused on other regions, and the global COVID-19 response. Separate desk review reports were developed for each of the country case studies.

During phase two, key informant interviews were undertaken with representatives from government, academia, development partners, and the private. In the initial half of 2022, the WHO/WCO, in collaboration with the WHO Regional Office for the Eastern Mediterranean, identified relevant stakeholders based on their roles within the health system. These stakeholders were then engaged in insightful discussions using a semi-structured interview guide (see Annex). This was developed by WHO and adapted to country context and the respondent's specific areas of knowledge and expertise. Quotations are referenced accordingly in the document.

Interviews were conducted by two researchers using Microsoft Teams software. Written consent was obtained in advance of the interview. Interviews were transcribed using an Artificial Intelligence (AI) software (i.e., Otter.ai). A coding frame was developed for data extraction and analysed using a framework analysis approach, built on the six governance behaviours, as detailed below. Framework analyses is increasingly used for policy research because it provides an efficient, transparent and systematic way to compare and combine data *(8)*. The approach is also useful for conducting analysis across teams. The framework matrix was developed by the researchers for the analysis using Microsoft Excel 2016. The matrix was constructed horizontally with the key themes and vertically by respondent. Interview notes were condensed, with information arising from data sources inserted into the matrix. Quotes from the transcripts were inserted as part of data extraction. Where needed, the researchers compared notes and understanding to ensure completeness of information and consistency of interpretation. Discussion of draft findings within the research team supported reliability of analysis.

The researchers are public health specialists with extensive contextual experience, subject matter expertise and qualitative research skills. Three researchers are with the Special Programme on Primary Health Care while the other two researchers were contracted by WHO specifically for the country case studies. Ethical approval was granted under protocol [ID: CERC.0142].

Analytical framework

The paper has been structured using the WHO governance behaviours, as presented in the WHO strategy, "Engaging the private health service delivery sector through governance in mixed health systems." Governance behaviours have been operationalized for the COVID-19 response as follows:

- **Delivery strategy:** inclusion of the private sector in health in policy to promote and protect essential public health functions at national and subnational levels as part of the COVID-19 response
- **Align structures:** alignment of public and private structures for the COVID-19 response
- **Enable stakeholders:** implementation of financing and regulatory measures for the COVID-19 response
- **Build understanding:** private sector data capture and information exchange for the COVID-19 response
- **Foster relations:** coordination arrangements and sectoral engagement and its institutionalization in health decision-making for the COVID-19 response
- **Nurture trust:** recognition and management of competing interests as part of the COVID-19 response

Findings have been framed under each of the governance behaviours. Key messages are outlined for consideration by EMR Member States.

Findings

In phase I, a total of 78 articles were extracted and fully analysed. Most articles were on Lebanon (n=31) followed by Iran (Islamic Republic of) (n=28) and Egypt (n=11). While only eight articles were found to be relevant in Iraq.

Phase II included 17 stakeholder interviews which were conducted over the period April to July 2022. Stakeholders included six academic respondents, three private sector respondents, seven development partner respondents and one government respondent.

Emerging themes were consistent with the pre-defined themes outlined in the analytical framework as follows.

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Deliver strategy

There is need to review, update and align legal provisions and institutional arrangements to ensure these guide emergency preparedness and response. The inclusion of the private and civic sectors within provisions and arrangements should guide engagement and facilitate surge capacity.

CONSIDERATIONS

- Define a health emergency and disaster risk management (HEDRM) strategy and system that integrates public health and emergency preparedness and response functions.
- Use review processes to inform national legislation and other relevant policy frameworks for public health and emergency preparedness and response (and health resilience more broadly).
- Include the private and civic sectors within public policy frameworks, emergency preparedness and response functions.

In some EMR countries, policy vacuums pre-existed the pandemic which created legal and institutional barriers for the COVID-19 response and the effective inclusion of the private sector in health. In Iraq, despite legal provisions and institutional arrangements for disaster preparedness, there has been a tradition of reactive response to emergencies *(9)*. While private health service providers have demonstrated resilience in the face of emergencies, its role is not recognised within provisions and arrangements *(10)*. During the COVID-19 pandemic, the role of private providers in the Iraqi response expanded due to population demand and public sector constraints (private sector respondent). This was pragmatic, not based on precedent or founded in public health law, which was considered outdated. In Egypt, governance functions and the quality of public administration have constrained health protection with de facto privatisation of the health sector over time *(11)* . During COVID-19, while a clear strategy was developed to optimise care pathways, this only envisaged a role for the public sector. Overtime, central control of the response was relinquished as governorates sought to contain COVID-19 surges using alternative means, including the private sector in health (*academic respondent*).

In contrast, in Iran (Islamic Republic of) and Lebanon, intersectoral collaboration had been promoted prior to the pandemic and included the private sector in health. Iran (Islamic Republic of) had learned from previous emergencies and recognised the importance of partnerships with the private sector, institutionalization of a multisectoral response, integration of emergency response into primary care, and the need for civic and municipal engagement *(12)*. In Lebanon, an emergency health contingency plan was in place and provided a framework for public-private engagement for the COVID-19 response *(13)*. In both countries, respective COVID-19 response plans identified a range of private sector entities and assigned broad roles but did not provide modalities for surge response, which had to compete with other intersecting crises, as in the case of Lebanon, and economic sanctions, as in the case of Iran (Islamic Republic of).

Align structures

There is need for a functional public health review to address role alignment across sectors and organisational structures. The review should clarify the role of primary care entities within public health, preparedness and emergency response to ensure that models of care and referral pathways are reinforced and utilised.

CONSIDERATIONS

- Employ a resource-based approach to the COVID-19 response by enlisting all available public, private and civic structures.
- Jointly define and align roles and responsibilities of public, private and civic sector entities in public health, emergency preparedness and response.
- Recognise the critical role of primary care, including pharmacies, as the first line of essential health services and emergency "defence" by integrating response functions within frontline structures (public, private and civic).

In some EMR countries, there is limited integration of the private sector in health into service delivery organisational structures. The health system backbone typically comprises a network of hospitals and primary health centres with increasing private sector ownership and dual practice reflected within these structures over time, often as a counter to poor remuneration and conditions in the public sector. Health service delivery is usually decentralised and has resulted in large differences in the composition and capacity of structures across administrative divisions. The private sector itself is generally diverse and divergent and includes private-for-profit, civic, non-profit, and sectarian entities. The COVID-19 response therefore drew on different organisational structures across the humanitarian-development nexus with the role of private sector entities reflective of this variation. This created an uneven response across and within EMR countries, particularly those considered fragile or in conflict.

There was limited change in surge capacity within public sector infrastructure for the COVID-19 response, which, in some contexts, was already in a weakened state due to economic and humanitarian crises. Initially designated testing and treatment facilities were limited to the public sector or allied hospitals, such as university or military facilities. Private for-profit facilities were reportedly engaged "on short-notice" in some contexts, such as Iraq (*private sector respondent*), or their entry into the response guided by "market forces" rather than an official stance, as was the case in Egypt (*development partner respondent*). There emerged a logical delineation of roles across private sector entities however this was not always grounded in an articulated or adapted response plan. There were also examples of innovative public-private partnerships to address capacity in public sector institutions. However, more often than not, contingency plans did not keep up with the progression of the pandemic or the entry of the private sector in the response.

There was limited optimization of primary care in most response structures as a means of triage and referral. As such, many people bypassed primary care facilities and sought care in hospitals which contributed to an overwhelmed public sector. For example, in Lebanon, primary care facilities were engaged to play a role in COVID-19, particularly in rural and disadvantaged areas however they were not utilised by patients due to underfunding and resource gaps. In Iran (Islamic Republic of) counter measures were introduced to distribute COVID-19 cases across public and private hospitals. In Tehran province for example, a bed management system was established, supported by a telephone call centre, staffed by highly skilled health professionals to facilitate referral pathways (*government respondent*).

In many contexts, private pharmacies remained open and provided patient education and essential services however, their role was less supported or acknowledged by ministries of health. Laboratories also featured prominently in the early phase of the pandemic as they were the first point of contact with suspected COVID-19 cases. The entry of private laboratories was often through market forces and reliant on household financing, limiting testing to those who could afford it.

Enable stakeholders

Use of available fiscal space and existing financing arrangements can facilitate access to emergency care, including through the private sector. This should be coupled with establishing the fair cost and monitoring pricing for emergency services in the private sector.

CONSIDERATIONS

- Create financial incentives for private sector participation in emergency preparedness and response using regulatory and payment levers.
- Review temporary emergency regulatory measures to determine if these can be adopted in the long-term to achieve more efficient regulatory systems.
- Review the fair cost of emergency services (including a gendered analysis of cost).
- Commit to easing the regulatory burden through the adoption and use of digital technologies as well as alignment of authorities and regulatory functions.

Public financing of the response varied by EMR country and was dependent on pre-existing financing arrangements. In the absence of established strategic purchasing schemes, as in the case of Iraq and Egypt, there was heavy reliance on access services in the private sector through household out-of-pocket expenditure. In contrast, in Iran (Islamic Republic of), the government put in place measures to adapt established social health insurance schemes for COVID-19 diagnosis and treatment in participating public and private facilities. However, inclusion of COVID-19 under social health insurance limited the private sector's ability to charge more than the standardized tariff which acted as a disincentive to participate in the response. In Lebanon, where the government is the insurer of last resort for half of the population, the pandemic exacerbated a pre-existing reimbursement crisis, as private hospitals assumed enormous COVID-19-related costs on top of what was already owed to them *(17)*.

Ministries of health sought to reduce catastrophic expenditure through price caps and other regulatory measures. For example, in Iraq, the MoH engaged in dialogue with medical syndicates on pricing and developed a policy position according to which each private hospital should have treated a number of patients for free. In Egypt, the government used price caps as entry point to private sector dialogue which led to an impasse between sectors (*academic respondent*). In this context, proposed price caps were not based on fair costing nor were prices in the private sector considered fair, as these were driven by market demand.

Ministries of health introduced fast-track systems to expedite the procurement processes for COVID-19 items and other essential health medicines and commodities. In Iran (Islamic Republic of), other incentives were also introduced allowing private hospitals to upgrade facilities and equipment for the response (*government respondent*). The government also collaborated with local technology companies to incentivize domestic production of needed essential supplies. In Egypt and Iraq, the government struggled to engage the private sector in regulations, given pre-existing complexity, with roles and authority distributed across different government entities.(15)19) In Lebanon, due to the financial crisis, the government had no resources to establish a stimulus package to help either public or private sector hospitals to respond to COVID-19 *(17)*.

Build understanding

There is need to review and enhance the capture of private sector data in national health information systems, its aggregation and use, and optimisation at national and sub-national level. Data capture and enhancement extends to "normal" times and times of emergency across different levels of care.

CONSIDERATIONS

- Strengthen the mandate and cross-sectoral reach of national health information directorates to improve private sector data capture.
- Strengthen governance and use of digital technology (inclusive of legal and regulatory provisions) to reduce information (and digital) fragmentation.
- Conduct rapid research to understand barriers and enablers to data sharing and information exchange between sectors and levels of healthcare.

In the EMR, data and information were not consistently used for information exchange or as a means to build understanding between sectors. In a number of contexts, there was a high degree of suspicion about the veracity of official COVID-19 data and information that was shared, further reducing confidence in information exchange. In Iraq, pre-existing weaknesses in the health information system constrained the COVID-19 response. The informal nature of private sector inclusion within the response may have also impacted the willingness to report, which was limited and diluted over time (*non-governmental respondent*). Similarly, in Egypt, the health system also suffered from poor availability of data which shackled the agility of the COVID-19 response *(21)*.

In Iran (Islamic Republic of) and Lebanon investment in information systems included the private sector and were available for the response. Prior to COVID-19, Iran (Islamic Republic of) had invested in a comprehensive integrated health information system that covered the majority of the population. As part of the COVID-19 response, multiple health information systems were used for data capture with challenges experienced in relation to system interoperability and duplication of data *(22)*. Information systems within hospitals, both public and private, were reportedly functioning well and were used to allocate medicines and health devices as well as mediate supply shortages (*government respondent*). In Lebanon, the health information system was fragmented prior to the COVID-19 response which contributed to gaps in the collection, analysis and sharing of data during the pandemic *(20)*. Furthermore, a lack of shared understanding of COVID-19 reporting elements contributed to data quality issues (*academic respondent*). Despite challenges, some private sector entities were perceived as extremely transparent in their reporting

Foster relations

As the COVID-19 response was initially public sector driven/led, this also limited coordination, as the role of the private sector was not adequately anticipated. To rectify this, there is need to address fragmentation within the private sector in health and improve intersectoral and interorganizational coordination.

CONSIDERATIONS

- Include diverse interest groups in emergency preparedness and response structures, accounting for differences in gender, ethnicity, geographic location, among others.
- Facilitate the engagement of sectoral constituencies and sub-group interests (such as gender and diversity specific interests) by incentivising private sector organisation.
- Optimise intersectoral and interorganisational relationships through the use of virtual communication platforms and protocols.

The degree to which existing stakeholder engagement mechanisms were used to foster coordination and collaborative decision making varied across and within countries, given devolved response mechanisms. Alternative mechanisms were also used by non-state actors and UN agencies to coordinate directly with municipalities and communities *(9, 21)*. In some contexts, there were underdeveloped and fragmented coordination arrangements in place. In Iraq for example, coordination mechanisms are established on ad hoc basis to respond to specific needs and are usually dismantled when they have fulfilled their intended purpose *(9)*. While some mechanisms, such as professional syndicates play a role in coordination efforts within the private sector, they do not have a very clear role in emergencies. Humanitarian settings (such as internally displaced people's (IDP) camps) was managed through existing UN coordination cluster arrangements and not ostensibly through the ministry of health or regional governorates.

In Egypt professional syndicates are well established, organized by profession, with limited interprofessional collaboration *(22)*. Public sector coordination structures also vary, across government departments and sub-national administration functions. For example, private-not-for-profit entities are overseen by the Ministry of Social Solidarity while private-for-profit entities fall under the Federation of Egyptian Industries.

In Iran (Islamic Republic of) the government fostered multisectoral collaboration at national and sub-national level, optimising the wide availability of Iran (Islamic Republic of) medical universities *(23)*. While these mechanisms included the private sector, some sub-sectors, such as the pharmaceutical sector were not adequately engaged, particularly at the onset of the pandemic (*academic respondent*). Similarly, in Lebanon there were a number of coordination mechanisms established prior to and as part of the pandemic response, which provided for multi-stakeholder representation.

Nuture trust

There is need to align health systems and sectors around inclusive and equitable emergency preparedness and response, to build trust across sectors and define a policy agenda that matches public health interests.

CONSIDERATIONS

- Recognise, mitigate and manage competing and conflictive interests as part of emergency preparedness and response.
- Demonstrate constancy in communications and engagement (across stakeholders and over time).
- Emphasise the "public" in governance arrangements to build awareness and voluntary cooperation with emergency response measures.

In a number of EMR countries, sectoral distrust, especially during the early phase of the pandemic, further fuelled population distrust. Vulnerable groups were left to navigate the health system on their own with limited ability of ministries of health to ensure access to COVID-19 and essential health services despite government decrees. In many settings, out-of-pocket expenditure increased during the pandemic. Health workers were also left exposed during the response due to a lack of personal protective equipment (PPE). Some EMR governments did not construct a clear and public request to civic and private sectors on their role in the response. As a result, civic and private sector initiatives were not anchored to policies and priorities; ultimately, this turned the COVID-19 response into a government problem rather than a societal problem as part of a whole of society approach *(14)*.

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Conclusion

The comparative analysis highlights a range of practice in response to COVID-19. Practice built upon available institutional arrangements, organisational structures, mechanisms for coordination and information exchange. The degree to which this was effective varied and is reflective of the attributes of EMR contexts to manage change and secure essential public health functions. WHO seeks to support Member States with a practice-based and action-oriented approach to governance of the private sector in health, one that is grounded in context.

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Annex
Topic guide

Background

Can you provide a brief summary of your role (*optional*: and that of your organisation)?

Align structures

Was an emergency response plan ('rule book') developed for the COVID-19 response?

- Did this require any changes to the health policy framework?
- Did this require any changes in roles and responsibilities of health actors?

How was surge capacity addressed? (in the public and private sectors)?

- Were options for expanding infrastructure identified as part of surge capacity?
- Were the needs of specific populations of locations considered as part of surge capacity?
- Were all available private sector entities included in plans for surge capacity?
- Were changes in roles and responsibilities envisaged as part of this?
- Did the response plan cater to the needs and capacities of different private sector entities?

Has the response adapted over time?

- Were there any adverse practices displayed by some segments of the health sector during the COVID-19 response that you are aware of? [probe for specific examples]
- Did these emerge over time, in response to emergency peaks in demand?
- What were the root causes?
- What were the consequences?

Foster relations

How was coordination of the COVID-19 response structured?

- Did the coordination platform include the private sector?
- Which private sector entities were represented in coordination platforms?
- How were these entities identified?
- How did these entities cascade information to their constituencies? [probe: formal and informal channels]
- In your opinion, were all critical voices represented? Were any left out?

What digital tools/platforms have been established or optimised for communication and coordination as part of the response?

Build understanding

What information was available on the private sector before the pandemic?

- How was sectoral reporting catered for in the HIS?
- Which parts of the private were reporting?
- What informational gaps were present?
- What data quality gaps were present?

What information was collected on the private sector as part of the COVID-19 response?

- Were private providers identified and mapped for the COVID-19 response?
- What reporting mechanisms were put in place for the COVID-19 response?
- Were any enhancements needed/taken to optimise reporting mechanisms?
- Were any enhancements taken to improve data quality as part of the response?
- Did this vary by private sector type?

How were data and trends communicated across sectors and levels of the health system during the COVID-19 response?

How did data and information inform decisions in relation to the private sector?

What other information sources were available/used during the COVID-19 response?

Enable stakeholders

What regulatory measures were introduced or adapted by government as part of the COVID-19 response?

- When were they introduced/adapted for the response?
- What was the motivation for their introduction/adaptation?
- Were measures specific to the private sector?
- How was compliance monitored and enforced?
- Was there a means of receiving feedback to address emergent concerns? [probe: formal and informal]
- Overall, how do you think the regulatory measures performed? [probe: capacities, resources]

Were any financing measures introduced as part of the response?

- When were they introduced/adapted for the response?
- What was the motivation for their introduction/adaptation?
- Were measures specific to the private sector?
- If measures addressed subsidy/reimbursement to the private sector, how was a fair cost established?
- How was compliance monitored and enforced?
- Was there a means of receiving feedback to address emergent concerns? [probe: formal and informal]
- Overall, how do you think the financing measures performed? [probe: capacities, resources]

Nurture trust

How was equity considered as part of the COVID-19 response?

- How were the needs of specific populations catered for as part of the response?
- How was affordability addressed/monitored?
- How were consumer concerns communicated as part of the COVID-19 response?
- How did government act upon such information/concerns?
- Were perspectives of frontline service providers (public and private) considered as part of the COVID-19 response?
- Overall, do you think the response instilled trust in the health system?

Deliver strategy

How did the COVID-19 response perform in your context? Was this considered effective?

- What metrics were defined for the response?
- How were these monitored and communicated?
- How was learning captured?
- Was there a platform or process for this?
- Was there solicitation and incorporation of diverse perspectives and feedback as part of this? [private sector, frontline workers, the public/civil society]
- What, in your view, were the key learnings from the COVID-19 response?

What actions are needed to improve governance of emergency response and health system resilience?

- Are there specific actions needed for the private sector in health?
- What steps are needed to initiate change?
- What tools, resources and assistance are needed?
- Are there tools or guidance for engaging the private sector that you have consulted in the past 18 months for the delivery of COVID-19 vaccines, therapeutics, and diagnostics?
- Are there challenges that you are facing in engaging with the private sector for which you would like guidance, tools, or resources?
- What features would make you more likely to use a tool or resource? These could include: website accessible or downloadable, video or audio format, or others factors.
- Are there specific tools or guidance you wish you had or need access to?

Closing

Do you have any final comments or questions?

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