



Protocol:

using data to
drive governance



World Health
Organization

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Using data to drive governance: study protocol

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Contents

Acknowledgements	v
Conflict of interest.....	v
Abbreviations and acronyms	iv
Abstract	1
Introduction.....	1
Methods	1
Key words.....	1
Discussion	1
Ethics and dissemination.....	1
Summary	2
Strengths and limitations	2
Background	3
Research questions	4
Strategic frame	6
Box 1: The governance behaviours	7
Figure 1: Mapping data for governance to the governance behaviours	7
Methodology	8
Design	8
Data parameters.....	8
Literature review	8
Ethics and consent.....	8
Country case selection will consider:	8
Key informant interviews.....	8
Data collection.....	9
Sample selection	9
Collaboration	11
Analysis	11
Gantt chart	12
References	13
Annex 1: Governance of health systems: a data journey	14
Annex 2: Topic guide	19

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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.

Abbreviations and acronyms

CCPSH	Country Connector on the Private Sector in Health
ERC	ethical review committee
FP	Family planning
GFF	Global Financing Facility
GPW	general programme of work
HIS	health information systems
MNCH	Maternal, newborn and child health
WHO	World Health Organization



Abstract

Introduction

This study seeks to identify what data and information is currently being collected by governments and how this is used for governance of the private sector in health. Information will consider routine and other data sources, as well as innovations in data science and technology as part of the information landscape.

This study responds to recommendations from the private sector landscaping undertaken as part of the WHO strategy report “Engaging the private health service delivery sector through governance in mixed health systems” (1). The strategy conceptualized six governance behaviours to foster effective public-private engagement, as part of more resilient and responsive health systems.

Methods

To develop this study protocol, we first created a strategic frame using the governance behaviours. We then developed a theory of change to show how “data for governance” works across the governance behaviours. The theory of change (see Annex 1) will be used as a basis for expert group consultation to map health data and information sources and systems and identify key informants for the study. The study will be implemented in two phases. Phase 1 will entail a rapid literature review, while phase 2 will be carried out through key informant interviews and focus group discussions.

Key words

#Health information

#Private health sector

#Health governance

Discussion

By applying this study protocol, we seek to generate insights on information requirements governance behaviours, as illustrated in the theory of change. The case studies and comparative analysis will inform a planned WHO normative guidance on data for governance of the private sector in mixed health systems.

Ethics and dissemination

The case studies will entail data collection from persons working in their official capacity on issues in the public domain. Ethical approval has been granted under protocol [ID: ERC.0003662] and is exempted from further ERC review. The study will be disseminated through a peer-reviewed publication, working groups, webinars and partners.



This study seeks to identify what data and information is currently being collected by governments and how this is used for governance of the private sector in health.

Summary

Strengths

- We have taken a collaborative approach to conceptualise the study protocol, guided by the CCPSH Steering Committee and the Country Connector Data Working Group on data for the governance of mixed health systems
- A theory of change has been developed, based on the WHO governance behaviours and will be used in-country as a basis for mapping data systems, sources and use cases for governance
- Research teams will be country-based, drawing on contextual knowledge and perspective, supported by the CCPSH Data Working Group and Secretariat
- The literature draws from a literature review undertaken for the development of a related WHO normative product as well as grey and published literature identified for the country cases
- A case study approach is proposed as it allows exploration of the richness of actual cases and reinforces adaptive and shared learning

Limitations

- Only five country cases will be explored due to the resource intensive nature of a case study approach
- National researchers may have varying familiarity with data for governance as a study topic and the conceptual framework limiting consistency in study execution and comparability of findings
- Key informant interviews may be limited by interviewer skills and respondent bias, in which participants do not objectively share information
- Our non-probabilistic sampling strategy limits our ability to generalize the findings

To minimize limitations

The WHO HQ study team will ensure that national researchers are orientated on the study topic, conceptual framework, and theory of change. National researchers will participate and play a key role in country inception and validation meetings. Interviews will be conducted jointly with a WHO HQ study team member to ensure consistency in how the topic guides are used and interviews conducted across country cases

The study team will offer respondents a choice of how the interview is conducted (e.g., telephone, video conference, in person), seek to establish a good rapport with respondents before the interview begins, guarantee confidentiality, and use active listening to develop trust

Our approach and final sample will have “symbolic representation” that illustrates the diversity within the population’s boundaries and allows for comparisons between subgroups (e.g., gender, rural/urban location, public/private sector). By consulting members of our technical working group and national experts on the research design and selection of respondents, we aim to reduce sample bias and ensure that key informants reflect the population of interest

Lastly, we will use mixed methods to triangulate findings; these will be validated through the aforementioned multistakeholder workshops

Background

Health systems embody people, institutions, and resources, arranged together following policies established by a government to improve the health of the population it serves (2). Within the health sector, arrangements are intended to improve health system performance - equity in the use of health services, service quality and financial protection. Most countries have pluralistic health systems, where a mix of public and private entities deliver health related goods and services. This may include a large variety of health entities, from small not-for-profit providers to large multinational private for-profit companies.

Despite increasing recognition of the importance of the private sector in health for public health goals, there remains little consensus on how to develop and implement national health policy that effectively includes the private sector. Many countries do not have explicit policy related to the private sector in health nor to the role of component entities in national health systems. In the absence of clear direction, a policy vacuum may coalesce in which the growth, form, and function of the private sector in health are left to other forces, to the detriment of efficiency, quality, and equity (3). As part of inclusive health policy, 'situational awareness' and the generation of intelligence is needed by governments on the private sector in health. Additionally, to perform specific governance functions, such as contracting, more explicit information on the private sector is required.

Many low- and middle-income (LMIC) governments have attempted to address health system information requirements through the collection of more, better, and different types of data on the private sector; increasingly, this is collected in a routine manner, through national health information systems. Alongside these efforts, other sources of information may exist, such as programmatic, financial, geospatial, survey and other structured or unstructured data sets. Innovations in data capture and interoperability between information sources, as well as advanced analytics using machine learning and artificial intelligence techniques are also increasingly available and being tested in LMICs as part of a broader toolkit of tech solutions. Despite these advances, data and information may not be used to govern the private sector or build understanding with component entities. The WHO's Thirteenth General Programme of Work (GPW13) recognises this challenge and has called for the definition of global indicators to deliver measurable health impacts and benchmark health systems performance (4).



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

Research questions

This document introduces a collaboratively developed study protocol to identify what data and information is currently being collected by governments and how this is used for governance of the private sector in health.

Key questions that will be addressed through this research are outlined below.

- **performance:** How do national health entities use information to govern the health system? What sources are used? Do these capture the private sector in health?
- **structural:** How do private sector entities report into national health systems? Are there concerns with the quality of reporting? Has this changed over time?
- **procedural:** What are the incentives and disincentives for private sector reporting in national health systems? Have these changed over time?
- **innovations:** How do technology solutions address fragmentation across sectors, sources, and systems?
- **technical:** What are the minimum information requirements to generate/demonstrate situational awareness and perform specific governance behaviours and functions?

The study and research questions predominantly focus on private sector inclusion in national health information systems (HIS) and less on regulatory systems. This is in recognition that access to accurate information about private health service utilization can limit other domains of private sector engagement, particularly regulation and financing (5).

A HIS is broadly defined as a system that integrates data collection, processing, reporting, and use of the information necessary for improving health service delivery. HIS may include data from different sources, including routine service statistics, population-based surveys, vital statistics, and surveillance systems. The purpose of a HIS is to produce high-quality information that can be used at all levels of a health system for program monitoring and improvement, to inform strategy and policy development, planning and implementation (6).



This document introduces a collaboratively developed study protocol to identify what data and information is currently being collected by governments and how this is used for governance of the private sector in health.



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Strategic frame

We use the governance behaviours as a strategic frame for the study (Box 1). The governance behaviours break down what have tended to be long lists of governance activity, i.e., “ensuring [that] strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system design and accountability” (7). They reinforce the notion of governance as practice, with activity determined through day-to-day decision making and improvisation by actors at multiple levels (8). Linked with this, there is an emphasis on governance as involving negotiation of networks rather than hierarchical authority (9). Foundational to improvisation and interaction are “data for governance”.

Our data for governance strategic frame starts with build understanding as its entry point as it relates to the availability of data and its conversion into information. Under foster relations, we consider how information is used as a basis of sectoral engagement and knowledge exchange. Under deliver strategy and enable stakeholders, we consider how “situational awareness” (gained through exchange) is translated into intelligence and reflected in public policy and interpreted in policy instruments (e.g., regulation and financing) to enable (or constrain) health entities to perform. Under align structures, we consider how policy and related instruments affect the operations of health entities in their service delivery roles. Under nurture trust, we consider how information is used for accountability and agency, to protect and empower health workers and health consumers and correct health system performance. This is illustrated in **Figure 1**, where we have mapped aspects of “data for governance” under each of the six governance behaviours.

In an Additional File we provide a theory of change to show how “data for governance” works across the governance behaviours. Key terms are defined, and ideas illustrated. While we have adopted the term “data for governance”, data is fundamentally raw information and as such, may not be in a form that can be used to govern. Given this, we elaborate on the data to information to intelligence pathway as part of the theory of change. This work will primarily focus on the “build understanding” governance behaviour but will seek to generate insights on information requirements and use across governance behaviours.

Our definition of private sector are those entities directly involved in health service delivery. This includes private-for-profit and not-for-profit entities, both local and international, including primary care clinics, maternity/nursing homes, pharmacies (in their service extension role) and hospitals. It does not include other private entities operating along the healthcare value chain. Additionally, we focus on data generated at a national level and not through global or regional initiatives (while acknowledging that this is an important body of information which could be used for governance of the private sector in health).



We consider how information is used for accountability and agency, to protect and empower health workers and health consumers and correct health system performance.

Box
1

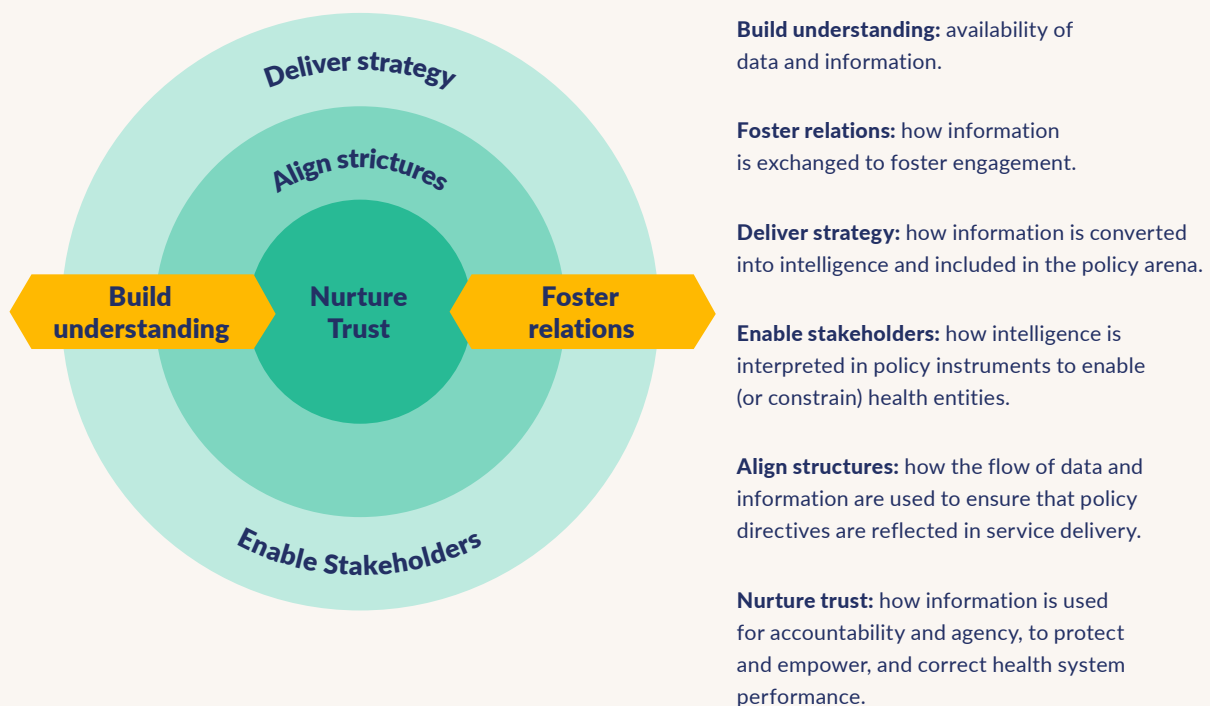
The governance behaviours

The governance behaviours are fundamentally a socio-ecological approach. They build from an understanding of health systems as “everybody’s business” and governance as a dynamic process through which governments engage public, private, and civic actors to achieve health policy and improve health system performance.

- **Deliver** strategy and enable stakeholders focus on broader institutional arrangements for health system performance; these include health priorities and strategic direction, articulation of the principles and values of the health system and the underlying policy and regulatory framework.
- **Align** structures considers the organisation of the health system to deliver on health priorities, principles and values. This focuses on the mix of public-private entities, the division of roles and activities among entities, and the integration of entities within the health system.
- **Build** understanding and **foster relations** consider system and interactive processes using information and engagement as levers for improving institutional and organizational (structural) performance.
- **Nurture** trust considers how well this is done, in terms of the quality of integrative engagement, how power and responsibilities are exercised, and the centrality of people, principles and values to sectoral roles and interactions.

Figure
1

Mapping data for governance to the governance behaviours



Methodology

Design

A case study methodology is proposed as it allows exploration of the “richness of actual cases” and reinforces adaptive and shared learning (10). This will entail a literature review and qualitative research carried out through key informant interviews, focus group discussions and multi-stakeholder workshops. Up to five country case studies will be done to allow for regional and data maturity variation. An over-arching synthesis will be prepared to compare country case studies and illicit insights on data for governance and information requirements across country cases.

Data parameters

As part of the case study design, we will consider the following data parameters.

- **Performance:** value of information for health system performance monitoring, knowledge exchange
- **Structural:** information architecture, legislative and compliance mechanisms for information sharing
- **Procedural:** routine data sources, data collection, reporting requirements, data quality
- **Innovations:** use of mixed methods/multiple data sources; use of tech solutions
- **Technical:** minimum information requirements

Data parameters will be explored through maternal, newborn, child health (MNCH) and family planning (FP) using these as ‘tracer’ programmes.

Literature review

The literature review will draw on a systematic review being conducted by Oxford Policy Management on the six governance behaviours and on a literature review supported by the GFF on data for governance of mixed health systems. This will be supplemented by grey and published literature identified through the Country Connector working group on data for the governance of the private sector in health and by the in-country expert group as part of the country case study inception workshop.

Ethics and consent

The case studies will entail data collection from persons working in their official capacity on issues in the public domain. Ethical approval has been granted under protocol [ID: ERC.0003662] and is exempted from further ERC review.

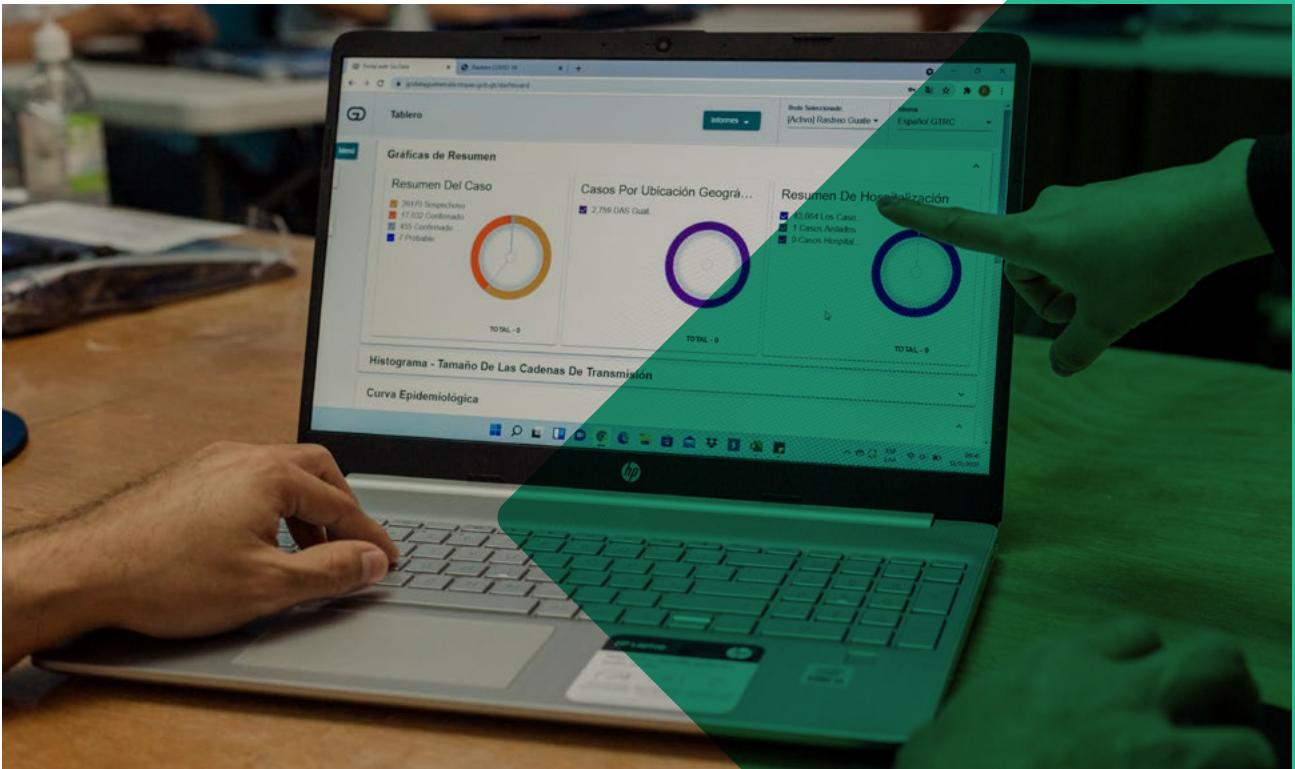
Country case selection will consider:

- Country interest and willingness to participate
- Level of health information maturity/ extent of private sector engagement
- Level of decentralisation (at least one devolved context)
- Priority countries for WHO, USAID and/or GFF.

Country level work will entail an initial introductory workshop with 5-10 individuals at national level representing key constituencies across the public and private sectors. During this workshop we will outline the concept and map sources, systems and sectors of relevance to the case study. Additional grey literature will be identified, and tools will be reviewed and refined. A second confirmatory validation workshop will be held once the case studies are drafted (this may also be a combined exercise across countries to generate peer learning and exchange).

Key informant interviews

As part of the case studies, semi-structured, in-depth interviews will be conducted with identified key informants. These will be drawn from private sector, academia, government, and intermediary/ partner organisations. Targeted sampling will be employed based on feedback from the participants in the introductory workshop. Following WHO communication protocols, informants will be contacted through WHO Regional and WHO Country Office. Informants will be provided with a note (‘participant information sheet’) explaining the study (objectives, scope, methodology and timeframe) and the implication for the informant (what is expected of them). If they agree on participating, informed consent forms will be shared and completed by the informants (information on informed consent forms are detailed below).



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Sample selection

Eligible respondents will be selected purposively using a sampling matrix to capture a range of viewpoints and experiences on data for governance. In addition to the categories in this sampling matrix, we will pay attention to gender balance and rural/urban experience when selecting participants. Key informants will be identified so that there is at least one respondent for each category listed in the sampling matrix. In total, 15-20 key informant interviews are envisioned.

Key informants will participate in their official capacities as representatives of their organizations, and they will be asked to provide permission from their managers/supervisors to represent the point of view of their organization. The participants information sheet will be sent to the identified key informants, to provide them with adequate background on the study and on their rights in case they agree to participate. There will be no adverse consequences of a decision not to participate or to withdraw during the study. All potential participants will receive the consent form once they agree to take part in the study. In order to schedule the interview with participants who agree to take part to the research project, an email will be sent to respondents by WHO Staff with the aim to agree on a selected date and time for the interview to be carried out.

A case study methodology is proposed as it allows exploration of the “richness of actual cases” and reinforces adaptive and shared learning.

Data collection

Once consent forms have been signed, the principal investigator together with in-country consultants and/or WHO HQ staff will carry out the interviews, using a semi-structured interview guide developed by the team of investigators, validated in the inception workshop and approved by WHO Regional and country office (see Annex 1). The guide will be adapted depending on the type of informant interviewed (e.g., MoH, private health sector federations, healthcare professional associations, consumer organizations, etc.).

Interviews will be recorded and transcribed. For remote interviews, respondents will be compensated for their internet usage in the form of data bundles.



Collaboration

The methodology was developed collaboratively, as a means of strengthening stakeholder engagement and retaining support. The development of the protocol was guided by the WHO Systems Governance and Stewardship (SGS) unit, the World Bank GFF and USAID and stewarded by the Country Connector on the Private Sector in Health Steering Committee. Further technical inputs were provided through the Country Connector Working Group on data for the governance of private sector in health (see acknowledgments for a full list of contributors).

The data for governance protocol complements work on a progression pathway for the governance of mixed health systems that is being supported by Oxford Policy Management. Minimum capacities and data for governance requirements will be considered as part of this and inform work on a WHO normative product. This normative product will enable countries to benchmark and align capacities, behaviours, and instruments for governance of the private sector in health.

Analysis

A coding frame using Microsoft Excel 2016 will be developed for data extraction, based on the data parameters and semi-structured interview guides. The matrix will be constructed horizontally with the key themes and vertically by information source (i.e., interview respondent, document review).

Notes will be condensed, with information arising from data sources inserted into the matrix.

Gantt chart

Country case studies will be conducted from late 2023 to mid-2024, with regular working groups scheduled at periodic intervals to guide and review progress.

Activity	2023			2024		
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 1	Quarter 2
Approach document (draft and finalize)						
Write the protocol to be published in a journal (GFF, USAID, WHO MNCH, Data WG)						
Case country selection Country consultant						
Case study team formation						
Country IRB						
Desk review (grey)						
Literature review (published, peer reviewed)						
Country kick-off meetings (five in total)						
Country data collection						
Case study draft						
Confirmatory validation workshops (five in total)						
Case study finalize/publication						
Comparative synthesis report						

Indicates planned completion

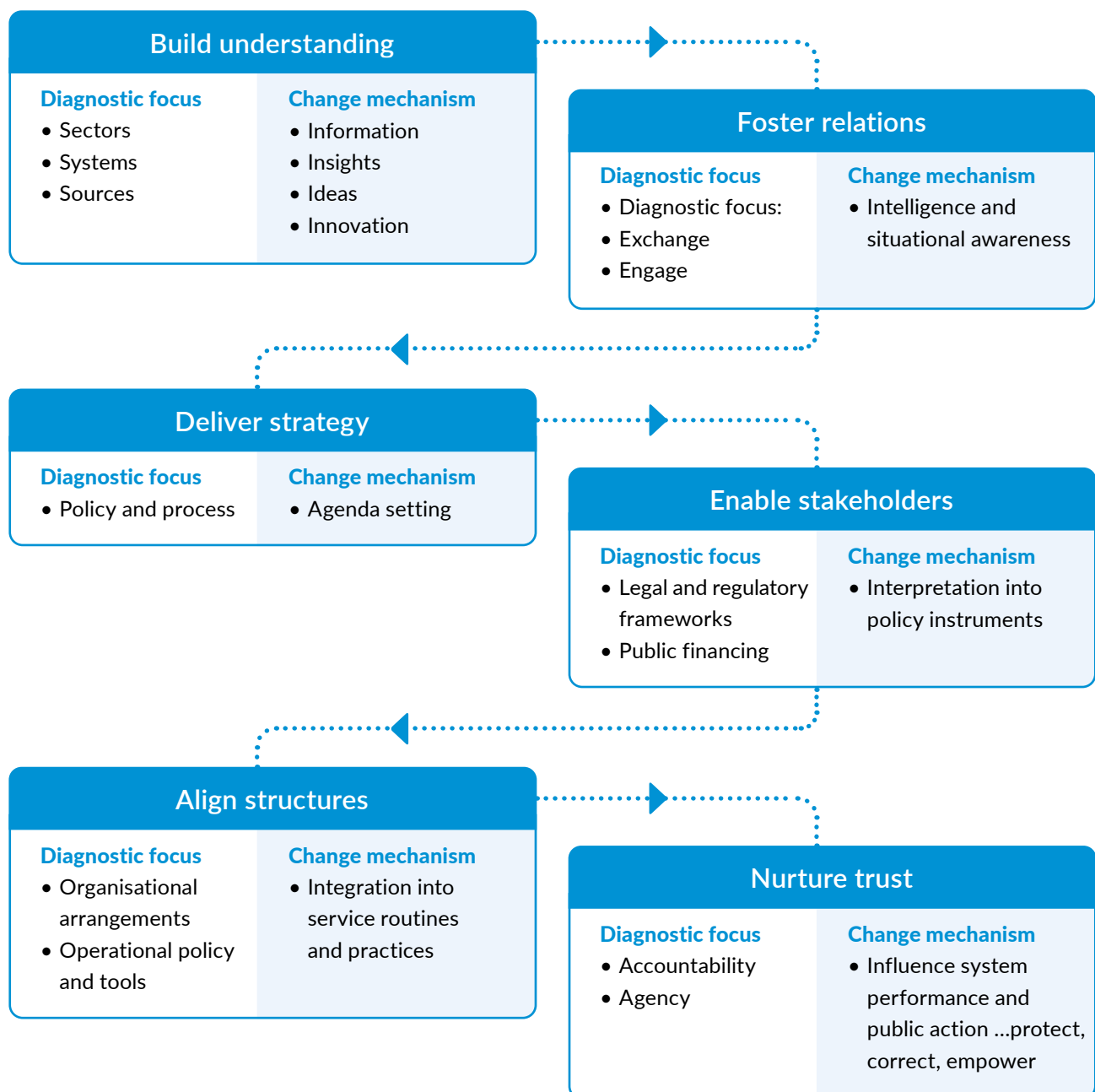
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Annex 1. Governance of health systems: a data journey

Given that data is fundamentally raw information and as such, may not be in a form that can be used to govern, we elaborate on the data-to-information-to-intelligence pathway as part of a theory of change, using the governance behaviours as a strategic frame (Figure 1). Of note, our definition of private sector are those entities directly involved in healthcare service delivery. This includes private-for-profit and not-for-profit entities, both local and international, including primary care clinics, maternity/nursing homes, pharmacies (in their service extension role) and hospitals. It does not include other private entities operating along the healthcare value chain. Additionally, we focus on data generated domestically and not through global or regional initiatives (while acknowledging that this is an important body of information which could be used for governance of the private sector in health).

Figure 1. Data journey



Build understanding: Availability of data and its conversion to information

Data can come from multiple systems and sources. These can be combined or remain as fragmented strands of data. Information is data that has been organized into a format that is meaningful. This can take multiple forms, which may or may not include the private sector. Examples of data systems, sources and products are outlined below. These are not exhaustive and are likely to vary by country and region. Other examples are provided under related governance behaviours.

- **Systems:** Health information system, health facility registry, surveillance/reportable disease system, maternal and peri-natal death surveillance and response system, logistics management information system, human resource system
- **Sources:** Reporting forms, registers, surveys, assessments, research, mapping, etc.
- **Products:** Service reports, programme reports, benchmarking and trend analysis (e.g., league tables, scorecards), research papers and studies, advanced analytics, (info)graphics, dashboards, maps, etc.

An important feature of build understanding is how data is converted to information and insights. Insights are the interpretation of information, based on context, knowledge and experience. Ideas are generated through insights and may motivate action. Innovation (in our theory of change) relates to data capture and interoperability between information systems and sources as well as the use of novel formats to convey information. While information, insights, ideas, and innovation are introduced under build understanding, as with other mechanisms of change, they work across the governance behaviours.

Foster relations: how information is exchanged and used to foster engagement

The conversion of information to insights and ideas is facilitated through exchange as the basis for engagement and coalition building. Engagement may be sectoral or intersectoral, formal or informal, virtual or in-person. It may be routine or event-based, through technical working groups or policy dialogue mechanisms. It should result in shared understanding of the situation – or situational awareness - defined as a well-informed interest in a situation or development. The availability of information is critical to developing

such an awareness and generating intelligence. Indeed, a function of governance is ensuring that all health system actors have access to the information they need to contribute to public policy and system performance [1]. Examples of mechanisms and formats for engagement and exchange are outlined below. While situational awareness and intelligence are introduced under foster relations, as with other mechanisms of change these inform other governance behaviours.

- **Mechanisms:** meetings, conferences, online platforms, associations, federations, syndicates, group chats, etc.
- **Products:** manifestos, memos, briefs, communiqués, minutes, action plans, etc.

Deliver strategy: how information is converted into intelligence and included in the policy arena

Deliver strategy is fundamentally about policy and the policy making process. Here we consider how information is converted into formal intelligence (the evidence base) and included in the policy arena. Information in the policy arena may be used instrumentally, to identify priorities and inform decisions, or strategically, to support pre-existing decisions [2]. Both uses are legitimate, and both approaches may be apparent in policy making. Factors affecting the use of intelligence and evidence include perceived credibility, accessibility, and the support base [3].

Our theory of change suggests a linear approach to policy, that information informs policy and drives implementation. However, the policy making process does not necessarily occur in linear, sequential stages [4]. Intervention itself may activate the policy cycle, providing the basis for intelligence gathering and policy formulation. This may be driven by policy entrepreneurs outside of government, including the private sector, using intelligence and evidence generated through multiple sources, not solely government systems. Examples of mechanisms and products to deliver strategy are outlined below.

- **Mechanisms:** policy review, policy dialogue tours, monitoring systems, consultation processes, formal petition, etc.
- **Products:** public policy documents, roadmaps and strategies, progress reports, advocacy and policy briefs, etc.

Enable stakeholders: how intelligence is interpreted in policy instruments to enable (or constrain) health entities

This behaviour considers how intelligence and policy are interpreted in policy instruments and financing arrangements. These, in turn, inform programme and services delivery [5]. Here, information requirements may be both strategic and operational. Strategically, information on the private sector is needed to guide the development of inclusive policy instruments and financing arrangements. At an operational level, information is needed to develop and implement specific tools, such as accreditation and contracting.

Information may be siloed, limiting its effective use, particularly in contexts where roles are divided across government entities and administrative levels. Information reservoirs may also sit unutilized for governance such as data collected on participating facilities in national or social health insurance, and related information on costing and service provision. In response, e-governance systems may be introduced to reduce information fragmentation, improve compliance and ease of doing business for private health entities.

- **Sources:** Legislation, regulation, rules, and procedures, claim management systems (insurance or vouchers), compliance systems, communication systems (e-governance), etc.
- **Products:** Circulars, guidelines, checklists, expenditure reviews, standards, benefits packages, etc.

Align structures: how the flow of data and information are used to ensure that policy directives are reflected in service delivery

This behaviour considers implementation of policy instruments and related tools, how these are recognised and distributed across organizational structures, including private health entities. Governance at this level may be devolved to sub-national administrative units and suffer from implementation disconnects with central policy, national programme strategies and information systems. This highlights the need for bi-directional flow of data and information to ensure that policy directives are reflected in service routines and practices (and vice versa), inclusive of reporting practices and the maintenance of information. Increasingly routines and practices may extend to

digital health and self-care, creating new pools of services and data that may or may not be integrated into health information systems.

At this level, technical and procedural capacities (e.g., technology, skills, processes), values and relationships play a role [6]. These may facilitate or limit the availability of data; ease of access (to data and data systems); the capacity to use data and convert it into useful information; and generate insights and ideas to improve health system performance [7]. Research on decision making at this level suggests that “formal” data, through health information systems may be combined with local contextual understanding and experience-based knowledge (a form of information that may not be recognised within information systems). At this level, there may be more reliance on muddling through rather than formal policy or information sources and products, such as those in the examples below.

- **Sources:** routine service statistics, technical working groups, programme/partner reports, assessments, audits, supervision, self-regulation, peer benchmarking, etc.
- **Products:** plans, presentations, reviews, dashboards, reports, etc.

Nurture trust: how information is used for accountability and agency, to protect and empower, and correct health system performance

Both sectors should be accountable to the delivery of quality health services and commit to reduce unnecessary or ineffective care [8]. Information is critical to this intent and may be used to empower and educate users to demand state obligated services, and support health-service actors to recognize and act on these demands (inclusive of the private sector) [9]. Furthermore, information may be used to address asymmetries of power and exert pressure on the health system. Information and user perspectives (health workers and consumers) may be helpful in generating a system-wide perspective on policy implementation, system performance and the effectiveness of interventions (e.g., regulations, contracting) again reflecting the importance of bidirectional flow of information [10]. Examples below illustrate the bidirectionality of information sources and products.

- **Sources:** communities, health committees, media, social media, Ombuds office, parliamentary committees, patient organisations, civil society, watch dog organizations, feedback mechanisms (websites, chalk boards, chat bots, etc.)
- **Products:** codes of conduct, patient charters, social audits and scorecards, reports/directives, etc.

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Annex 2. Topic guide

Note: the topic guide is illustrative only and will be refined (and shortened) based on contextualization.

Introduction

We would like to interview you about your views and experience with data for governance and the inclusion of the private sector for health within routine and other data sources and systems. Your participation in the interview is completely voluntary and is your choice. You can stop participating at any time without any consequences. If you decide to take part, our discussion should take no more than one hour. If you agree, we'd like to record our discussion and take notes. All recorded data will be destroyed after completion of data analysis. Your name(s) will not be included in this information.

Technical

Please describe the minimum reporting requirements by the private sector in health.

- What is required by legislation?
- Is this largely adhered to?
- How is this information collected and by whom?
- How is compliance monitored?

Structural

Please describe the public-private mix for health services in your country.

What are the total number of health facilities reporting in the national HIS?

- Of this number, what proportion are private?
- Of the private facilities, which proportion are registered?
- Has the proportion of public and private health facilities changed over time?
- How are non-facility-based services and products (e.g., via pharmacies, CHWs or outreach services) reflected in reporting?
- What is the volume of health services like in the private sector?
- Does this vary by entity type (pharmacies, dispensaries, medical clinics, maternity homes, hospitals), or by ownership (NGO, FBO, private)?
- Has this changed over time? [probe: self-care, health seeking during COVID-19]

Procedural

Please describe private sector reporting.

What is the extent of private sector reporting in practice?

- Does this vary by entity type (pharmacies, dispensaries, medical clinics, maternity homes, hospitals), or by ownership (NGO, FBO, private)?
- Does this vary by month/seasonally?
- Does this vary by report type?
- How are NGO outreaches captured in reporting? Is this through the public sector?
- How are community and self-care activities captured in reporting? Is this through the public sector?

What is the quality of reporting by the private sector?

- Are there any concerns with over or under reporting of services?
- Are there any concerns specific to different reports?
- Are there any concerns with late reporting?
- What is the quality of reporting relative to the public sector?
- Has the quality of reporting changed over the last few years?

Structural

Please describe private sector reporting pathways.

What proportion of private facilities report electronically into the national HIS?

- Are paper-based registers and reports still required?

For those without electronic access to the national HIS, how do they report?

- Does this require physical delivery of registers and reports?
- Are other modalities for submission used?
- What are the benefits and challenges in relation to paper-based registers and reports?
- Has the increased volume of private sector entities affected reporting pathways over time?
- Does this vary geographically? [e.g., urban-rural]

Innovations

Please describe the systems interface between the public and private sectors.

Has the “modernization” of reporting systems affected reporting?

- How has modernization of national HIS helped or hindered private sector reporting?
- How has modernization of private sector HIS (electronic medical records or other digital systems/tools) helped or hindered private sector reporting?

Performance

Please describe data use between the public and private sectors.

- How are data and information used across sectors and levels of the health system?
- Who is it used by and for what purpose? [probe: forecasting, quantification, target setting, performance monitoring, etc]
- What other information sources are available/used for performance monitoring? Do they include the private sector in health?
- Is the private sector engaged in information exchange on program performance?

Closing

- Thank you very much for your time. Is there anything else that would help me understand how data for governance can be optimized, inclusive of the private sector in health?
- Follow up on any additional documents or contacts mentioned during the interview.

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