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Frontier Health Markets (FHM) Engage

ACTIVITY 2.1.B CONCEPT NOTE

Address Evidence Gaps in Strengthening Quality of Care in Private Sector Provision of Child Health Services in Tanzania

September 2022

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Authors:
[Names redacted]

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Prepared by:

1275 New Jersey Ave. SE, Ste 200,
Washington, DC 20003

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Acronyms

ADDOs	Accredited drug dispensing outlets
Amox DT	Amoxicillin dispersible tablets
CHNRI	Child Health and Nutrition Research Initiative
EQuiPP	Enhancing Quality iCCM through Proprietary and Patent Medical Vendors (PPMV) and Partnerships (EQuiPP)
iCCM	Integrated Community Case Management
IMCI	Integrated Management of Child Illnesses
KII	Key informant interviews
MCSP	Maternal Child Survival Program
QoC	Quality of care
SBC	Social and behavior change
SHOPS	Strengthening Health Outcomes of Private Sector
SHOPS Plus	Sustaining Health Outcomes through the Private Sector
SPA	Service provision assessments
ToC	Theory of Change
WHO	World Health Organization

Background on the Activity and FHM Engage

This proposed activity forms part of the overall Frontier Health Markets (FHM) Engage core work plan.

FHM Engage is a global cooperative agreement providing technical assistance supporting local actors to improve the ability of health markets to meet supply-side capacity gaps and consumer preferences, contributing to equitable provision of and access to high-quality health services and products in mixed health systems. Building on more than 30 years of USAID investment, FHM Engage focuses on strengthening local health markets by addressing the root causes of market failures in the core market functions to create necessary behavior changes that catalyze supply and demand and support sustainable change. In line with this approach, FHM Engage seeks achievement towards two main results:

- Result 1: Improved market environment for greater private sector participation in the delivery of health products and services.
- Result 2: Improved equal access to and uptake of high-quality consumer driven health products, services, and information.

This concept note relates to activity 2.1.B of the core work plan, which seeks to **develop a research effort rooted in adaptive learning methodologies that will test promising interventions that have the potential to address one or more existing evidence gaps identified in the private sector Child Health and Nutrition Research Initiative (CHNRI) process** (Clarence et al, 2020). Activity 2.1.B is one of two activities in the FHM Engage work plan that addresses Sub-IR 2.1 Improved quality of care and user/client-centered focus of healthcare services in the private sector. Like other FHM Engage activities, this effort will apply a "Diagnose, Design, Deliver, Adapt, and Learn" approach to execute this activity over multiple years. This effort will work in Tanzania (where FHM Engage currently has a buy-in), and target improving private sector adherence to integrated management of childhood illness (IMCI) protocols. However, the activity could pivot efforts to other child health or newborn health evidence gaps, depending on the priorities of the USAID country mission.

Our team includes:
[REDACTED] - Associate Director, Results for Development
[REDACTED] - Associate Director, Results for Development
[REDACTED] - Program Officer, Results for Development
[REDACTED] - Child Health Expert
[REDACTED] - Tanzania-Based Consultant

Rationale

IMCI and integrated community case management (iCCM) are strategies for improving quality of care (QoC) developed by the World Health Organization (WHO)/UNICEF in the mid-1990s and are concerned with ensuring that the health system works to manage each child's health in an integrated and holistic way. Since the mid-1990s, more than 100 countries have adopted IMCI or iCCM policies as part of their national health policies, and in 2016 the WHO emphasized the importance of increasing engagement of the private sector in IMCI or iCCM, given that half of all treatments for diarrhea, fever, and cough originate in the private sector. Systematic reviews of global research have demonstrated that

effective IMCI implementation has been associated with improvements in QoC (Nguyen et al, 2013) and modest reductions in child mortality (Gera et al, 2016). In Tanzania, a five-year comparative analysis of districts that that implemented facility based IMCI observed a 13 percent lower mortality rate and improved QoC in comparison to districts not implementing IMCI protocols (Schellenberg, 2004).

Despite these promising findings, effective implementation of IMCI is not widespread. A recent, multi-country analysis facilitated by the Sustaining Health Outcomes through the Private Sector Plus (SHOPS Plus) project that examined IMCI adherence in service provision assessment (SPA) data (including the 2014-15 Tanzania SPA) found that there were generally low levels of protocol adherence in public and private clinical facilities (SHOPS Plus, 2021). In Tanzania, the analysis showed adherence was particularly low in relation to the number of children checked for general danger signs (10%), acute malnutrition (2%), HIV infection (7%), and immunization status (46%), and only 19 percent of children with diarrhea and 33 percent of children with a fever were assessed and treated correctly. Providers across both sectors do better when assessing for difficulty breathing (76%), and private providers had more success than public providers in correctly managing children with cough (67% vs. 37%).[1] Outside of the SHOPS Plus analysis, other studies in Tanzania have also highlighted significant gaps relating to QoC in both public sector clinical (Walter et al, 2009), and private sector non-clinical providers (SHOPS, 2012), particularly around lack of appropriate referral of patients to higher-level facilities in cases where children exhibited danger signs.

While existing evidence demonstrates that adherence to IMCI – within both private and public sector facilities in Tanzania, and globally – is low, there is very little global or country-specific evidence on either the factors affecting private sector IMCI implementation, or the potential for strategies and interventions to address poor performance. A 2014 review by Awor et al, on IMCI in Africa identified only one study on IMCI in the private sector, and noted that private sector studies and initiatives tended to focus on single disease interventions, rather than the integrated management of child health. Addressing the lack of existing evidence on factors affecting private sector IMCI adherence has been highlighted by WHO's strategic review of IMNCI as well as CHNRI, which developed a prioritized, global research agenda for private sector management of childhood illnesses. Of the 15 global research questions prioritized, seven directly relate to understanding more about the factors and interventions that impact private sector IMCI or iCCM adherence.

Considering that existing evidence in Tanzania shows that there are gaps in both private and public sectors in QoC of holistic management of childhood illnesses, there is a need in Tanzania to strengthen solutions aimed at improving of the QoC for childhood illnesses – including IMCI. At the same time, there is little evidence on the factors that impact effective IMCI implementation within the private sector, or what solutions might be effective for this sector – either globally or in the Tanzanian context. This activity aims to tackle these problems, through further understanding the factors affecting effective IMCI implementation in the private sector, as well as identifying and testing interventions for improving implementation.

[1] In this analysis correct management of cough included providers who first counted breaths, gave an appropriate diagnosis for pneumonia based on the number of breaths counted, and who prescribed an appropriate antibiotic if pneumonia was diagnosed. The specific antibiotic formulation (e.g., amoxicillin DT vs, syrup) was not assessed.

Activity Goals

The primary goals of this activity are to:

- Diagnose: Identify opportunities to improve the quality of private sector health care services provided for children under age five in Tanzania, and especially as it relates to managing childhood illnesses in a more integrated and holistic way.
- Design and Deliver: Work with a range of market actors to develop and test strategies or interventions for improving QoC for sick children (specifically around IMCI use and adherence) and identify what works.
- Adapt and Learn: In the longer term, work with market actors, to identify what is needed to scale and sustain successful interventions and begin supporting interventions for scale-up.

Proposed Approach

In Tanzania, FHM Engage will adopt an iterative, multi-phase process to identify and adapt existing evidence-based strategies and interventions for improving QoC for ill children – including interventions previously tested in the public sector and in other countries. FHM Engage will work in collaboration with country stakeholders – and over multiple years co-design, adapt, and test interventions. This includes identifying implementing partners interested in developing potentially scalable solutions, and testing what may be needed for solutions/interventions to operate sustainably and at scale.

Given that the activity budget will not be sufficient to fund implementation-related tasks, a key assumption is that through an initial consultative process, FHM Engage will be able to identify one or more partners who are both interested in and resourced to support implementation of solutions that might address private sector QoC gaps and priorities in Tanzania.

While FHM Engage will consider the possibility of finding an implementation opportunity via the FHM Engage Tanzania buy-in, as of May 2022, the initial FHM Engage work plan for Tanzania includes a minimal set of child health-related activities – mainly efforts to increase availability of commodities such as amoxicillin dispersible tablets (Amox DT) and oral rehydration salts (ORS) and zinc co-packs in accredited drug dispensing outlets (ADDOs) and potentially extend IMCI training to private clinical providers. These may or may not provide an appropriate springboard to design a holistic, QoC-focused intervention.

A detailed outline of what FHM Engage aims to accomplish at each stage of the project can be found below within the High-level Activity Overview section. An outline of specific tasks for Phase 1, can be found under Task Plan – Phase 1.

What types of interventions might be in scope for eventual testing?

While studies have approached QoC from the perspective of adherence to IMCI protocols, our proposed approach for this activity is to take a broader market system perspective and look to identify what may needed from a range of different market/system actors to implement effective IMCI and/or address other priority gaps in QoC, if warranted.

The WHO and UNICEF have noted that IMCI requires a system-wide approach involving a range of stakeholders, and the delivery of three core component strategies: (1) improving skills of health workers, (2) health system strengthening and (3) improving family and community practices. Additional WHO guidelines for IMCI implementation include:

- Regular review and updating of IMCI clinical guidelines with adaptation to the country and health system context.
- Delivering training, mentoring and supportive supervision of health workers in integrated assessment, treatment, and effective counseling of caregivers.
- Ensuring availability of the essential medicines, laboratory tests, and key equipment for prevention and case management.
- Strengthening referral pathways and improving QoC in hospitals for management of severely ill children referred from the outpatient clinics or the community.
- Social and behavior change (SBC) activities for families and communities to prevent to prevent disease, seek timely care from qualified health care providers for illness, provide adequate home care for sick children, and support children's healthy growth and development.

Just as the WHO guidance articulates that IMCI is a strategy requiring a whole-systems approach to be implemented effectively, systematic reviews on the barriers and enablers to effective IMCI implementation have demonstrated that to understand the root causes behind and address gaps in IMCI QoC, a health systems perspective is also required (MOMENTUM, 2022).

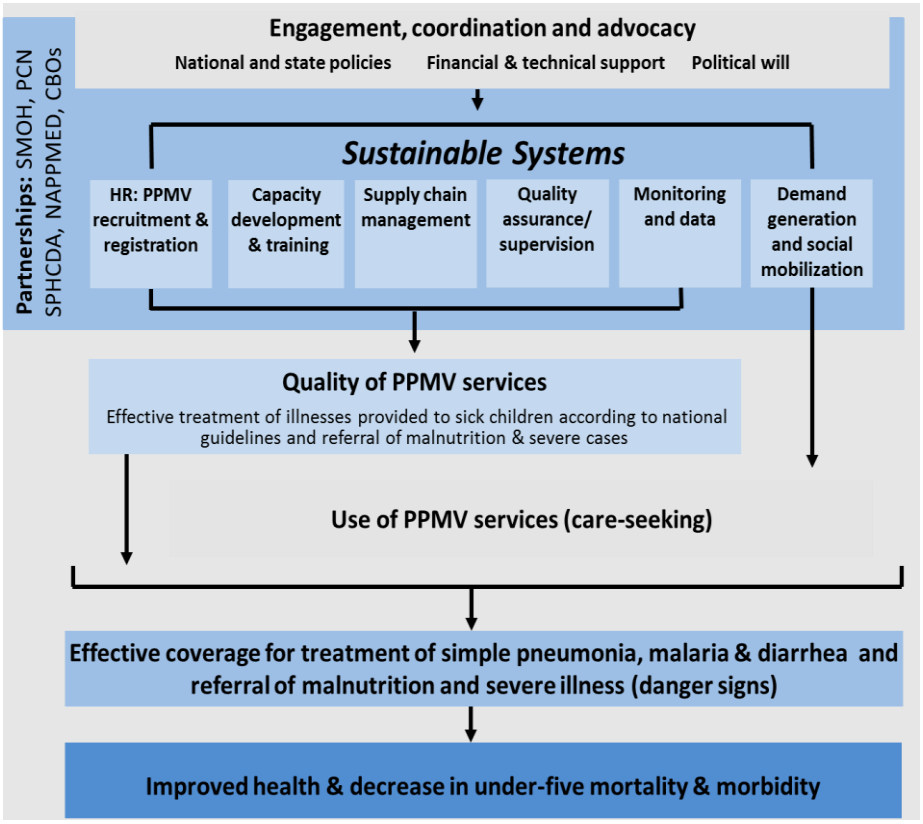
Building on this learning, our proposed approach for this work is to undertake a diagnosis of the problem and opportunities by first consulting with Tanzanian stakeholders (including USAID/Tanzania and members of FHM Engage in Tanzania), adopt a broader systems-lens, to first identify the priority system needs and system actor priorities for improving QoC and better implementing IMCI. The stakeholder consultation phase will include key informant interviews (KIIs) with government officials at the national and sub-national level, implementing partners currently implementing any programming that relates to IMCI, and a purposively selected group of clinical providers and ADDOs in three regions where IMCI programming is known to have included or engaged private sector actors. The information gathered from the KIIs will inform a co-creation workshop in which stakeholders will collectively review findings on barriers and facilitators to IMCI adherence and use in the private sector and identify opportunities to implement and test solutions for improving QoC. Opportunities identified in Phase 1 will be further developed into intervention strategies which can be lean tested in Phase 2, pending funding availability. In practice this could include a wide range of different intervention types, including strengthening or implementing:

- Training
- Supportive supervision
- Job aides
- Reporting tools (including digital case management solutions for health workers)
- Referral tools and processes
- Community SBC initiatives
- Working with market stakeholders to facilitate access to essential medical supplies
- Stewardship structures overseeing QoC and IMCI implementation in the private sector

A systematic review of more than 600 interventions for improving health care providers' QoC has identified that there is no single intervention or solution that is proven to consistently deliver positive impact across a range of contexts and use cases (Rowe, 2018), suggesting that improvements in IMCI are less likely with only single-strategy solutions (e.g. strategies with a single emphasis like training, supportive supervision, and/or product availability). For our work, FHM Engage intends to be solution agnostic and guided by findings that emerge through our stakeholder consultation.

Given that IMCI requires a system-wide approach, one model which may have potential value is that of the USAID-funded Maternal Child Survival Program (MCSP)'s Enhancing Quality iCCM through Proprietary and Patent Medical Vendors (PPMV) and Partnerships (EQuiPP) approach. EQuiPP sought to improve PPMV's engagement in iCCM implementation by testing a range of supporting and integrated interventions (including interventions that strengthened training, supervision, and access to medical supplies). Notably the origin of EQuiPP was an interest by USAID/Nigeria to increase the availability of Amox DT in PPMVs, which is similar to USAID/Tanzania's interest in improving the availability of Amox DT and Zinc/ORS co-packs in ADDOs. EQuiPP emerged because of MCSP stakeholder consultation that concluded that simply making Amox DT more available in PPMVs was insufficient to affect the child health outcomes sought (e.g., increased/improved treatment of childhood illnesses and ultimately reduced child mortality and morbidity). The approach that MCSP eventually developed (Figure 1) was multi-faceted and involved a range of public and private actors. Given similarities between ADDOs and PPMVs, EQuiPP could provide a potential starting place from which to adapt and develop an approach in Tanzania.

FIGURE 1: EQUIPP APPROACH AND THEORY OF CHANGE



What health providers are in scope for this activity?

While this work will focus on private sector providers, it is not yet clear which type(s) of providers will be the focus of any subsequent intervention. Our intention is to include ecosystem stakeholders in our discussions, to understand the specific in-country priorities and opportunities relating to improving care, before deciding on the target providers for this activity.

To date FHM Engage has identified three initial options that will be explored with stakeholders, including:

1. WORKING TO IMPROVE THE QOC OF PRIVATE CLINICAL PROVIDERS: Based on the recent analysis of IMCI adherence across the public and private clinical providers in Tanzania, it is clear there are gaps in the provision of and/or adherence to IMCI by this provider type (SHOPS Plus, 2021). Given differences in training levels and exposure to IMCI concepts during pre-service training, interventions to address gaps would likely need to consider and be differentiated by cadre (e.g., medical doctors vs. mid-level providers like nurses or clinical officers). However, regardless of cadre, there is currently little focus or inclusion of private clinical facilities or providers in interventions with IMCI components. For example, at the Tanzania Ministry of Health's Reproductive and Child Health Section's annual planning meeting in August 2022, there was virtually no emphasis on IMCI in private clinical settings, and there are few (if any) implementing partners whose programming includes a substantial number of private sector clinical providers.
2. WORKING TO IMPROVE THE QOC AT ADDOS: These community-level providers are trained according to national policies to deliver cadre-appropriate elements of IMCI, including asking questions about danger signs and conditions, categorizing symptoms, and referring patients to a clinical facility. Based on DHS analysis from the SHOPS Plus project (2018), private non-clinical providers including ADDOs were a source of treatment or advice for a substantial proportion (43%) of caregivers of sick children. Despite this, a SHOPS project analysis on ADDO adherence to IMCI (SHOPS, 2012) found significant gaps in the extent to which ADDOs were fulfilling functions on which they were trained. ADDOs are also somewhat limited in their abilities to implement IMCI because they are not authorized to stock and sell key commodities needed to treat diagnose and treat key child illnesses. This option may not be as fruitful as the other option due to the evolving policy context. As of July 1, 2022, the Government of Tanzania is pausing all registration and training of new ADDOs to be better able to regulate supervise, and re-train ADDOs in a sustainable way at scale. At the same time the Government of Tanzania is grappling with a glut of trained clinical health workers, which is prompting policy level discussions on how ADDOs are positioned and used in the health system.
3. WORKING ACROSS A RANGE OF PROVIDER TYPES: By doing this, we can aim to support more integrated and higher quality care across health systems. For example, while interventions to improve linkages between ADDOs, community health workers, and public health have showed potential promise (Dillip et al, 2017), sustainability and scaling challenges suggest further need model refinement.

High-level Activity Overview

Phase 1 (Year1 Q3 to Year 2 Q2) – Consult with stakeholders to diagnose and identify an initial design

The focus for the first phase of this activity (through Year 2 Q2 2023) will be to diagnose the problem(s) this activity will seek to research by conducting stakeholder interviews to identify the factors affecting IMCI use and adherence, priority areas and opportunities for interventions, and opportunities to partner with implementing organizations to develop and test interventions and strategies in Year 2. Once interviews are complete, FHM Engage will conduct co-design activities (e.g., via an in-country workshop) and develop a draft Theory of Change (ToC) with wider system actors (such as public sector, private sector, and/or donors). Using the ToC, we will identify formative research and baseline data collection needs and identify model components to test for efficacy and suitability as the intervention is further developed and implemented in Phase 2.

Phase 2 (Year 2 Q3 to Year 3 Q1) – Iteratively design (with lean testing) and deliver (via a partner)

During Phase 2, assuming availability of resources to implement both a technical activity with an integrated research component to address prioritized QoC gaps identified in Phase 2, FHM Engage intends to adopt an adaptive learning approach, which may incorporate lean testing of interventions at a relatively small scale. Phase 2 testing approach will be informed by the assumptions in the intervention ToC and may use a variety of qualitative or quantitative methods (e.g., surveys, analysis of service delivery data, observations, and/or interviews and focus groups). Testing protocols will need to be reviewed and approved by an appropriate, local institutional review board and supplemented with learning checks with partners and other stakeholders. These learning checks will provide partners with opportunities to use the insights from testing to make iterative design decisions about the types of interventions that should be implemented for improving QoC for sick children. These decisions will inform subsequent rounds of experimentation and testing – and will allow the team, over time, to develop and adapt the draft ToC developed in Phase 1, which articulates how different interventions improve QoC.

Additional Phases (Year 3 Q2, onward) – Adapt, learn, and (potentially) scale

We anticipate that at the beginning of any subsequent phases of work, a case study report will be produced to share learning from Phase 2 – including what strategies and interventions are likely to prove most effective at improving IMCI adherence, and any emerging considerations relating to known ecosystem and market development needs for implementing these solutions (including minimum core functions, institutional arrangements, and capacity). If feasible and pending the availability of budget and mission buy-in, FHM Engage could expand the intervention tested in Phase 2 into a larger scale (and more robust) implementation and research effort to test the efficacy of proposed interventions and solutions. This would require larger funding than Phase 2 to take on a more robust study design. FHM

Engage's long-term vision for the project, once it is understood 'what works' for improving QoC, will be to understand how to effectively scale and sustain these solutions. FHM Engage could consider supporting implementing partners to scale solutions, by providing adaptive learning support, to help implementing teams adopt an implementation science approach, and conduct experiments to learn what is needed to scale. By combining an adaptive learning approach with an implementation science approach, FHM Engage hopes to be able to de-risk the process by which solutions are scaled – by conducting short experiments to quickly establish what models for scale are likely to be sustainable – before any considerable investment is spent supporting solutions for scale.

Task Plan – Phase 1

Table 1 below provides a summary of the Phase 1 task plan and is followed by detailed descriptions of each task.

TABLE 1: SUMMARY OF PHASE 1 TASKS

Activity	Estimated Timing
Conduct literature review	May 2022 (complete)
Develop concept note, consult with USAID/Washington Child Health Team and USAID/Tanzania, obtain mission concurrence	May-August 2022 (complete)
Conduct stakeholder consultation and KIIs	September-October 2022 (in-progress)
Host workshop to explore and co-design intervention options with relevant system actors	November 2022
Develop analysis brief summarizing the facilitators and barriers to IMCI in the private sector, the co-created strategies to improve adherence, and associated learning activities (formative research, baseline, and/or lean testing opportunities)	January 2023

Global Literature Review [April to May 2022 – complete]

Look through existing literature to identify the key factors that affect QoC (and IMCI implementation) across different countries, and in Tanzania (including the private sector) specifically. Gain a stronger understanding of needs and priorities relating to QoC in the Tanzanian private sector (which we will build on via stakeholder consultations). Identify existing strategies and interventions for improving QoC (and the relative evidence base for each) globally and within Tanzania.

Output: Literature review

Tanzania Mission Consultation [August 2022]

Engage USAID/Tanzania and identify any specific priority and opportunity areas for improving QoC in the private sector, that can help to inform the focus for this work.

Output: Mission concurrence

Stakeholder Consultation [September to October 2022]

Consult with ecosystem stakeholders (private sector representatives, Ministry of Health, donors, implementers) – to understand more about the specific needs, priorities, and barriers affecting QoC for ill children in Tanzanian private sector (as well as effective IMCI intervention specifically). Identify partners, including implementing organizations, with whom FHM Engage could potentially partner with in Year 2 for testing interventions aimed at improving IMCI adherence and use.

Outputs: Produce findings summary that identifies what has been learned in relation to the performance, needs, priorities, and barriers affecting IMCI adherence and use in the private sector. Including details on:

- → The stakeholders' understanding/prioritization of IMCI in the Tanzanian private sector (including any specific priority areas/provider types where intervention could have the biggest impact)
- → The role different market actors, institutions, structures, and incentives currently play in shaping the use of and adherence to IMCI
- → The needs and barriers affecting IMCI
- → The types of interventions that may be most appropriate for addressing needs and barriers for IMCI

Co-design activities [November 2022]

Co-design workshop with implementing partners and other ecosystem stakeholders to co-create and/or adapt/expand existing IMCI-related interventions for testing in private sector settings in Phase 2.

Output: Synthesis report from the co-design workshop with private sector child health stakeholders to articulate strategies for improving private sector IMCI adherence

Analysis Brief with Testing Opportunities Identified [January 2023]

Based on outputs of a co-design workshop, FHM Engage will identify aspects of the strategies and interventions for potential testing in Phase 2. The brief would outline potential features of ToC for the proposed intervention, the assumptions, the experiments, and associated methodologies, indicators, and timescales.

Output: Analysis brief summarizing the facilitators and barriers to IMCI in the private sector, co-created strategies to improve adherence and associated learning activities (formative research, baseline, and/or lean testing opportunities)

About FHM Engage

Frontier Health Markets (FHM) Engage is a five-year cooperative agreement (7200AA21CA00027) funded by the United States Agency for International Development. We work to improve the market environment for greater private sector participation in the delivery of health products and services and to improve equal access to and uptake of high-quality consumer driven health products, services, and information. Chemonics International implements FHM Engage in collaboration with Core Partners: Results for Development (co-technical lead), Pathfinder, and Zenysis. FHM Engage Network Implementation Partners include ACCESS Health India, Africa Christian Health Association Platform, Africa Healthcare Federation, Amref Health Africa, Ariadne Labs, CERRHUD, Insight Health Advisors, Makerere University School of Public Health, Metrics for Management, Solina Group, Strategic Purchasing Africa Resource Center, Scope Impact, Stage Six, Strathmore University, Total Family Health Organization, and Ubora Institute.

1275 New Jersey Ave. SE, Ste 200,
Washington, DC 20003