Question 2: *What are effective and sustainable mechanisms or processes to integrate local, community, sub-national, national, and regional voices, priorities, and contributions into health system strengthening efforts?*

# Facilitating Uganda's private health sector stakeholders to drive improved Quality of Care: Self-regulatory Quality Improvement System Plus (SQIS+)

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## Context

- The Lancet Global Health Commission on High Quality Health Systems in the Sustainable Development Goal Era (2018) emphasizes that poor quality care is a bigger barrier to reducing mortality in low- and middle-income countries (LMICs) than insufficient access. Quality matters for equity: poor and vulnerable groups experience worse quality care. Systematic reviews show that quality of care (QoC) tends to be even lower in the private sector than the public sector, but with significant variation. The Lancet Commission emphasizes that improving quality in the private sector is challenging: regulatory bodies tend to be under-resourced and under-capacitated. Partnership models of private sector engagement, that ensure the private sector and their representative bodies are actively involved as stakeholders in designing reforms and improvement strategies, tend to be lacking in most LMICS. This can lead to ineffective approaches that do not fit well the needs of the private sector, and that have low legitimacy and compliance. Self regulation through professional associations is underutilized in LMICs but has been an important driver of quality in high-income contexts.

- Uganda has a dynamic public-private health system, and the private health sector is expanding rapidly, especially in cities and peri-urban locales. As of 2023, the country has over 4000 private health facilities, over 10,000 drug shops and pharmacies, and over 2000 diagnostic units and standalone medical centers. In Kampala, the capital city, private service delivery points (SDPs) make up 94% of all the city's 1497 health facilities (N=1497), of which 96% are private-for-profit SDPs. Approximately 60% of Kampala residents reside in informal settlements (slums), and many of these private SDPs serve the urban poor.

- Uganda's Ministry of Health (MOH) regulates healthcare provision in Uganda in partnership with medical councils (MCs), health professional associations (HPAs), and local governments. The MOH is responsible for legislating standards of education and practice set by the MCs, HPAs facilitate member access to guidelines, protocols, and continuing professional development to adhere to these standards, and both MCs and HPAs jointly monitor adherence and censure health facilities and individual practitioners failing to perform appropriately. When facilities and providers are censured, the local government administers warnings, suspensions and sometimes closures against those who fail to comply.

- In practice, the regulation of private SDPs in Uganda has been hamstrung by a myriad of challenges including ill-defined rules for a poorly understood private health sector, limited statutory powers, and inadequately resourced and understaffed regulatory bodies to monitor and enforce adherence to standards in a context with politicians who are highly invested in the private health sector and health workers who depend on income from fee-paying clients. Altogether, these factors make formal regulation very difficult. According to the 2020 findings from a preliminary SQIS+ assessment exercise with 2170 private SDPs in Metropolitan Kampala (Kampala, Mukono, and Wakiso) by the MOH, Uganda Medical and Dental Practitioners Council and Uganda Healthcare Federation (UHF), 35% of private SDPs lack a current health facility registration certificate, 28% of private SDPs lack a current annual operating license, and 82% lack a current health facility trading license. Additionally, some of the health workers were practicing with an expired license, and few facilities received supervision in the past 12 months. Inadequate regulation contributes to variable QoC.

## Activity Description

**Self-regulatory Quality Improvement System Plus (SQIS+) Development**

- To drive up standards, the MOH and private health sector collaborated in partnership to develop a self regulation model to improve QoC, rather than trying to impose a top-down model. Spearheaded by UHF, an umbrella entity of all the HPAs and representative of all private health entities in Uganda, the partnership model ensured that all stakeholders were involved in the design of reforms; voices that are often unrepresented in policy design.

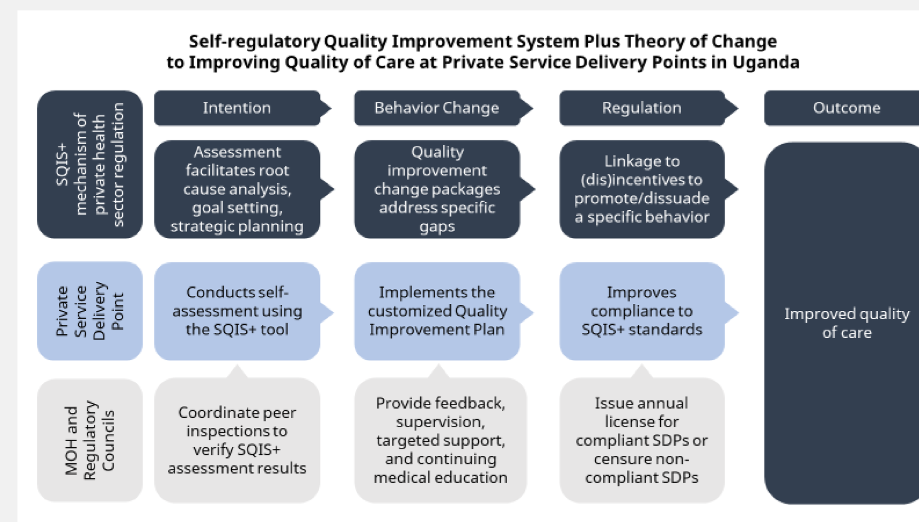
- The model links self-regulation to health facility annual licensure (Figure 1, *Theory of Change*). UHF and the MOH worked with the Council for Health Service Accreditation of Southern Africa (COHSASA), the only internationally recognized, quality improvement accreditation body for healthcare facilities in Sub-Saharan Africa.

- UHF, supported by USAID/Uganda Private Health Support Program (2013-2018), and in collaboration with the MOH, Kampala Capital City Authority, and the regulatory councils (MCs and HPAs), developed, tested, and piloted the initial Self-regulatory Quality Improvement System (SQIS) tool, which was launched by the MOH in 2016. The SQIS tool, drawn from existing MOH quality assurance (QA) and quality improvements (QI) and Self Care tools, was a comprehensive checklist on 16 basic health management standards for primary health care (PHC) facilities only, and utilized a 'yes' or 'no' scoring system with weighted scoring to profile facilities' scope of services and infrastructure.

- Working closely with the regulatory councils and the MOH Standard Compliance Accreditation and Patient Protection Department, UHF coordinated the revision of the SQIS into the digital SQIS plus (SQIS+) with support from MasterCard Foundation. USAID/ Maternal Child Health and Nutrition (MCHN) Activity (2020-2024) provided technical assistance in the revision of the tool, including strengthening of the maternal child health and nutrition assessments under the Maternity Service Element. The SQIS+ tool expanded beyond PHC to cover relevant standards for specialist units and standalone services (e.g., dentistry, ophthalmology, radiology, laboratory, and pharmacy), and featured a more nuanced scoring system of compliant, partially compliant, and not compliant. UHF engaged both private and public stakeholders through the MOH Supervision Monitoring Evaluation and Research Technical Working Group to critically review and input into the SQIS+. The digitized tool automatically generates a dashboard with analytics to guide informed decision-making at the health facility level. Since its launch in August 2022 by the MOH, the digitized SQIS+ was made mandatory for all private SDPs and its compliance is linked to the issuance of the health facility annual licenses by the regulatory councils through the e-licensing portal.

- Notably, peer-to-peer inspection is incorporated in this model to enhance accountability of self-regulation and address limitations of self-reported data. The regulatory councils identify peers (providers from other private SDPs) to conduct the SQIS+ assessment alongside the site conducting its self-assessment. This process enables the regulatory councils to verify the results and issue the annual license for compliant sites and censure non-compliant sites.

**Figure 1. SQIS+ theory of change**




**SQIS+ improvement collaborative implementation in Kampala**

- With support from USAID MCHN Activity, UHF launched a SQIS+ improvement collaborative with 12 private SDPs in Kampala (5 hospitals, 2 medical centers, and 5 clinics; 2 PNFP and 10 PFPs) that had high-volumes of maternity clients.
- The collaborative prioritized improving four service elements: 1) leadership, governance, and management; 2) maternity services; 3) health education and promotion; and 4) infection prevention and control we envisaged that their improvement would also positively impact the other SQIS+ service elements .
- UHF QI coaches provided technical assistance to the private SDPs' QI leads to carryout the self-assessment with the person in-charge for each service domain. The data were collected and entered onto the free tool hosted on the MOH server (http://sqis.health.go.ug/).
- The tool automatically scored the overall assessment and by service domain and generated data analytics on compliance. In addition, the tool generated a customized QI plan based on the identified gaps.
- UHF QI coaches worked with the facility to implement the QI action plan to improve its compliance and re-assesses after 12 months. A facility that attained an overall score of 85% and above was considered compliant and qualified for the annual license.

## Activity Impact

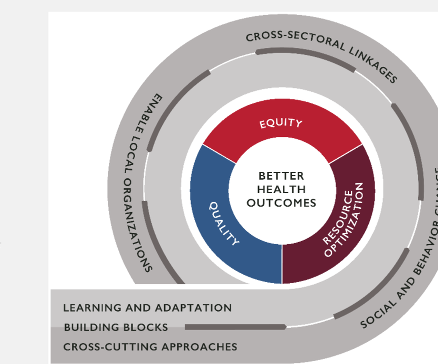
**How SQIS+ strengthens the health system**

- The SQIS+ approach is fundamentally about governance: how the MOH engages in a partnership mode with the private sector and its representative bodies to design a self-regulation approach that is owned by those stakeholders. By giving these bodies the privilege and responsibility of self-regulation, it promotes professionalism, the sense of accountability among professionals to people, and reduces transaction costs to government.

- At the service delivery level, SQIS+ strengthens the private SDPs by bringing data on service delivery readiness and quality of care. The digital tool automatically analyzes the SQIS+ assessment and summarizes results on the dashboard, facilitating easy identification of priority areas for improvement and resource allocations to address gaps. MOH structures, HPAs and MCs, and the USAID MCHN Activity provide practical support to help translate this data into improved service delivery (e.g., through training on QI). The links to licensing provide the incentives to comply with the system and actively work towards improved outcomes.

- This approach supports all dimensions of the USAID Vision for Health System Strengthening (Figure 2):
  - It improves **equity** by strengthening the quality of care amongst private SDPs that serve the urban poor
  - It improves **quality** by strengthening governance processes for ensuring quality across the private sector, particularly by linking with systems for licensing and regulation and mobilizing the private sector to self-regulate and use its capacity and structures to drive improved quality.
  - It improves **resource optimization** by reducing the quality assurance and regulation costs of the MOH, because more self-regulation is done through the private sector. Improved quality of care will also improve the efficiency of health spending.

**Figure 2. USAID Vision for HSS**




**How engagement of new voices contributed to impact**

- SQIS+ was driven by UHF and its private sector provider and health worker association members. Their strong involvement in the design meant that it was appropriate and tailored for their need and challenges, and they had strong buy-in and ownership which drove its enthusiastic adoption.

- Many countries have struggled to constructively involve private sector representatives in a partnership mode; as such, SQIS+ is an exemplar of how to engage the private sector in a partnership mode so that it drives quality within itself.

## Evidence

- Twelve private SDPs participated in the SQIS+ assessment. Between baseline and endline, the average compliance score increased by eight percentage points from 79% to 87% (Table 1). Disaggregated by facility types, clinics made the largest gains with an 11-percentage point increase in its compliance score, followed by medical centers with a 9-percentage point increase, and hospitals with a 3-percentage point increase (Table 1).

- The overall number of private SDPs that met compliance with an overall score of ≥85% increased from seven to nine and they qualified for health facility annual licensure in 2023 (Table 1).

- The 12 private health facilities implemented QI changes according to its customized QI plan. Figure 3 illustrates average compliance scores at baseline and endline by service elements.

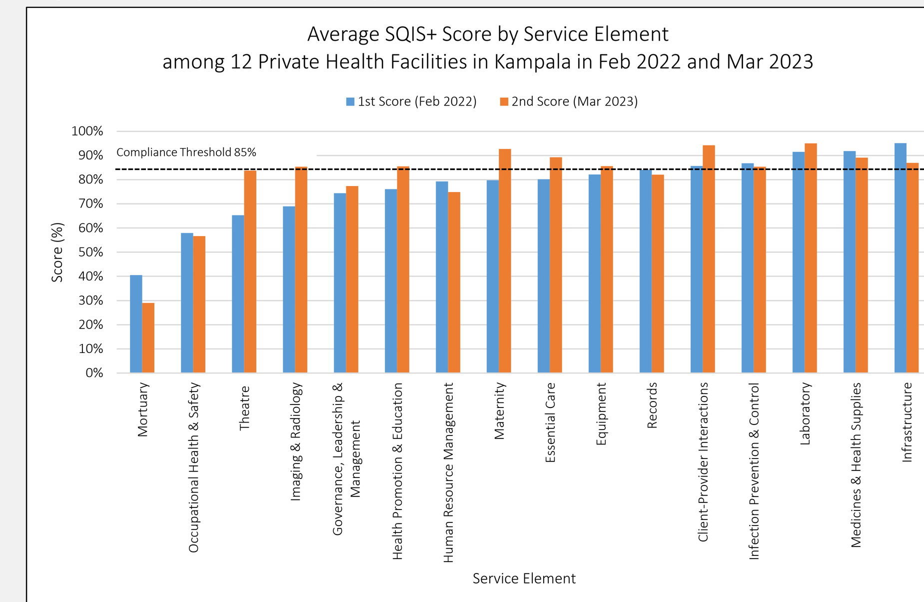
- Among the collaborative's prioritized service domains, governance, leadership and management improved from 74% to 77%, health promotion and education improved from 76% to 86%, maternity services improved from 80% to 93%, and infection, prevention and control improved from 85% to 87% (Figure 3).

**Table 1. Average Overall SQIS+ Score**

| Facility (names anonymized) | 1st Overall Score (Feb 2022) | 2nd Overall Score (Mar 2023) | Qualified for health facility annual licensure |
|---|---|---|---|
| Clinic 1 | 84% | 94% | √ |
| Clinic 2 | 76% | 91% | √ |
| Clinic 3 | 76% | 70% | X |
| Clinic 4 | 64% | 65% | X |
| Clinic 5 | 50% | 86% | √ |
| Medical center 1 | 89% | 90% | √ |
| Medical center 2 | 75% | 92% | √ |
| Hospital 1 | 90% | 82% | X |
| Hospital 2 | 93% | 93% | √ |
| Hospital 3 | 88% | 95% | √ |
| Hospital 4 | 80% | 92% | √ |
| Hospital 5 | 85% | 91% | √ |
| Total Average (N=12) | 79% | 87% | |

| Facility Type | Average 1st Overall Score (Feb 2022) | Average 2nd Overall Score (Mar 2023) | Change in Percentage Point |
|---|---|---|---|
| Clinic (n=5) | 70% | 81% | 11% |
| Medical center (n=2) | 82% | 91% | 9% |
| Hospital (n=5) | 87% | 91% | 3% |

**Figure 3. Average SQIS+ Score by Service Elements**




**Spotlight on improving SQIS+ compliance and QoC in maternity services**

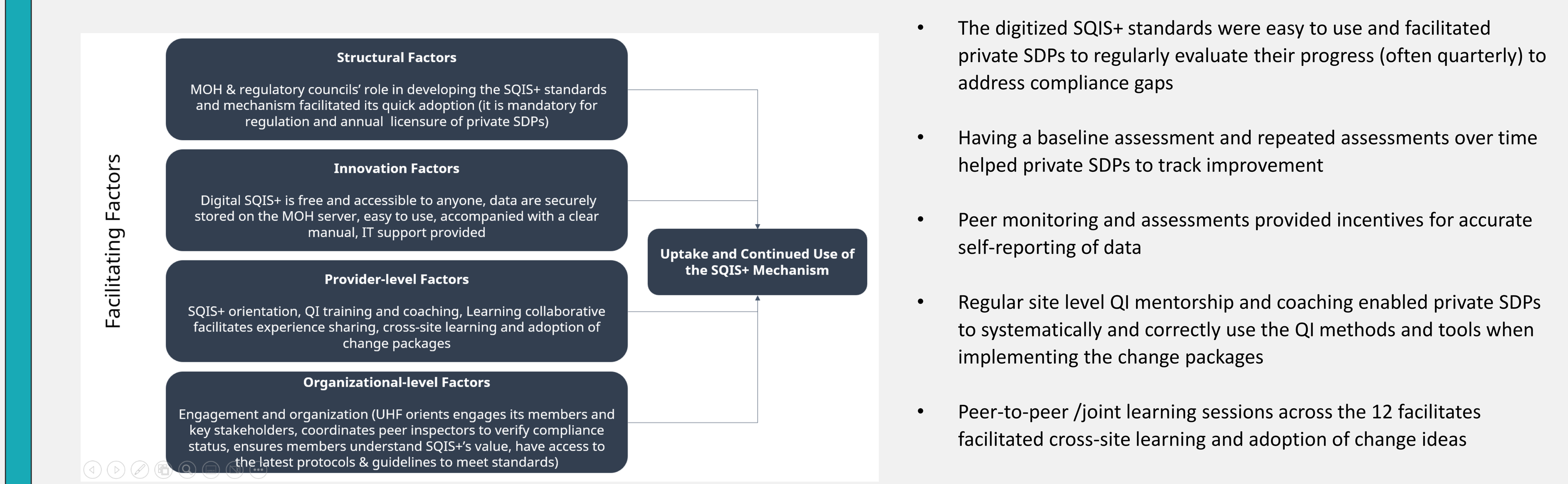
- Overall, maternity services improved by 13 percentage points from 80% at baseline to 93% at endline.

- Facilities implemented different tested changes according to its customized QI Plan.
  - Three clinics addressed the issue of clients missing some essential tests during antenatal care (ANC) by embedding the costs of essential tests in the ANC package to cater for missing tests.
  - Three hospitals and two clinics addressed low or no partograph use for monitoring mothers in labor by redesigning the admission booklet to include partograph or attaching a blank partograph in the patient's admission files.
  - Three clinics addressed knowledge gaps on goal-oriented antenatal care (ANC) by getting the goal-oriented standard operating procedures and mentorship.
  - Four hospitals and five clinics addressed the issue of poor documentation of nutrition services by appointing a nutrition focal person to oversee nutrition services, including its documentation, and providing targeted mentorship for health workers on documentation and categorization of nutrition services in the register

## Facilitators

Overall, facilitating factors to the uptake and continued use of SQIS+ can be grouped by structural, innovation, provider-level, and organizational-level factors (Figure 4).

**Figure 4. Facilitating factors for uptake and continued use of SQIS+**




**Specific examples:**

- The digitized SQIS+ standards were easy to use and facilitated private SDPs to regularly evaluate their progress (often quarterly) to address compliance gaps
- Having a baseline assessment and repeated assessments over time helped private SDPs to track improvement
- Peer monitoring and assessments provided incentives for accurate self-reporting of data
- Regular site level QI mentorship and coaching enabled private SDPs to systematically and correctly use the QI methods and tools when implementing the change packages
- Peer-to-peer /joint learning sessions across the 12 facilitates facilitated cross-site learning and adoption of change ideas

## Challenges

- **High staff turnover affected effectiveness and continuity of QI interventions.** Frequent staff turnover is common in private SDPs in Kampala. For example, four out of five QI team members at a hospital were relocated to work at a newly opened branch outside Kampala. QI Coaches had to reorient newly recruited health workers and leveraged the remaining staff from the original QI team to guide colleagues.

- **Health facility leadership was not responsive to the needs of teams implementing QI interventions, especially when facility had competing priorities and inadequate funds for all needs**. Initially, health facility leadership were not responsive to the needs of the QI teams. They had to be sensitized on the multiple benefits of QI – that QI strengthens not only QoC but also institutional development and performance – in order to lend their support to QI interventions. This was especially challenging for facilities had competing priorities and limited funds to address the multiple needs.

- **Large facilities had more cumbersome administrative processes that affected outcomes**. Large health facilities had more cumbersome administrative processes than smaller health facilities, especially on requisitioning and approval of activities. Health facility QI teams had to lobby their departmental heads to support QI projects by showcasing the benefits that were realized from the initial efforts. Inviting departmental heads to attend the QI meetings to appreciate the outcomes was helpful.

## Lessons Learned

- **Partnership model key for acceptability:** A partnership model between the MOH and private sector representative bodies can generate important and successful reform initiatives that have high legitimacy and compliance, even in contexts where there are institutional and political economy challenges impeding greater private sector regulation. By ensuring that private sector stakeholders are intimately involved in the design, it is feasible to implement ambitious reform initiatives – e.g., linking quality improvement to relicensing – that would be hard to enforce through top-down reform efforts.

- **Role of USAID MCHN Activity:** An external project can play a catalytical role by supporting engagement between government and the private sector and facilitating stakeholders (private sector federations and worker associations) to play key roles in the reform process.

- **Self-regulation can drive improvements in quality of care in the private health sector:** The Lancet Global Health Commission on High Quality Health Systems sets out that self regulation, through professional associations, is a potentially important mechanism to raise quality of care in the private sector, but that it has not been used much in LMICs. The Uganda experience shows that it is feasible and can be used to drive meaningful improvements in quality in short periods of time.

- **Regulator bodies facilitate acceptance:** Regulatory bodies such as medical councils play a central role in facilitating acceptance and adoption of standards in private sector especially where tools/policies are made mandatory and attached to the licensing process.

- **Peer assessments for accountability:** Combining self assessments with peer assessments by other private facilities is a potentially effective means of ensuring avoiding data falsification and is imperative if data is to be linked to relicensing.

- **Quality improvement changes easier to realize in small and medium sized facilities:** It is easier for small and medium sized health facilities (health center IIs & IIIs) to realize improvements in QI interventions using the SQIS+ standards compared to the large-sized facilities (hospitals). This is possibly because of the differences in management and decision-making structures but also the complexity and dynamics surrounding hospitals.

## Next steps

- Continue scale-up of SQIS+ across private SDPs across the country using the lessons from Kampala.

- Just as SQIS+ is mandatory for annual licensure of health facilities, UHF is working with the Pharmaceutical Society of Uganda to lobby the National Drug Authority to make SQIS+ a mandatory requirement for annual licensure of pharmacies.