SECURING THIRD-PARTY FINANCING THROUGH ACCREDITATION-LEVEL QUALITY
LESSONS LEARNED FROM IMPLEMENTATION OF SAFECARE IN UGANDA

INTRODUCTION

Under USAID's Support for International Family Planning and Health Organizations 2 (SIFPO2) project, Population Services International (PSI) and PharmAccess Foundation (PharmAccess) sought to test how to financially sustain high quality, equitable health outcomes through social franchises. The social franchise networks that were the focus of this work were predominantly donor-supported and "fractionally-franchised" family planning (FP) services.

At the outset of SIFPO2, dialogue was taking place in Uganda among numerous private and public actors around introducing a third-party payer mechanism to leverage private health sector resources and allow more equitable access to these facilities. SIFPO2 saw an opportunity to test if improving quality towards established accreditation standards could lead to securing third-party financing for such franchises in a real-world setting.

This initiative assumed that implementing a recognized quality improvement (QI) program would provide the transparency and trust that third-party payers require when selecting providers. As many large internationally-accepted accreditation programs are not limited to one health area,[1] and the role of accreditation in improving quality of care is still largely unproven,[2] SIFPO2 acknowledged that this initiative may not result in a measurable improvement in FP-related outcomes. However, the assumption was that general quality may improve FP outcomes, while third-party financing of private facilities could, if realized, improve FP equity and outcomes in private facilities long-term, with reduced need for donor subsidy.

Under this activity, SIFPO2 introduced PharmAccess's SafeCare QI model into a subset of private sector clinics within PSI Uganda's ProFam social franchise network. SafeCare's

1. Tabrizi, J., Farid Gharibi, Andrew Wilson. *Advantages and Disadvantages of Health Care Accreditation Models.* Health Promotion Perspectices. 2011; 1(1): 1-31. Accessed March 28, 2020.

2. Brubakk, K., Gunn E. Vist, Geir Bukholm, Paul Barach, Ole Tjomsland. *A systematic review of hospital accreditation: the challenges of measuring complex intervention effects.* BMC Health Serv Res. 2015; 15: 280. Accessed March 28, 2020.

aim is to catalyze broad, continuous health care improvement by creating transparency around performance and by making quality data actionable for purchasers, providers and patients. To manage SafeCare implementation costs and encourage localization of the approach, the activity included a licensing model with the Uganda HealthCare Federation (UHF), a national member association representing the interests of the private health sector in Uganda. UHF also ensured links with other QI initiatives under the Ministry of Health (MoH).

Uganda Healthcare Federation (UHF) is a Ugandan membership association founded with USAID/Uganda support in 2010 to champion the interests of the private health sector in Uganda. Its membership comprises more than 55 non-state health associations and organizations in Uganda, including service providers, health professionals, distributors and manufacturers, as well as civil society partners. UHF offers its members opportunities to contribute to health sector policy discussions and to access the latest health sector information. UHF also provides access to fee-based and subsidized training, professional development and capacity building opportunities.

PURPOSE AND METHODOLOGY

This brief captures learning from the implementation of the SafeCare approach to QI within the Ugandan context under SIFPO2 from 2016 to 2019. It discusses:

- Participation and performance of providers in the SafeCare program
- Experiences and perceptions of SIFPO2 partners and the MoH
- Market and government engagement in the SafeCare program

The brief drew on primary and secondary data sources. Primary data was collected through key informant interviews with:

- Nine private providers, including owners and managers (herein referred to collectively as "providers"), participating in the SafeCare activity
- Activity managers from PharmAccess, UHF and PSI

Secondary data included routine monitoring data from PSI and PharmAccess's SafeCare program documentation. Data was collected in May and August 2019 through site visits and remote interviews with the nine private providers as well as meetings with PSI Uganda in Kampala. Further meetings were held with PharmAccess staff in Kenya and the Netherlands as well as with PSI Washington, DC.

TECHNICAL APPROACH

The SafeCare model, launched in 2010 by PharmAccess, is the first set of standards for resource poor settings accredited by the International Society for Quality in Health Care (ISQua). As of 2018, approximately 2500 health facilities across sub-Saharan Africa have been enrolled in SafeCare in collaboration with 18 implementing partners. These facilities range from primary outpatient health centers to larger tertiary referral hospitals in both the public and

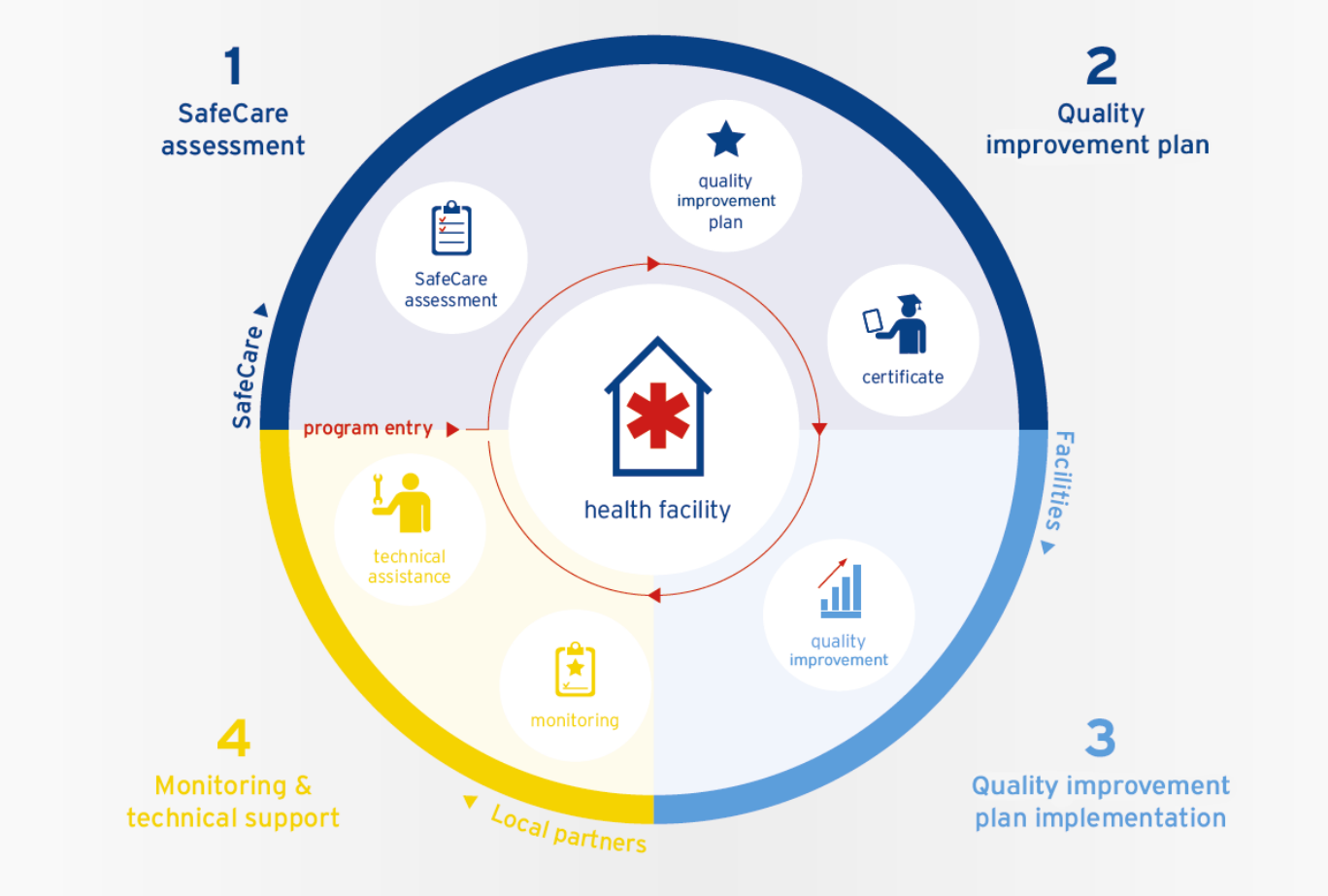


Figure 1: *The SafeCare model developed by PharmAccess*

private sectors. SafeCare has directly contributed to the development of national quality guidelines and standards in countries including Kenya, Tanzania and Uganda.

SafeCare implements a horizontal QI approach using a five-level rating system. "Horizontal" refers to a facility's structural or operational quality. The SafeCare cycle (see Figure 1) starts with a facility assessment that scores 13 service elements important for high quality service delivery, such as leadership and governance, patient rights and responsibilities, inpatient/outpatient and surgical care, diagnostics and medication management. Unlike other pass/fail accreditation programs, the facility is assigned a rating as a "level" amongst a total of five. It then receives a detailed quality improvement plan (QIP) that outlines steps required to progress towards Level 5, the level at which a facility meets accreditation standards. Throughout the next 12-18 months, the facility receives technical support to implement its QIP. At the end of this period, if the facility has completed more than 80% of its QIP, it receives a follow up assessment, final level rating, and certificate of progress. This stepwise approach offers a benchmarked, holistic view of a facility's current scale, scope and management of clinical services. The model is not designed to score or track clinical services related to one vertical health area, e.g., HIV or FP.

At the outset of SIFPO2, PSI and PharmAccess also planned to explore how social franchises supported by PSI could be linked to access to credit, particularly with the Medical Credit Fund managed by PharmAccess. The assumption was that access to credit could directly strengthen the business and its ability to deliver quality healthcare, as well as incentivize the providers to engage with the SafeCare QIPs. However, when SIFPO2 gauged preliminary interest in this activity with PSI Uganda and with providers, the providers were more interested in the SafeCare QI methodology itself, which could theoretically provide better linkages to access to credit or to domestic financing.

The activity's aim shifted to try to demonstrate that an established clinical network, like the ProFam franchise, could improve members' horizontal quality to the standard required to position for, and access, local third-party financing initiatives. For example, at the time, Merck was exploring the possibility of supporting a financing scheme for reproductive health services that would contract with high quality private providers in Uganda. While it was recognized that SafeCare is a costlier and more time-intensive methodology than other quality approaches, its clear applicability to internationally recognized accreditation standards made it a preferred approach to test. This premise acknowledged that the model could be perceived as unaffordable for many facilities if third-party financing did not materialize and subsequently incentivize provider buy-in by the end of the activity.

Prior to SIFPO2, in other countries where SafeCare had been implemented, technical assistance had been provided by PharmAccess staff primarily based in the Netherlands. To implement a more cost-effective strategy under SIFPO2 than in these previous models, PharmAccess negotiated a licensing agreement with UHF to implement parts of the SafeCare approach locally. Under this change, PharmAccess trained two local assessors initially employed by UHF who were authorized to perform SafeCare assessments independently. PharmAccess then worked with UHF to leverage its broader links with non-ProFam providers, in order to enroll additional facilities into the program.

Summary of roles and responsibilities

- SIFPO2/PSI: Overall management and strategic oversight
- PharmAccess: Technical management of SafeCare implementation in Uganda and UHF activities
- PSI Uganda: Oversight of QIP implementation by each ProFam clinic
- UHF: Implementation of independent initial and follow up assessments of clinic's progress against SafeCare standards; engagement with membership and MOH stakeholders

INTERVENTION TIMELINE

The activity launched in 2016. Previous to SIFPO2, PharmAccess had already scoped potential technical assistance partners in Uganda and had identified UHF as having the requisite private health sector experience and existing business capacity skills. PharmAccess provided in depth training, initial shadowing, and ongoing coaching to the two UHF staff hired to conduct initial and follow up assessments. PSI Uganda also received basic training from PharmAccess in order to better orient PSI QI staff to the SafeCare methodology and prepare them to assist facilities to implement their QIPs.

Under this activity, the SafeCare QI approach was combined with PSI's existing QI approach, which focuses on improvements in technical and clinical competence through the ProFam network.[3] PSI Uganda recruited and selected the initial 47 pilot facilities based on the following criteria:

- Demonstrated interest by the facility, and history of responsiveness to PSI staff and programs
- Minimum number of services provided (i.e., provision of outpatient/inpatient services rather than standalone maternity or FP services)
- Satisfactory performance in PSI-supported intervention areas and competent business management
- Expectation that the facility would continue membership in the ProFam network due to demonstrated compliance with ProFam expectations

Because SafeCare conducts an advanced follow up assessment when a facility or provider achieves more than 80% of its QIP, advanced assessments were conducted at different times amongst the initial 47 facilities. 25 of these achieved more than 80% of the QIP within the first year, and received a follow up assessment. An additional 10 reached this stage within the life of the activity, but are still in process of receiving a follow up assessment. The remaining 12 facilities continued to work against their QIPs, but never reached 80% achievement within the life of the activity. Throughout the activity, QI support tapered over time to focus on providers who were more rapidly progressing through the SafeCare certification levels. In order to make most efficient use of resources in the last year of the activity, SIFPO2 focused QI support on the six facilities which had reached Level 4 (pre-accreditation level) in an effort to move them towards accreditation status at Level 5.

3. PSI's Tunza social franchise brand was also introduced in Uganda during the pilot. Where indicated, some providers implementing SafeCare were operating under this brand rather than the ProFam brand.

SIFPO2 partners, led by UHF in country, continued to discuss and publicize the value proposition of SafeCare with the Ugandan MoH and local health care market actors over the course of the activity. UHF also continued to position the SafeCare methodology within the private sector and test the willingness of facilities to pay for subsequent assessments without subsidy. As part of these efforts, in 2018 UHF carried out a rapid market assessment of private sector stakeholders to gauge willingness and ability to pay for SafeCare. The survey showed that fees associated with SafeCare were still perceived as too high for local providers, and confirmed that available loans through the Medical Credit Fund were too large for the incremental improvements providers wanted to make to their services or infrastructure. These findings indicated that ensuring the availability and interest of a third-party purchaser was key in strengthening SafeCare's financial sustainability amongst the private providers involved in the activity.

PharmAccess and UHF's subsidized licensing model included performance elements, such as the completion of market studies and the identification of providers willing to pay for SafeCare. Ultimately, with a lack of facilities willing or able to pay for SafeCare, UHF could not afford to retain the two certified assessors with available funding in the last year of the pilot. These individuals have now been contracted as PharmAccess consultants, available to support local SafeCare assessments on an as-needed basis. SafeCare operational arrangements in Uganda beyond the life of SIFPO2 will continue to evolve as a more financially sustainable model of delivery is defined. Figure 2 provides a timeline and overview of the key interventions implemented during the SafeCare pilot.

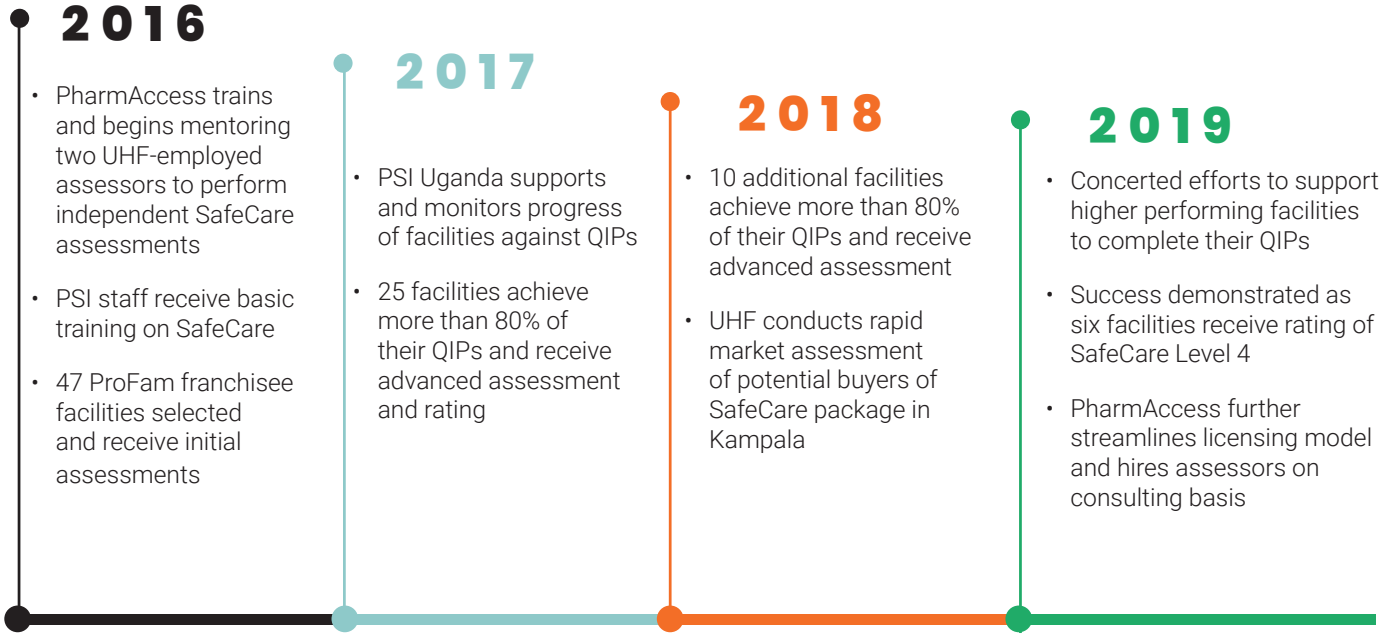


Figure 2: *Pilot timeline and key activities*

RESULTS

Among private providers that progressed with SafeCare, the approach led to measurable horizontal quality improvement according to SafeCare standards. SafeCare provided a more deliberate, transparent and focused strategy to improving overall facility quality, which providers cited as helpful. While PSI Uganda provides QI support for FP services specifically, many facilities indicated that previously, they did not know if they were providing high quality across their services generally, as they had no benchmark for horizontal quality from which to assess themselves. Some providers set up QI teams to guide implementation of their QIPs and were supported by PSI Uganda's QI staff, who provided technical support during quarterly visits.

Figure 3 provides an overview of the change in SafeCare service element scores from the first to second assessment in 25 of the 47 total facilities. These 25 facilities succeeded in implementing 80% of their QIPs during the life of the activity, and were thus eligible for a second assessment. The figure demonstrates marked improvement in scores across all SafeCare service elements.

> ***"SafeCare helped us focus, realize what we are supposed to do."***
>
> (ProFam provider implementing SafeCare)

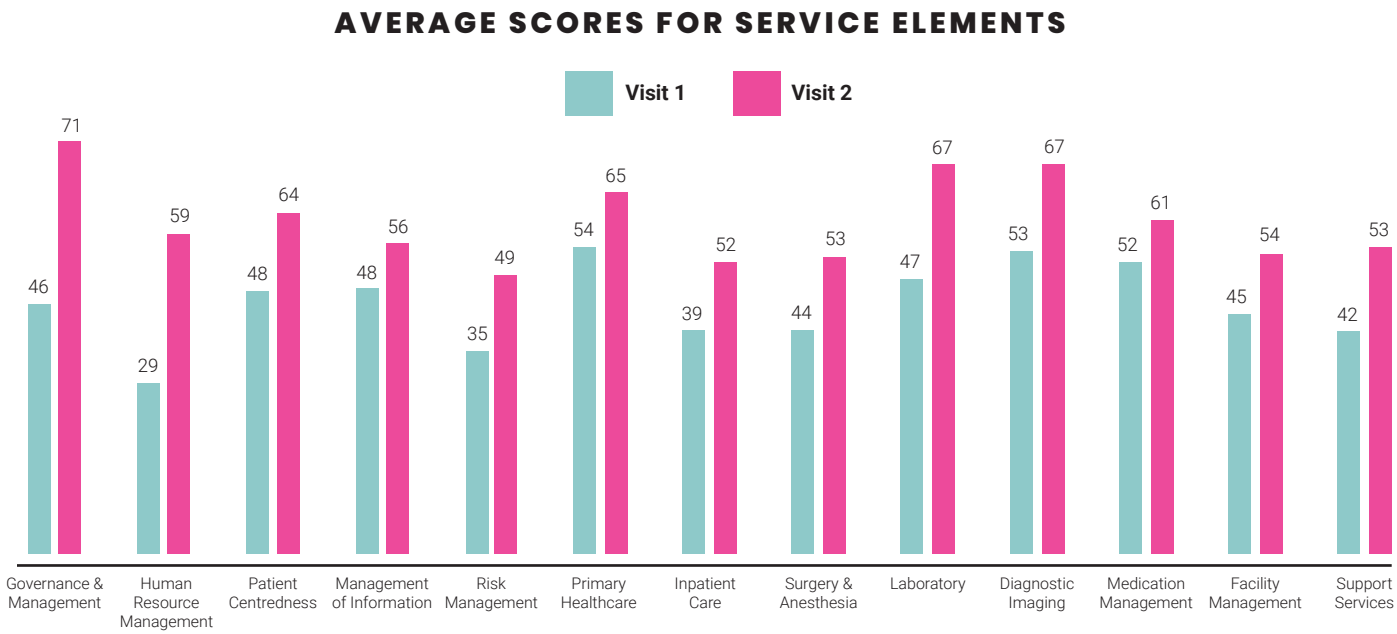


Figure 3: *Overview of average scores for service elements*

There were visible structural quality improvements made in facilities. In all facilities visited for this brief, investments were made by facilities in infrastructural expansion and segregation of service areas. Structural improvements, as well as improved client flow (i.e., reduced waiting times), were reported by providers to have contributed to an increase in general service utilization. Increased utilization was predominantly associated with the introduction of new services, such as radiology in one hospital, and MNCH services in all facilities. In some instances, providers reported improved utilization of FP services, through cross promotion with child health services as well as overall improvements in client footfall. However, this increase in FP utilization cannot be attributed to the SafeCare activity alone, as PSI Uganda was concurrently implementing activities under separate donor funding that supported free FP commodities and demand creation/event days at the same facilities.

As a result of the financial and technical support provided by SafeCare, providers frequently reported an ability to be more adaptive to changing circumstances. For example, providers indicated that it was easier to maintain improved standards of quality under the SafeCare methodology, even with staff attrition, as *"all standard operating procedures and policies are [now] in place"* to facilitate orientation of new hires. They also reported greater utilization of data for decision making. In one facility, this data was used to course-correct where service utilization was found to be dropping, and in another instance, the data was used to direct further investment to high-demand services. This form of proactive and adaptive management was through a combination of PSI social franchising support and SafeCare standards; as one provider noted, *"Tunza [PSI] provides the business framework, SafeCare provides the quality framework."*

SafeCare has informed MoH quality standards. At the time of the pilot, the Ugandan MoH was developing standards under a USAID/Uganda project[4] to drive quality in health service delivery. UHF, a grantee of that project, was involved in those efforts and brought its experience with SafeCare into discussions with the MoH and into its own member association. Through this UHF succeeded in having SafeCare standards inform the MoH's now-mandatory Self-Regulatory Quality Improvement System (SQIS) for private sector self-assessment; this is explicitly acknowledged in the SQIS guidelines. However, despite this achievement, SafeCare has not been fully embraced by the MoH. As reported by UHF, of concern for the MoH was that the SafeCare *"cycle had not been completed"*[5] and questions remained: *"Who has done it? What has it done for them [private providers]?"* In an effort to address this concern, UHF secured support from MoH regional public referral facilities to undertake SafeCare basic assessments, outside the context of the pilot. At the end of the pilot, dialogue continues with the MoH to consider SafeCare as a complementary QI tool for both public and private health facilities. UHF is also leading efforts among local private health sector stakeholders to establish a community of practice that can benchmark achievements and share learnings.

4. The USAID/Uganda Private Health Support (PHS) Program, 2013-2018.

5. While no facility has reached Level 5 of the SafeCare rating, incremental improvements were demonstrated through the ratings and scores.

LESSONS LEARNED

Where external incentives to drive quality up are not present (e.g., third-party payments), greater market analysis and provider segmentation are required to optimize the pilot phase and position for scale up. When Merck decided not to go forward with the anticipated financing, and a national insurance scheme had still not materialized, it became clear that many of the providers included in the segment did not have the means to afford implementation of SafeCare, whether or not they were committed to investing in QI. Attempts to seek co-payment for SafeCare within the ProFam network demonstrated minimal success, as the external incentive of third-party financing did not exist. This result may have been mitigated if there had been a more clearly articulated "go-to-market strategy" when the pilot began; its initial positioning as a free program without a formal reciprocal commitment may have created a sense of it being optional. Similarly, efforts to promote SafeCare within UHF's membership were also not successful as only a few providers indicated that they would be willing or able to pay for SafeCare. This was not enough of a market base to sustain SafeCare in Uganda. However, as SafeCare gains more visibility in Uganda, it is starting to generate more interest and willingness to pay from other, more financially secure private providers outside of UHF's membership.

Opportunities remain to explore the relationship between horizontal vs. vertical approaches to quality improvement as a pathway towards accreditation. SafeCare was incorporated into social franchising primarily as a horizontal intervention. But despite the goal to integrate the approaches, for various operational reasons, PSI's existing quality approach, which is more vertically- and service delivery-oriented, largely remained the same. This PSI system is scored by the Health Network Quality Improvement System (HNQIS) tool, which focuses on high quality delivery of, and ongoing coaching for, specific PSI-supported health services. PSI staff were oriented to SafeCare, but as the SafeCare pilot was one activity among many implemented by PSI Uganda staff, a vertical focus on quality also had to be maintained, particularly under donor agreements. Given competing priorities, it was challenging to seamlessly integrate the structural focus of SafeCare with the service delivery focus of HNQIS together at a programmatic level. This was also felt by some providers who found the implementation of two QI systems heavy, even if they were complementary. This extended to data collection and presentation, which ultimately had to remain parallel due to different donor requirements, despite efforts to fully integrate them.[6] Consolidating the data between SafeCare and PSI into DHIS2 was an ongoing effort throughout the activity in order to help generate a more congruent narrative.

> ***"We didn't operate from a full enough understanding of the private sector market or what market segments would be more fitting for this work."*** **(PharmAccess Senior Advisor, SIFPO2 SafeCare Activity Partners' Meeting, Dec 2018)**

6. SafeCare scores are manually added by PSI Uganda to PSI's DHIS2 system in order to improve data integration.

Data insights from the pilot demonstrate that a horizontal approach to quality can strengthen vertical QI systems. Within the overall SafeCare standards, PharmAccess has designated certain subsets of service elements that are directly indicated in MNCH and infection control and prevention outcomes. Over the course of the pilot, as demonstrated in Figure 4, there were clear improvements in these criteria. While there is no designated subset within the SafeCare standards that links solely to FP outcomes, many of these same standards are a prerequisite element in the delivery of high quality, compliant FP services.

In both sets of facilities – the 25 that significantly progressed and the 22 that saw incremental progress – there was initial hesitation amongst facility staff to contribute their efforts towards achieving the QI milestones within their QIPs. Providers reported that administrative staff required more explanation for changes to systems and protocols, and one provider reported that technical staff had received inadequate training around the facility's quality standards. In both instances, there was need for hands-on "change management" by facility managers.

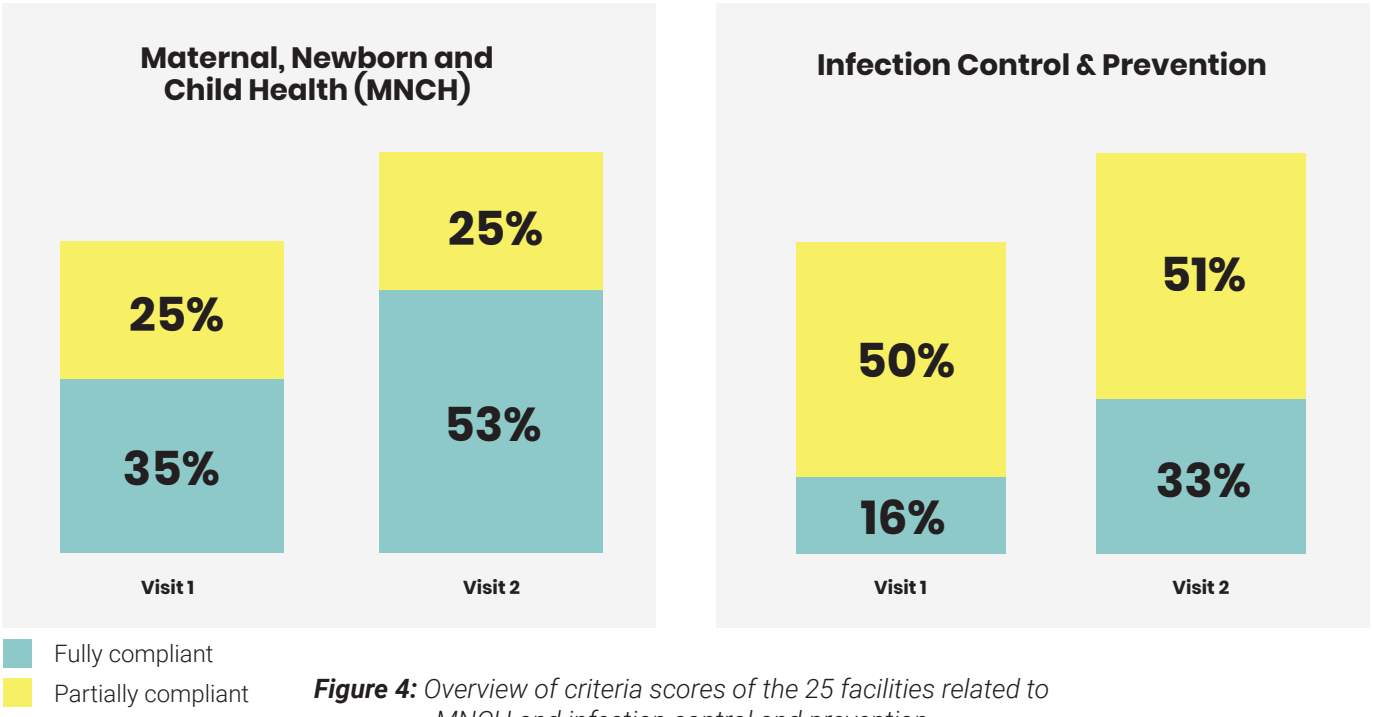


Figure 4: *Overview of criteria scores of the 25 facilities related to MNCH and infection control and prevention*

Facility managers and the SafeCare quality assessors found that emphasizing health worker occupational health and safety resonated with staff and helped address this initial reluctance. Some managers also reported that the QIPs empowered staff through greater procedural clarity and knowledge, as managers invested more in continuing medical education (CME) to maintain, develop, or increase the knowledge, skills, and professional performance of staff.

This also extended to job security as, in some facilities, staff were issued contracts and job descriptions for the first time as a result of the SafeCare intervention.

Among those providers that did not advance with SafeCare, there were several challenges which may have impeded progression. Based on the assessors' perspectives, these included:

- The effects of staff attrition in smaller facilities due to smaller staffing complements
- Lack of financial resources to expand infrastructure, segregate spaces or buy equipment
- Perceptions by managers and staff that implementing horizontal quality standards had little if any added value, e.g., *"what is this going to do for us?"* or *"what's in it for me?"*
- The quality and lack of consistent availability of quality-controlled supplies for laboratory processes, such as testing of reagents (as these types of supplies are not supported by the ProFam social franchise)

As the program ran its course, key insights were generated that have informed both PharmAccess and PSI Uganda strategies to drive uptake and scale. Critical factors to successful engagement that were cited included: ownership of facility properties, as infrastructural improvements are difficult through rental and leasing agreements; staffing, in terms of total number and their retention; knowledge barriers of facility proprietors/managers and their willingness to invest time and resources into QI; and the presence of the proprietors/managers as visibly championing and owning the QI strategy and process.

While SafeCare has not been adopted by government, it informed MoH approaches to certification and accreditation. Advocacy with the MoH was the remit of UHF, which initiated various activities to position SafeCare as complementary and supplementary to other QI approaches. During the pilot timeframe, the MoH had only started to consider options for country-wide quality assurance and improvement, and it was working through the landscape of different tools and approaches. The government also wanted ownership over their QI program; as SafeCare data is housed in the Netherlands this posed a barrier to embracing the overall program. Despite this barrier, as noted above, SafeCare informed the SQIS for the private sector and the Health Sector Quality Improvement Framework and Strategic Plan (2016-2020).

There is a need to recast SafeCare as an affordable approach to QI. As noted by an in-country stakeholder, *"the MoH did not buy into SafeCare as they considered it too expensive, they wanted a process that they could own, that is affordable and suitable to small and medium enterprises."* In response to this and feedback from other contexts, this pilot played an integral role in PharmAccess's organizational decision to leverage technology and develop a digital tool in order to decrease cost and increase efficiency. In May 2019, PharmAccess developed a "lighter" version of SafeCare using a shorter standards checklist which can be implemented by one assessor in one day.

Because it is digitized, it can produce the QIP quickly and automatically.[7] These features have the potential to greatly reduce the cost of using SafeCare in Uganda and have been demonstrated in other country contexts such as Kenya. Furthermore, while SafeCare QIPs are also viewed as expensive for providers to implement, the improvements most valued by providers were those that addressed processes and systems. These did not require large capital investments, but they did require change management. Applying lessons learned from this pilot, the cost of implementing the SafeCare model has now reduced from more than $2,000 when the pilot started to approximately $500.

***"There is a lot that can be done with small changes. SafeCare is the way to go, health service needs to improve."* (ProFam provider implementing SafeCare)**

CONCLUSION AND RECOMMENDATIONS

SafeCare remains a strong tool for horizontal clinical improvement across all operations and management of a facility, and it is complementary to vertical programs and/or health areas. This may mean that applying SafeCare to donor-funded support of vertical health areas will need to include more intentional thinking towards what outcomes can realistically be achieved as well as a greater focus on integrating vertical and horizontal quality goals more efficiently. Otherwise, the SafeCare model should be applied towards broader primary health care (PHC) focused objectives. Despite this, learning has been generated through the SafeCare pilot in Uganda, which has already resulted in tangible changes to PharmAccess's model and tangible benefits to providers and clients of private healthcare in Uganda. However, questions remain and are relevant to different market players in the Ugandan context. These include:

For regulators: How can quality standards be used as a lever for certification or accreditation in a context where strategic purchasing for health services is nascent? Uganda does not currently accredit private providers for national health insurance or other large-scale purchasing mechanisms. While the MoH wishes to improve regulation – including self-regulation – of the private sector through SQIS, there are few rewards or sanctions for quality or its improvement. In future, SafeCare could be adapted and positioned as a certification module that bridges the gap between the voluntary SQIS and more sophisticated SafeCare standards as they were applied in this initiative.

For PharmAccess, PSI, UHF and similar Ugandan health market players: Given the lack of incentives in the market for quality, and current dependence on subsidy for QI initiatives, what are reasonable expectations for SafeCare in the Ugandan context? As learned through the pilot, commercial licensing may be premature as there appears to be a limited willingness or ability of providers to pay for SafeCare.

7. This feature was not available during the time of the SIFPO2 pilot but was informed by the pilot.

The limited financial buy-in from providers may have been due to a lack of perceived incentives in implementing a QI program, but it may also have been due to the selected market segment. The ProFam fractional franchise was developed to serve PSI's target archetype of "Sara," who in Uganda is modelled to be a rural woman living between the 2nd and 3rd socioeconomic quintiles. Subsequently, many of the franchisees may not have had the necessary client base to sustain the revenue needed for reinvestment in horizontal QI initiatives.

There is a need for greater understanding of this market, its segmentation and the subsequent positioning of the SafeCare value proposition. There are also implications for the social franchise network and using SafeCare to, as described by a PharmAccess Regional Director, *"create more clarity on quality and how [it] is reflected in the network."* The implications of enrollment and progression in the SafeCare program, and what this means for eligibility in the social franchise, have not yet been digested or defined. There are opportunities for social franchise networks to set horizontal quality as a criterion for sustained membership and progression in the social franchise. For PharmAccess, there may be a need to develop an adaptable package for such franchises that accounts for providers' differences in income/capital levels, given that finances were the most often cited reason for non-progression.

For providers: Given the lack of external drivers of private health sector QI in Uganda – in terms of both reward and sanction – what are the benefits for providers of participating in QI initiatives such as SafeCare? These questions were asked by stakeholders and remain relevant. If there is no clear benefit, then providers will remain hesitant to invest. For those providers who embraced SafeCare, this appears to have been largely driven by self-motivation as market signals and regulatory requirements are not yet very demanding or quality-driven, despite emerging national strategies. More providers may embrace QI initiatives in future as Uganda is planning to introduce national health insurance as part of universal health coverage. In the meantime, access to voucher programs and low interest, smaller loans may create further incentives for providers to invest in quality.

For clients: Anecdotally, according to providers visited as part of the learning brief, clients signaled the value they placed in quality services. There was greater client footfall, more extensive word of mouth promotion, constructive client feedback on services, and responsiveness to this feedback by providers involved in this activity. However, more can be done to bring client perspectives into the health system, so that clients are able to direct market signals by seeking out facilities with better quality care and client-centeredness.

ANNEX A: SELECT CLINIC EXPERIENCES

Spotlight: Span Medicare Clinic

Span Medicare Clinic is a privately-owned facility located in Kisasi Town Nakawa Division, Kampala, Uganda. It offers basic in/outpatient services, antenatal and postnatal care, cancer screening, safe delivery, voluntary FP, laboratory services, physiotherapy, ultrasound, X-ray, immunization services, and major and minor operating services. The healthcare facility has a general ward, with both male and female patients, and a capacity of six beds.

The facility serves an average of 100 clients per day and has a large staff complement that includes medical and clinical officers, locum doctors and specialists, midwives and nurses, laboratory staff, one administrator, one counselor and five support staff. In the years that Span Medicare Clinic has been in the SafeCare program, the facility has expanded and added a new floor to assure adequate space and segregation of services, which is currently operational. The clinic's ongoing SafeCare journey started in 2016.

A baseline assessment was conducted in 2016 with the SafeCare basic methodology, followed by a SafeCare advanced assessment in 2017 and 2018. In between the SafeCare assessments, Span Medicare Clinic executed its QIP in collaboration with SafeCare and PSI. During the SafeCare journey most of the service element scores have improved (Figure 5). These higher scores have resulted in improved client flow, with marked increases in all services, most notably ultrasound and outpatient services, which increased 79% and 56%, respectively.

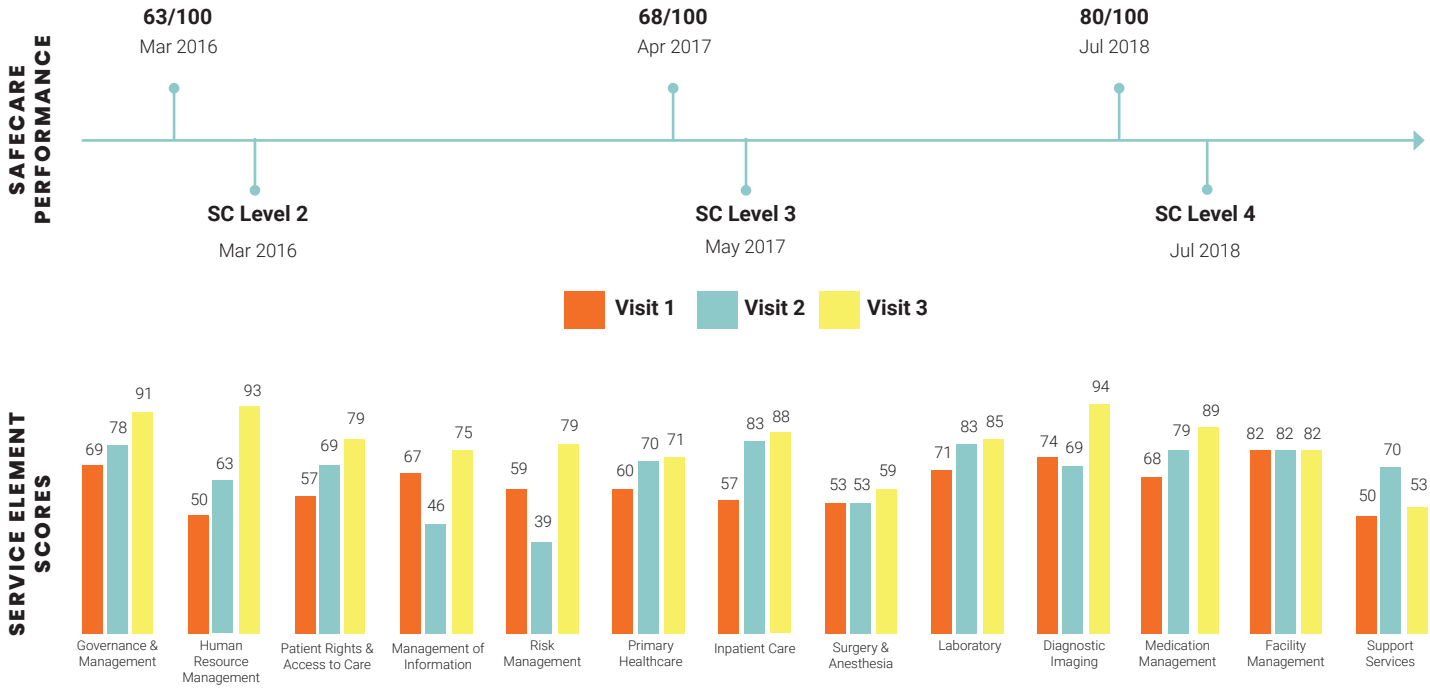


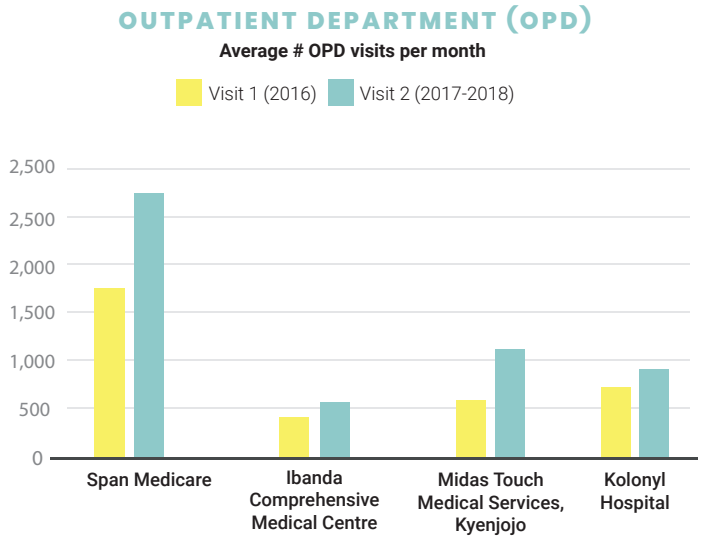
Figure 5: *Spotlight on the SafeCare journey and scores per service element for Span Medicare Clinic, which advanced from a Level 2 to Level 4*

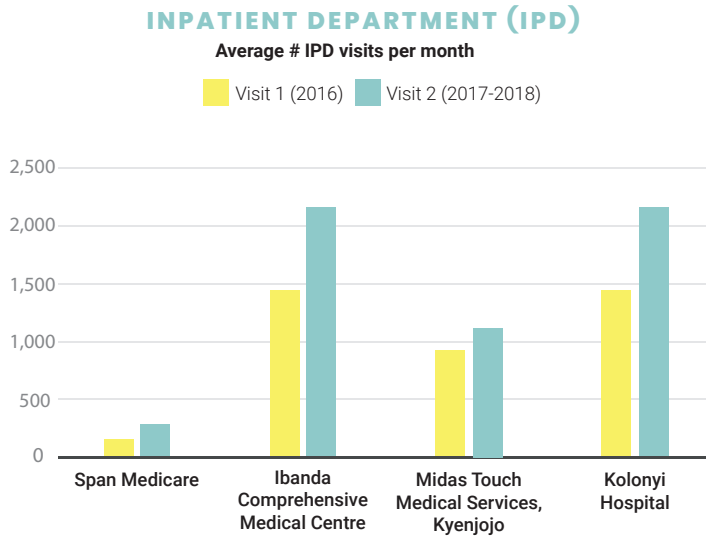
ANNEX B: SERVICE UTILIZATION AT SELECT FACILITIES

In the graphs below, the effect on service utilization is shown for four healthcare facilities, three of which reached Level 4 of the program (the highest level attained during the pilot and one level below readiness for international accreditation). All the healthcare facilities are classified as type healthcare system facility IV/ District Hospital in Uganda.

- Span Medicare Clinic (SafeCare Level 4)
- Ibanda Comprehensive Medical Center (SafeCare Level 4)
- Midas Touch Medical Services (SafeCare Level 4 Tunza clinic; not part of the ProFam social franchise)
- Kolonyi Hospital (SafeCare Level 3)

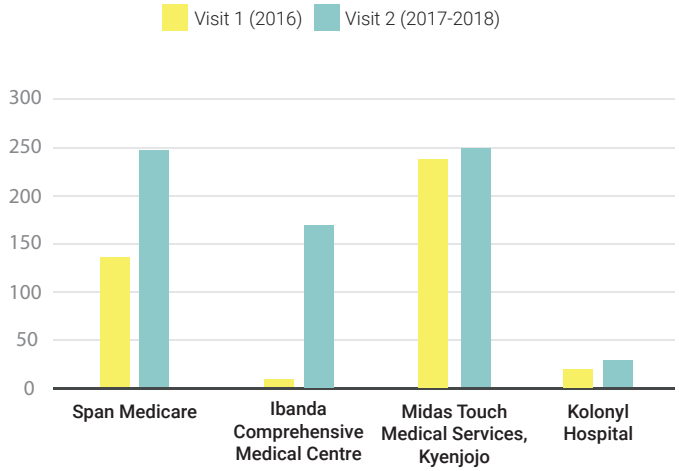
For each of the four facilities, the average utilization figures per month of the baseline year (2016) and the follow up years (2017/2018) are shown. The graphs show in general that the average number of patient visits and service utilization has increased across all healthcare facilities listed. This analysis does not take into account any factors other than SafeCare that may contribute to these results.





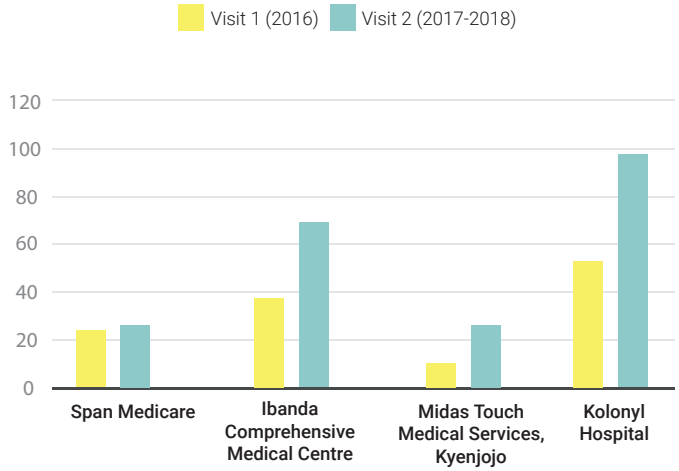
ULTRASOUND (US) SCANS

Average # US scans per month



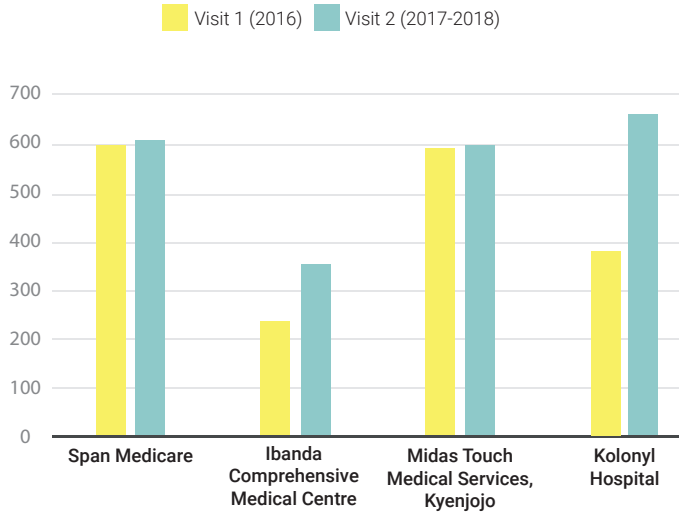
ANTENATAL CARE (ANC)

Average # ANC visits per month



MALARIA

Average # malaria tests per month



DELIVERIES

Average # deliveries per month