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PRIVATE PROVIDER MAPPING AND ACCREDITATION FOR CONTRACTING: LESSONS LEARNED FROM AFTER ACTION REVIEW



ABOUT THE UGANDA VOUCHER PLUS ACTIVITY

The Uganda Voucher Plus Activity (the Activity) is designed to provide quality obstetric, newborn, and postpartum family planning (PPFP) services to very poor women in Northern and Eastern Uganda. To do so, the Activity identifies and accredits private providers to deliver a package of safe motherhood services, for which providers are then reimbursed. Simultaneously, the Activity works with Village Health Team members who offer vouchers at 4,000 UGX to women who qualify, while also providing safe motherhood information to target populations (pregnant women, youth and male partners). The subsidized voucher service package includes four antenatal care visits, elimination of mother to child transmission of HIV services, delivery with a skilled attendant and referral if needed, postnatal care, and PPFP. The Activity team builds the capacity of participating private providers through mentoring, supervision and annual clinical audits to improve service quality; ensure providers contribute to the health management information system; address health system gaps in their facilities; and manage timely claims submission and reimbursement.

USAID/Uganda Voucher Plus Activity Districts



Uganda Voucher Plus Output Based Financing Mechanism

KEY FUNCTIONS:

ONGOING DEMAND GENERATION
AND COMMUNITY MOBILIZATION

STRENGTHENING SUPPLY
THROUGH QA AND QI

IMPROVING DISTRICT AND PROVIDER
SYSTEMS FOR COLLABORATION



INTRODUCTION

To provide quality services, the Activity had to map and select private providers to participate in this output-based financing mechanism. The mapping included a desk review to identify all potential private facilities. This was done in collaboration with district health officers (DHOs), district health teams (DHTs), and medical bureaus. The selection process included conducting facility audits to assess service standards and the infrastructure needed to provide quality voucher services, developing robust selection criteria, and finally selecting facilities for Activity accreditation. The accreditation team was not involved in the initial clinical audit of potential facilities to avoid biases. The Activity primarily used a facility clinical quality assessment tool adapted from an existing Ministry of Health (MOH) maternal voucher activity to assess facilities. In a few cases the Activity selection team found it necessary to lower eligibility criteria to include facilities that served women in very remote areas, and it later provided training and mentoring to increase their capacity. Otherwise, there would be no way to reach these poor populations.

The Activity's Monitoring, Evaluation, and Learning (MEL) team conducted an After Action Review (AAR) in August 2017 to document lessons learned from the process to map and accredit private providers to participate in this output-based financing mechanism. This report describes successes, challenges, and recommendations based on the AAR findings, and provide knowledge and recommendations to the MOH, other implementing partners (IPs), and other stakeholders as they strengthen selective provider contracting for strategic purchasing of health services in Uganda.



AFTER-ACTION REVIEW METHODS

As part of the Activity's learning agenda the MEL team led the AAR in August 2017. The MEL team interviewed 19 key informants in four main categories: Activity staff, staff from other IPs using output-based financing with selective provider contracting, DHOs, and voucher service providers (VSPs). Activity staff, staff from other IPs, and DHOs were purposively selected, while stratified sampling was used to

identify private providers according to region and Activity status (active, suspended/terminated, below accreditation threshold, or opted out). After semi-structured, in-person interviews, an MEL team member read each interview transcript multiple times to gain an in-depth understanding and then identified important comments in each transcript, along with repeated themes across interviews.



AFTER-ACTION REVIEW FINDINGS

The AAR yielded the following salient findings on the successes and challenges of the Activity's private provider mapping and selection process.

Successes

- **Using multiple approaches to map private providers enabled a comprehensive review in each region.**

The desk review of existing private facility databases maintained by other IPs and professional bodies provided reliable data for validation by district health teams (DHTs). Engaging local stakeholders, including working with DHTs, was effective in ensuring no providers were missed.

- **Involving medical bureaus is critical** to the success of the mapping process. These stakeholders often directly manage or supervise potential private providers and are able to provide valuable input.
- **Adapting the MOH's clinical quality assessment tool** from the MOH Voucher Project ensured correct understanding of clinical assessment questions, clarity of clinical assessment concepts and standards, and collection of meaningful service delivery data.
- **Adapting assessment cut-off scores** to include private providers in hard-to-reach and underserved areas ensured that underserved populations could access services through the voucher mechanism.

human resources, infrastructure, or other system inputs. This necessitated the Activity developing additional tools, making the overall process more time-consuming.

- **A critical step missed was requiring private providers to express their interest and conduct a self-evaluation prior to project assessment to confirm their ability to meet minimum standards, resulting in time wasted visiting unsuitable providers.** The concept of provider self-identification has been used successfully in Uganda and other countries. It allows private providers to self-assess their capabilities, begin making improvements ahead of clinical assessments, and saves time and resources for clinical assessment teams.
- **Supervision of the assessment teams was inadequate**, which resulted in scores that did not accurately reflect the quality of care provided. During a subsequent validation exercise by other Activity clinical staff, 46 facilities were either terminated (13) or suspended (33) because they did not meet minimum standards.
- **Health facilities misrepresented infrastructure and human resource capacity during assessments.** Although the Activity did not inform private providers of the assessment date, some facilities still borrowed equipment and health workers from public facilities in preparation for the assessment.
- **While the Activity sought input from DHOs during mapping, it did not involve the DHOs substantively in the clinical assessments. Key informants deemed this a missed opportunity** for increased public sector engagement and buy-in to strengthen private sector health services.

Challenges

- **While offering excellent clinical assessment and service delivery standard details, the clinical quality assessment tool had a few drawbacks including that it was electronic, too lengthy, and did not include health system assessment standards.** The tool required access to a laptop, which was problematic in facilities with unreliable power. Also, the tool took two to three hours to complete, and it did not assess



AFTER-ACTION REVIEW RECOMMENDATIONS

- Medical bureaus along with DHOs should participate in mapping and identifying private providers.
- Private providers should self-assess to determine if they meet minimum standards to participate which in turn offers them time to improve inputs, i.e., infrastructure and HR, and saves time and resources of clinical assessment team.
- DHOs must be involved throughout the process, including in developing facility assessment tools and collecting data.
- Effective supervision of assessment teams is critical to ensure validity of results.
- Different Activity staff with the DHOs should conduct a verification visit to all facilities prior to final selection.
- More than two staff members and the DHO should be part of the selection committee involved in final selection to maximize objectivity.
- Develop quality improvement plans with private providers who had lower clinical assessment as part of the selective contracting process with providers to ameliorate quality issues when selecting private providers in remote locations.
- Streamline clinical assessment tool and include health systems components for robust provider assessments.
- Surprise visits for clinical quality assessment are critical to counter health facility's potential misrepresentation of its staff and infrastructure capacities, although does not entirely eliminate this risk.