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GLOBAL LANDSCAPE ASSESSMENT FOR QUALITY OF CARE (QoC)

Opportunities for Strengthening QoC for Family Planning Services in the Private Sector

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Opportunities for Strengthening QoC for Family Planning Services in the Private Sector

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Acronyms

CDO	Community Development Officer
CDI	Continuous Quality Improvement
CME	Continuous Medical Education
FP	Family Planning
LC	Local Chairperson
LMIC	Low- and Middle-Income Countries
HUMC	Health Unit Management Committee
MCF	Medical Credit Fund
MOH	Ministry of Health
NGO	Non-Governmental Organizations
PDSA	Plan-Do-Study-Act
PPFP	Post-Partum Family-Planning
PCC	Person-Centered-Care
QOC	Quality of Care
QA/QI	Quality Assurance/Quality Improvement
TMA	Total Market Approach
VHT	Village Health Team
WHO	World Health Organization

Executive Summary

In low- and middle-income countries (LMICs), a substantial portion of health expenditures, up to 50–70%, is allocated to private-sector health services, including family planning (FP). Despite investments to enhance FP product quality, significant challenges persist in ensuring effective quality assurance and improvement (QA/QI) mechanisms for person-centered FP services. These challenges include heterogeneity among providers, lack of collaboration and standardization in QA/QI systems, limited platforms for peer learning, absence of dedicated QI focal persons, inadequate data reporting systems, and insufficient visibility of FP quality of care (QoC) data. The Frontier Health Markets (FHM) Engage project conducted a landscape assessment, synthesizing successful approaches to address these challenges. This executive summary outlines key findings from the assessment, aimed at informing development partners, LMIC policymakers, and the global health community on effective strategies for enhancing quality of care in private healthcare provision, particularly for FP services. The report includes sections on methodology, key learnings, and conclusions.

The study employed the Modified Person-Centered Market Systems Framework to investigate quality of care (QoC) mechanisms for family planning (FP) services in low- and middle-income countries (LMICs). Seven research questions were structured around three themes: QA/QI mechanisms, stewardship and market actors for QoC, and promising approaches. A qualitative study design, including desk review and key informant interviews, was conducted over five months, yielding 74 reports meeting inclusion criteria and involving 20 key informants across 11 countries.

Findings were synthesized using Pathfinder's Continuous Quality Improvement (CQI) Framework to organize gaps and challenges in FP QA/QI across three levels of influence. The FHM Engage Expanded FP QoC Framework, derived through this study from the CQI model, categorizes FP QoC solutions and approaches across operational sub-levels: policy and institutional arrangements for enabling factors, community and client engagement for reinforcing factors, and provider and facility capacity for predisposing factors (please see Figure 2 and Table 3).

In addition to identifying key solutions and approaches, gaps/challenges, and recommendations provided for each operational sub-level, this synthesis highlights five key opportunities for strengthening private sector FP QoC. Foundational to ensuring QoC is the need for legislative and policy mandates and incentives, yet many countries maintain a punitive regulatory approach lacking in self-regulation incentives for the private sector. Effective strategies such as supportive public-private collaboration models exist but are not widely institutionalized. Client empowerment and community engagement are crucial for reinforcing person-centered QoC, yet current regulatory models often overlook QA/QI interventions in this aspect. Provider behavior change approaches show promise in improving QoC, particularly in addressing provider bias, although most programs focus narrowly on clinical competence without broader behavioral transformations. Post-partum family planning presents an opportunity for enhancing QoC in the private sector, but training programs often neglect the private sector's needs, hindering its scalability.

A summary of gaps, challenges, and recommendations for each operational sub-level is presented in Table 1. Case studies are also described to illustrate the successful implementation of promising solutions at each operational sub-level, highlighting linkages between levels for strengthening QoC.

The conclusion of the report outlines several recommendations for creating an enabling environment to strengthen the quality of care (QoC) in the private sector, particularly for family planning (FP) services. These recommendations include deploying a systematic and multi-level Continuous Quality Improvement (CQI) framework, prioritizing the development and adoption of QoC regulations and standards, adopting a supportive regulatory approach, strengthening stewardship capacities, improving access to QoC data, institutionalizing supportive supervision, and incentivizing private providers through clinical training and certification. The report emphasizes the importance of aligning incentives, capacities, and accountability structures of market actors to achieve improved health outcomes and highlights the applicability of these recommendations to strengthen private sector capacity in delivering quality FP services and products. However, study limitations, such as the focus on general QoC rather than FP-specific aspects in literature, geographical bias in key informants, and fragmented documentation of QA/QI mechanisms for FP services, should be considered. Despite these limitations, the report suggests that many lessons learned from the broader health focus are applicable to improving QoC in FP.

Through the lens of CQI, the report underscores the complexity of QoC in the private sector and advocates for a collaborative approach involving various stakeholders including donors, policymakers, program planners, facility managers, private operators, NGOs, and community leaders to address the identified limitations and improve QoC across multiple levels of influence and operational sub-levels.

Table 1: FHM Engage Expanded Framework for FP QoC: Summary of findings across the QoC Ecosystem

LEVEL	OPERATIONAL SUB-LEVEL	FP QUALITY OF CARE SOLUTIONS & APPROACHES	GAPS/CHALLENGES	RECOMMENDATIONS	CASE STUDY
ENABLING FACTORS	POLICY LEVEL	1. Legislative provisions & mandates for FP Quality 2. Policies, Standards and Guidelines on FP standards, Quality of care, and incentives 3. Pre-service training requirements 4. Regulatory (Registration, Licensing, and Accreditation) mechanisms and implementation support provisions 5. Financing and resource allocation mechanisms	• Unclear roles of professional bodies and ambiguous laws • Laws restricting private sector engagement and FP services • Lack of policies facilitating public/private partnerships • Inadequate funding for sustainability • Inconsistent adolescent sexual and reproductive health laws/policies	• Ensure QoC is included in national policies and plans • Adjust mandates for the participation of market actors • Provide technical assistance for policy development • Assign specific QoC roles to professional associations • Develop task-sharing policies • Expand method mix offered by community-based services	**Cote D'ivore** Systematic Policy Review

LEVEL	OPERATIONAL SUB-LEVEL	FP QUALITY OF CARE SOLUTIONS & APPROACHES	GAPS/CHALLENGES	RECOMMENDATIONS	CASE STUDY
	INSTITUTIONAL ARRANGEMENTS	1. Management function ○ Leadership Roles for FP QoC ○ Mechanisms for collaboration, dialogue, and decision-making ○ Capacity for QoC leadership functions 2. Technical functions ○ Clinical governance ○ Supportive supervision and mentoring ○ In-service continuous professional development ○ Supply chains 3. Information Systems and Infrastructure ○ Information systems ○ Data visibility use ○ Data use	• Lack of shared vision for governing and regulating the private health sector • Absence of mechanisms/platforms to engage private providers on quality policies and FP standards • Fragmented regulation among professional bodies • Minimal interaction between regulatory agencies monitoring private sector services • Prolonged licensure procedures and rigid regulatory structures • Limited government capacity to monitor private sector quality • Private sector data gaps and Inadequate measurement tools for capturing negative experiences	• Strengthen channels for routine communication between public and private sector actors • Support dissemination of supply-management tools and digital technologies for monitoring • Enable routine facility-level monitoring in low-resource clinics and community settings • Prioritize essential medicines and make them available at subsidized prices	**Kenya** Joint Health Inspection System **Ghana** Safecare Quality Improvement System **Uganda** Digitizing Licensing & Registration of Health Professionals

LEVEL	OPERATIONAL SUB-LEVEL	FP QUALITY OF CARE SOLUTIONS & APPROACHES	GAPS/CHALLENGES	RECOMMENDATIONS	CASE STUDY
REINFORCING FACTORS	COMMUNITY LEVEL	1. Community outreach 2. Community in-reach 3. Community-facility/provider accountability 4. Community-Institutional accountability 5. Community inclusion in Stewardship Facility management	• Limited private sector presence at the community level • Entrenched social and gender norms restricting access to contraceptive services	• Ensure participation of community stakeholders in QoC processes through collaborative social accountability tools/processes	**Uganda** Community Score Cards (CSC) for MNH Services
	CLIENT LEVEL	1. Client empowerment and accountability 2. Client feedback and perceived quality of care of care	• Information asymmetry in clinical encounters hampers client awareness and understanding of healthcare options and rights • Lack of client feedback channels in the private sector • Limitations of traditional satisfaction surveys due to biases and difficulties in translating feedback into service improvements	• Provide adequate information on contraceptive methods for shared decision-making • Expand method mix offered by community-based services • Publicly display the Charter of Patient Rights • Use automated alerts and reminders for client care • Utilize online mechanisms for information and support • Engage clients in reviewing and improving service quality through enhanced feedback processes	**PSI & FP2020 Self-Care Trainblazers' Group** Quality Of Care Framework for Self-Care

LEVEL	OPERATIONAL SUB-LEVEL	FP QUALITY OF CARE SOLUTIONS & APPROACHES	GAPS/CHALLENGES	RECOMMENDATIONS	CASE STUDY
PREDISPOSING FACTORS	FACILITY LEVEL	1. Facility Infrastructure 2. Facility information systems 3. Availability of commodities 4. FP QoC functions and mechanisms at facility level 5. Client engagement and feedback mechanisms 6. Community engagement and feedback mechanisms	• Poor monitoring of contraceptive product quality, particularly Emergency Contraceptives • Inadequate equipment and stockouts limiting IUD provision • Lack of robust mechanisms for routinely assessing services aligned with person-centered care principles • High attrition among trained QA/QI personnel	• Utilize comprehensive and participatory QI approaches like Total Quality Management • Increase emphasis on ongoing monitoring of quality to reduce reliance on annual audit cycles • Simplify contraceptive service quality measurement tools • Include performance objectives related to QoC in staff job descriptions • Engage private logistics providers for managing deliveries to local health facilities • Establish separate spaces to ensure privacy for contraceptive services/counseling	**Multi-country** Client Oriented Provider-Efficient (COPE) Family Planning and Reproductive Health Services

LEVEL	OPERATIONAL SUB-LEVEL	FP QUALITY OF CARE SOLUTIONS & APPROACHES	GAPS/CHALLENGES	RECOMMENDATIONS	CASE STUDY
	PROVIDER LEVEL	1. Clinical competence and skills of service providers 2. Behavioral competence and counseling skills of providers 3. Supervision and monitoring support 4. In-service continuous professional development uptake 5. FP QoC data reporting and sharing	• Health workers lack updated knowledge of clinical guidelines • Job aids are underutilized by health providers • Limited trained providers for IUD insertion hinder PPFP scaling • Preference for methods requiring less time impacts service provision • Service providers exhibit judgmental attitudes towards adolescents' needs/preferences	• Integrate training and supervision to improve interpersonal care in PPFP initiatives • Prioritize investment in midwives' education, regulation, and work environment • Focus capacity building on master trainers, PCC training, and skills-building through simulations • Recognize best-performing providers to reinforce behavior change • Utilize QI collaboratives for cross-facility learning and application of CQI methods	**Pakistan, Tanzania, Uganda** Beyond Bias Provider Behavior Change Model

Introduction

As much as 50–70 percent[1] of health expenditures in some low- and middle-income countries (LMICs) is believed to be for private sector health services. (1,2) In many LMICs this also includes family planning (FP) services, products, and information. While there has been considerable investment by the private sector to improve the quality of FP products, many challenges remain that affect the effectiveness and sustainability of quality assurance/quality improvement (QA/QI) mechanisms for strengthening person-centered FP services (See Box 1).

BOX 1: QUALITY CHALLENGES IN THE PRIVATE SECTOR

- Heterogenous group of providers ranging from pharmacists to nurses, midwives, and clinical officers.
- Lack of collaboration and standardization in QA/QI systems.
- Limited platforms for peer-to-peer learning.
- Lack of QI focal persons responsible for ensuring quality of services and products in the private sector.
- Few systems that execute data reporting, especially incidence reporting and resolving issues.
- Data visibility regarding quality of care, particularly counseling, is also lacking.
- Onus of remaining up to date through continuous medical education for private providers is often on the provider.

The Frontier Health Markets (FHM) Engage project conducted a landscape assessment of quality of care (QoC) systems and approaches that have successfully addressed many of the challenges related to private sector services. This discussion report synthesizes the learnings from this landscape assessment to inform key stakeholder groups – development partners, LMIC policy makers, global health community – on what works in strengthening private healthcare providers' quality of care for FP and other health services.[2] This report is organized into the following sections: (i) methodology, (ii) key learnings, and (iii) conclusion.

Methodology

To better understand the reasons why and the evidence regarding which combination of QoC approaches address the root causes of market failures in regulating QoC in the private sector, FHM Engage conducted this assessment from September 2022 to January 2023.

Study Design

The Modified Person-Centered Market Systems Framework[3] was used as the study's guiding framework. This framework integrates Person-Centered Health Care (3,4) and allowed the study team to conceptualize QoC for FP inclusive of normative behavior in both providers (supply) and health consumers (demand) (5).

[1] Expenditure-based estimates likely overestimate the overall proportion of care delivered, because of higher prices in the private sector than in the public sector.

[2] Please note that this global review only focused on measures to assure quality of health services.

[3] Person-centered care (PCC) is defined as the provision of care that is respectful of and responsive to individual patient preferences, values and needs, and which ensures the patient values guide all clinical decisions.

A total of seven research questions were identified and organized around three themes (see Table 2):

1. QA/QI mechanisms;
2. Stewardship and QoC market actors; and
3. Recommended QA/QI approaches.

Table 2: Key Research Questions for the Study

THEME 1: QA/QI MECHANISMS	THEME 2: STEWARDSHIP[4] AND MARKET ACTORS FOR QOC	THEME 3: PROMISING AND NEW APPROACHES
Q#1: What QA/QI mechanisms exist at system, provider, community, and consumer levels in LMIC health sectors?	Q#4: Which market actors – public and private – are responsible for QoC in an LMIC health sector?	Q#7: What approaches can potentially incentivize private providers to improve their quality of care?
Q#2: What gaps and challenges do these QA/QI mechanisms face in their ability to ensure quality delivered by the private health sector?	Q#5: What are the gaps in market system rules (policies, regulations, standards, and norms) that influence private sector quality?	
Q#3: What QA/QI mechanisms and approaches can help improve the quality of FP services delivered by the private sector in LMICs?	Q#6: What stewardship approaches can facilitate strengthening of private provider quality of care	

BOX 2. STUDY LIMITATIONS

- Most of the available articles identified in the literature focused on private sector QoC in general and not FP per se.
- The key informants who participated in the study were in large part from South Asia and Africa.
- There are stronger documentation of regulations of manufacturing and product registration overseeing the quality of products. However, there remain inconsistencies and fragmentation across adequate documentation of QA/QI mechanisms for ensuring quality FP services and information. A secondary, manual, online search was needed to identify grey literature specific to FP solutions.

A qualitative study design, consisting of desk review and key informant interviews was conducted for 5 months from September 2022 to January 2023. The desk review took the form of evaluations of private sector QA/QI mechanisms, including operational studies, case stories, and documentation of real-life lessons learned. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses[5] summarizes the screening process. (See Annex 2). A total of 74 reports were selected that fulfilled the inclusion criteria. Using convenience sampling a total of 20 key informants were interviewed covering 11 countries from Africa, Asia, and North America (Annex 2). Two validation meetings were held with key informants to review the study's results. Validated findings were synthesized and analyzed using Pathfinder's Continuous Quality Improvement (CQI)

[4] Stewardship under MDA is viewed in functional terms, focusing on *"what is done," "what should be done,"* and *"who should do it"* to ensure that a health market performs well to achieve a country's state national health goals.

[5] Adopted and adapted from: Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., … Moher, D. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. BMJ

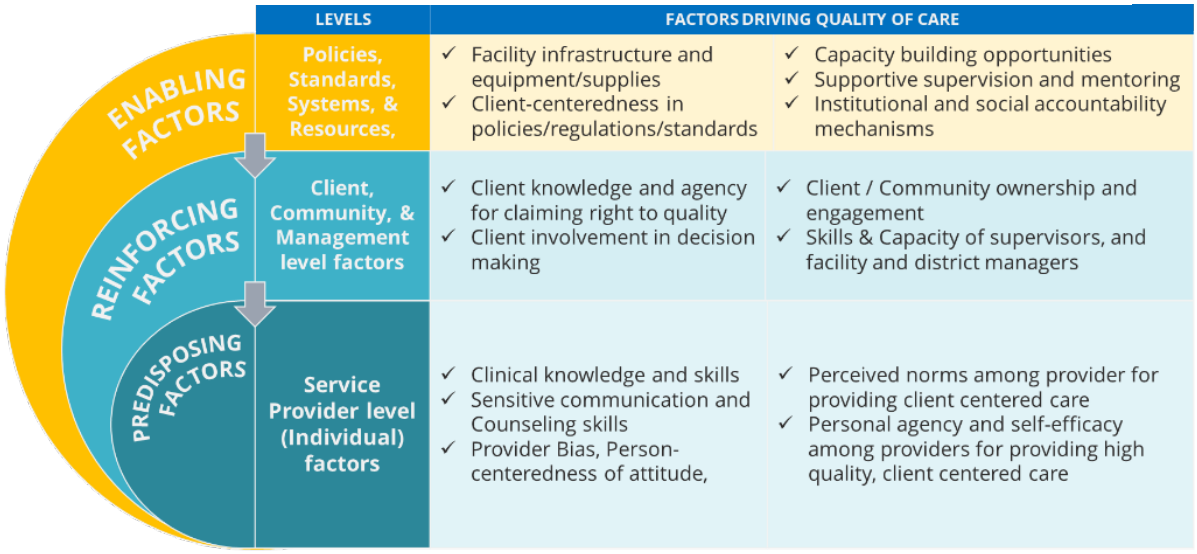
Framework. This CQI framework was selected because it adopts an ecological approach for understanding QoC and describing factors and solutions for quality across multiple, interconnected levels of influence. Based on learning from this application, the CQI framework was expanded to improve clarity regarding gaps/challenges, and potential solutions at each level of influence. Please see the next section for more details on this.

Pathfinder International's Continuous Quality Improvement (CQI) Framework

The CQI Framework (Figure 1) (6) adopts an ecological perspective for understanding QoC by maintaining a focus on developing individuals' skills as right-holders and viewing service quality as an outcome of the predisposing, reinforcing, and enabling factors that underpin service providers' competence for delivering quality, safe, person-centered contraceptive services. It is based on a landscape analysis conducted by Pathfinder in 2020 of QI approaches across its countries of operation across three levels of influence.

- ENABLING FACTORS refer to the policy, standards, systems, and resources that drive quality of care.
- REINFORCING FACTORS refer to mechanisms for client and community engagement that enhance the ability to discharge quality services.
- PREDISPOSING FACTORS refer to factors at the provider and individual level that influence the quality of care.

Figure 1: Pathfinder International's Continuous Quality Improvement Framework



Source: Pathfinder International. (2022). Person-Centered Continuous Quality Improvement: Global Strategy. Pathfinder International.

The framework facilitates a holistic and systematic way to understand the QoC ecosystem in each country. This includes analyzing the complex relationship between clinical competence and socio-culturally influenced behaviors to better understand the importance of context and the interplay among market actors and different levels of intervention for incentivizing private sector providers. In addition, it endorses a standards-based approach to improving QoC based on World Health Organization (WHO) guidelines and identifies enabling, reinforcing, and

predisposing factors driving QoC, with an operational model including a set of interventions to implement through a stepwise process. (7).

Application of the CQI Framework: The FHM Engage Expanded Framework for FP QoC

The CQI framework was used to organize FP QA/QI gaps/challenges that were identified through the study. Based on the driving factors, the key learnings are organized around the CQI framework's three levels. This allowed the study team to explore linkages across the levels of influence, and describe promising QA/QI solutions and approaches at different levels to address these gaps/challenges, including identifying relevant market actors to engage in scaling up and sustaining the practices. Findings identified discrete, operational sub-levels within each of the three levels of influence, with interventions at each of the operational sub-levels requiring very different types of action planning and investment. These were introduced to inform an expanded framework. The expanded FP QoC framework (presented in Figure 2 and described in Table 3) provides a comprehensive list of FP QoC solutions and approaches organized according to factors addressed at each operational sub-level of the three levels of the CQI framework.

Figure 2: FHM Engage Expanded Framework for QoC

- ENABLING FACTORS

Including policies, standards, systems, institutional arrangements, and resources, QoC approaches addressing enabling factors were described at two operational sub-levels: ***policy***, and ***institutional arrangements***.

- REINFORCING FACTORS

QoC approaches designed to reinforce policy and institutional arrangements support quality were described at two operational sub-levels: ***community*** and ***client*** levels.

- PREDISPOSING FACTORS

Finally, QoC approaches addressing predisposing factors were described separately for two operational sub-levels: ***providers***, and ***facility*** levels.

The expanded framework was used to map all identified FP QoC solutions and approaches at operational sub-levels of the quality ecosystem. Gaps, challenges, and recommendations were described for solutions and approaches at each operational sub-level. Case studies of effective QA/QI models/approaches are highlighted to demonstrate how some of the recommended solutions and approaches have been successfully implemented at each level of the expanded framework, as well as the linkages and synergies between levels for strengthening QoC. Tables 1 and 3, developed by the study team, provide an integrated overview of QA/QI solutions capable of influencing FP service quality at each level of the QoC ecosystem.

Table 3: FHM Engage Expanded Framework for FP QoC Solutions and Approaches

LEVEL	OPERATIONAL SUB-LEVEL	FP QUALITY OF CARE SOLUTIONS & APPROACHES
ENABLING FACTORS	POLICY LEVEL	1. Legislative provisions and mandates for FP quality 2. Policies, standards, and guidelines on FP standards, quality of care, and incentives 3. Pre-service training requirements 4. Regulatory (registration, licensing, and accreditation) mechanisms and implementation support provisions 5. Financing and resource allocation mechanisms
	INSTITUTIONAL ARRANGEMENTS	1. Management function ○ Leadership roles for FP QoC ○ Mechanisms for collaboration, dialogue, and decision-making ○ Capacity of QoC leadership functions 2. Technical functions ○ Clinical governance ○ Supportive supervision and mentoring ○ In-service continuous professional development ○ Supply chains 3. Information Systems and Infrastructure ○ Information systems ○ Data visibility and access to QoC market intelligence ○ Data use

REINFORCING FACTORS	COMMUNITY LEVEL	• Community outreach • Community in-reach • Community-facility/provider accountability • Community-Institutional accountability • Community inclusion in Stewardship Facility management
	CLIENT LEVEL	3. Client empowerment and accountability 4. Client feedback and perceived quality of care of care
PREDISPOSING FACTORS	PROVIDER LEVEL	7. Facility Infrastructure 8. Facility information systems 9. Availability of commodities 10. FP QoC functions and mechanisms at facility level 11. Client engagement and feedback mechanisms 12. Community engagement and feedback mechanisms
	FACILITY LEVEL	6. Clinical competence and skills of service providers 7. Behavioral competence and counseling skills of providers 8. Supervision and monitoring support 9. In-service continuous professional development uptake 10. FP QoC data reporting and sharing

Key Learnings

This discussion piece synthesizes the key learnings from the global landscape assessment and presents a summary overview of these in Box 3 with a more detailed description of learnings at each operational sub-level in subsequent sections.

Box 3. KEY LEARNINGS

- **Legislative and policy mandates** and **incentives for compliance** are foundational for ensuring quality of FP services, but the regulatory environment in most countries maintain a punitive approach to enforcing quality compliance, without incentivizing self-regulation by the private sector.

- **Supportive approaches delivered through public-private collaboration** are effective at promoting quality compliance, and collaborative models exist that countries can adapt based on local context, but these have not been institutionalized by most countries.

- **Client empowerment and community engagement** are effective at reinforcing person-centered QoC for FP, however, current models for operationalizing regulations, standards, and guidelines lack QA/QI interventions for engaging clients and communities in QoC.

- **Provider behavior change (PBC) approaches are effective** at improving QoC, particularly for FP given the role that provider bias plays in impeding access to vulnerable women and girls, but programs in most countries focus on clinical competence and rarely go beyond a standard value clarification and attitude transformation (VCAT) approach.

- **Post-partum family planning (PPFP) is an effective entry point** for improving QoC for FP in the private sector, however, it remains a missed opportunity for scaling up PPFP in the private sector given that donor and government training programs for service providers exclude the private sector and are not tailored to the behavioral and clinical learning needs of private providers.

Enabling Factors

Policy Level

Key solutions and approaches identified by the study, which work in combination to support creation of an enabling policy environment for FP QoC include clearly defined and consistently implemented legislative provisions and mandates for FP quality policies, standards and guidelines; pre-service training requirements; registration, licensing, accreditation mechanisms; implementation support provisions; and financing and resource allocation mechanisms. (See Box 3 for an overview of policy-level QoC solutions based on these enabling factors).

BOX 4: POLICY LEVEL SOLUTIONS

1. Legislative provisions and mandates for FP Quality
2. Policies, Standards and Guidelines on FP standards, Quality of care, and incentives
3. Pre-service training requirements
4. Regulatory (Registration, Licensing, and Accreditation) mechanisms and implementation support provisions
5. Financing and resource allocation mechanisms

The assessment found the following gaps/challenges at this level:

- Duplication and unclear roles of professional bodies and ambiguity in provision of existing laws
- Current laws and regulations pose barriers to private sector engagement and limit the provision of contraceptive services.
- Policies that facilitate public/private partnerships are yet to be endorsed in many countries.
- Sustainability is a major issue for various QA/QI mechanisms given available external and domestic funding is inadequate and fragmented.
- Inconsistencies in adolescent sexual and reproductive health laws/policies restrict access for diverse youth populations.

Despite these gaps/challenges, the following QA/QI approaches and practices for incentivizing private sector QoC at this level were identified:

- Ensure that QoC is included in national policies, plans of action, and other strategic directions.
- Adjust the mandates, accountability, and participation of market actors to better support the implementation of QA/QI mechanisms.
- Support provision of technical assistance for the development of policies and legal/regulatory frameworks, including FP standards, with clear and accessible information and guidance for private sector actors and relevant supervisory and quality control systems tailored to local needs.
- Assign specific QoC roles to health professional associations/councils including setting standards, accreditation of private providers, and monitoring quality at facilities.
- Develop task-sharing policies/guidelines to increase service coverage and improve patient outcomes.
- Expand method mix offered by community-based services.

Implementing these practices requires strong Ministry of Health (MoH) stewardship in QoC at national and subnational levels, to ensure healthcare policies align with evidence-based, globally accepted quality standards and support comprehensive planning across the public and private sectors through participation of relevant public and private market sector actors (e.g., policy makers and program planners, for-profit and not-for-profit implementing partners including social marketing and social franchise operators, professional associations, advocacy groups/networks, community leaders including women and youth). Case story 1 provides an example of institutionalizing QoC in national polices and plans of action.

CASE STUDY 1: SYSTEMATIC POLICY REVIEW IN COTE D'IVOIRE

Since 2019, the World Bank and Global Financing Facility are supporting the government in CIV to improve equity and efficiency in service delivery by scaling up strategic purchasing of services from private providers. Both parties quickly realized that many policies and regulations were out-of-date and restricted to private provision of health services. Over two years, the Ministry of Health (MoH) undertook a systematic review of its policies as well as key regulations overseeing private quality of care. Activities included:

- Landscaping all private sector actors to gauge interest and capacity to participate in policy dialogue and partnerships and supporting private sector participation in different policy and regulatory reform processes.
- Hiring an international law firm and local lawyers to review relevant policies and regulations to understand legal requirements and gaps in the framework to govern and engage the private health sector. The firm reviewed over 15 laws and policies (e.g., hospital act, quality policy, etc.) and recommended changes in the language to remove inconsistencies, harmonize the legal approach and align it with the government's new strategy on private sector engagement.
- Using the international firm, the MoH completely revamped the facility licensing regulations to reflect international best practices to simplify facility classifications and scopes of practice. The new licensing facility regulations became the foundation for the new digital platform for licensure.
- Supporting the MoH to carry out a consultative process with key private sector stakeholders to draft the first ever Private Sector Engagement Policy to articulate ministry goals to develop and integrate private sector in health.

By 2021, Côte d'Ivoire successfully expanded its performance-based program nationwide, now encompassing 102 out of 108 districts, a significant increase from just 21 districts in 2020. This expansion involved bolstering frontline services and enhancing accessibility for women and children across both public and private sectors at the district level. As a result, Côte d'Ivoire witnessed notable improvements, including a 38 percent increase in pregnancy care visits, a 15 percent rise in facility-based deliveries, and a remarkable 59 percent surge in postnatal care visits.

Strengths:

- Greater trust built between public and private sectors to embark on partnerships and reforms based on proactive engagement.
- Clear vision in place of ministry's goals to engage the private sector and strategic areas for partnerships.
- Updated regulations based on regional best practices to strengthen governing of private sector in health.
- Simpler facility licensure process encouraging private facility owners to comply with regulations.
- Aligned government and MoH vision and approach on how to engage the private sector.
- Clear MoH vision articulated on private sector role in health sector.

Limitations:

- Technical support and processes heavily dependent on donor support.
- Ministry support for dramatic and multiple reforms varies by different MoH departments and agencies.

Institutional Arrangements

Three key aspects related to systems, functions, and capacity of FP QoC were identified at the institutional level. The assessment also identified several gaps/challenges in these enabling factors pertaining to management and technical capacity (e.g., leadership and governance, reliable supply chains, mature information systems, etc.) and mechanisms to enforce quality regulations (e.g., platforms for collaborative dialogue and decision-making, supportive supervision and mentoring, ongoing professional development, etc.) that directly impact the quality of FP services. (See Box 4 for an overview of institutional QoC approaches based on these enabling factors).

BOX 4: INSTITUTIONAL APPROACHES

1. Management function
   - Leadership Roles for FP QoC
   - Mechanisms for collaboration, dialogue, and decision-making
   - Capacity for QoC leadership functions
2. Technical functions
   - Clinical governance
   - Supportive supervision and mentoring
   - In service continuous professional development
   - Supply chains
3. Information Systems and Infrastructure
   - Information systems
   - Data visibility and access to QoC market intelligence
   - Data use

Gaps/challenges at this level included:

- Lack of shared vision on how to govern and regulate the private health sector.
- No mechanisms /platforms to engage private providers on general quality policies and regulations and FP standards.
- Fragmented nature of regulation between the professional bodies.
- Minimal interactions between regulatory agencies monitoring private sector services and products.
- Prolonged licensure procedures and rigid regulatory structures.
- Limited government capacity to supervise and monitor private sector quality.
- Private sector data gaps in health management information systems making it difficult to track private sector contribution to FP services and compliance to standards (e.g. how many contraceptives are sold and what services are provided).
- Lack of adequate measurement tools to capture negative experiences including if and how client coercion occurs or how these experiences affect SRH outcomes.

Based on the assessment and country examples, several recommended approaches/practices for addressing these gaps/challenges emerged:

- Strengthen channels for routine communication between the public and private sector actors. For example, establish a sub-technical working group on PPPs under the MoH intersectoral coordination mechanism to facilitate routine communication between public and private sectors and joint action at all levels to improve service organization and delivery.
- Support dissemination of existing supply-management and reporting tools, and expand use of digital technologies for stock management, monitoring, and accountability. For example, digitization of the private health sector and integration of data into the District Health Information MIS software (DHIS2) is an opportunity for MoH to increase

reporting, strengthening collaborative frameworks and data transparency between the public and private sectors.
- Enable routine facility-level monitoring in low resource clinics and community settings by harmonizing and simplifying contraceptive service quality measurement tools.
- Prioritize essential medicines and make them available at a subsidized price.

Implementing these QA/QI interventions at the institutional level also requires strong stewardship at national and sub-national levels to translate policy and regulatory mandates into program strategies, and practice, using market evidence to inform decision-making. To build trust and legitimacy through effective stewardship involves identification and participation of relevant public and private market sector actors in designing and implementing relevant QA/QI solutions based on the local context. Market actors at this level include national and sub-national technical working groups, regional and district health management committees, facility health management committees, private professional associations, and community health committees.

Case studies 2 and 3, respectively, provide examples of public/private and private institutional arrangements for strengthening QoC in the private sector. Case study 4 provides an example of how technology can be leveraged to improve regulatory efficiency through digitizing registration and licensing of health professionals and facilities in the private sector. As noted under study limitations, literature on institutional arrangements was broadly focused on QoC for healthcare services and was not specific to FP QoC. Case studies 3 and 4 reflect this finding and pertain to overall institutional arrangements for healthcare quality. It is, however, assumed that these initiatives would also have a positive impact on FP QoC.

CASE STUDY 2: KENYA'S JOINT HEALTH INSPECTION SYSTEM

Compared to most other sub-Saharan Africa countries, Kenya's private healthcare sector is relatively developed yet remains poorly regulated. (8) More than half (52.6%) of Kenya's health facilities are private, of which 78% are for-profit, 16% FBO and 6% NGO (9). Although health service delivery is devolved to 47 semi-autonomous counties, regulation remains the responsibility of the national government, implemented by eight regulatory agencies (for doctors and dentists, clinical officers, nurses, public health officers (PHO), pharmacies, laboratories, radiologists and nutrition and dieticians), and overseen by the Ministry of Health (MoH). Kenya's eight regulatory agencies were mandated to visit facilities independently and conduct inspections using their own criteria. However, it was estimated that less than 5% of private facilities received any inspection each year, and even where inspections were done, records were poorly kept, making follow-up action difficult. In addition, there were complaints of conflicting standards across regulators, and lack of clarity on sanctions for non-compliance (9). These weaknesses were reflected in poor regulatory compliance, with 98% of Kenyan facilities failing to meet minimum patient safety standards in a nationwide survey (9). In 2010, a partnership between the MoH, eight regulatory bodies and the World Bank led to the piloting of an innovative shared regulatory system in the public and private sectors involving joint health inspections (JHIs).

The system had the following three broad components:

- A regulatory framework with clear guidelines on minimum patient safety standards and sanctions.
- A system for tracking compliance through inspection and enforcing warnings and sanctions, with an accompanying online monitoring system.
- Performance scorecards indicating compliance category posted on facility walls with leaflets explaining these provided for patients (9).
- Joint inspections conducted using an electronic joint health inspection checklist (JHIC) on a tablet, which automatically generated a facility score. Inspectors gave the facility a summary report indicating the scores, with a full physical report provided later.

The pilot demonstrated a significant improvement in regulatory compliance (9). Facility operators viewed the new system to be fair, objective, and supportive. JHI also curbed corruption and increased licensing requests. In addition, facility scorecards provided by inspectors motivated provider performance. Scale up to the national level, was estimated to cost approximately US $4,823,728, equivalent to US $103 per health facility visit and US $155 per inspection completed (10). JHIs are now being scaled up in Kenya, while the innovations have generated interest from other African countries.

Strengths:

- Inclusive regulatory reform process leads to high buy-in across regulatory agencies which was key to the system's success (9).
- Enhances cohesion and harmonization of inspections leading to buy-in from regulatory bodies.
- Enhances transparency, improved awareness of standards, and increased confidence in the process.
- Creates a supportive vs. a punitive regulatory culture.
- Rigorous inspector training involving intensive classroom exercises and practical experience.

Limitations:

- In addition to inspections, regulation as a shared responsibility requires financial and technical support for some facilities, strong focus on continuous process improvement, and an emphasis on behavior change.
- The effectiveness of inspection in improving compliance may be hampered by limitations in related systems, particularly facility licensing, enforcement of closures and, in the public sector, control of funds (9).

CASE STUDY 3: GHANA'S SAFECARE QUALITY IMPROVEMENT SYSTEM

SafeCare is a regional initiative currently adopted in Ghana, Kenya, Tanzania, Uganda, and Nigeria. This case study focuses on its Ghana application.

Quality standards to assess, rate, and benchmark facilities can be an effective tool for regulation and incentivizing improvement, but it is time-consuming and can be cost-prohibitive (11, 12). Innovative health care standards, a grading system for quality of care, and a QI process that is broken down into achievable, measurable steps would be particularly needed when licensing and pass-or-fail accreditation systems cannot yet be adequately implemented (13). SafeCare was created to help address this gap. Founded in 2011 by PharmAccess, Joint Commission International (JCI) and Council for Health Service Accreditation of South Africa (COHSASA), SafeCare empowers private providers to improve clinical and business performance based on a set of internationally recognized quality standards and a step-by-step improvement path that includes:

- Trained SafeCare surveyors measure the quality of the enrolled providers through 1- to 2-day assessments and jointly identify improvement priorities, which are translated into a Quality Improvement Plan.
- Assessment data are reviewed and approved by a country-based quality manager to ensure that national guidelines and regulations are observed and SafeCare scoring guidelines are followed. With the plan's successful implementation, the provider aims to achieve the next SafeCare level until they reach accreditation.
- During the implementation process, quality assurance officers visit the health care providers quarterly to monitor progress, identify bottlenecks, and help the providers identify appropriate solutions.
- Monitoring and evaluation are also incorporated into these visits to measure the extent to which the improvement plan has been implemented.

The SafeCare standards were internationally recognized and accredited in 2012 by the International Society for Quality in Health Care (ISQua) and have been introduced in Tanzania, Ghana, Kenya, and Nigeria. Innovative public-private partnerships with the Medical Credit Fund in Uganda and the National Health Insurance Fund in Kenya have helped sustained the approach in these countries.

Strengths:

- Makes the scale and scope of QoC more transparent, thereby increasing trust between the key market actors in LMIC health systems—providers, patients, investors, insurers, and policy makers (13).
- Focuses on basic and primary health care facilities that are most common in LMICs.
- Reduces risk for banks and investors and stimulates investment in private sector by increase efficiencies in health care provision (13).
- Rating system allows for comparison of (gaps in) quality of care between health care providers of similar size and scope.

Limitations:

- The costs of the full cycle of assessments and improvement is donor subsidized, and few facilities have been willing and able to self-finance these costs, as they do not see the financial benefits of improvement (13).
- The responsibility to recruit health care facilities the program, conduct assessments, gather, and submit SafeCare data, and support facilities to implement QIPs is borne for a significant part by these technical assistance partners (13).

CASE STUDY 4: DIGITIZING LICENSING AND REGISTRATION OF HEALTH PROFESSIONALS IN UGANDA

As part of their mandate, the health professional councils in Uganda are responsible for licensing health facilities and registering health professionals, regulating private practice, and applying sanctions as appropriate. They are also responsible for ensuring the continued professional development of its members. Prior to digitization, the process for obtaining practice and facility licensing were lengthy and cumbersome (14). The development of on an online platform to support registration and licensure functions was supported by USAID and the World Bank's Health in Africa Initiative between 2016 to 2018.

The new web-based system – called the eLicensing Platform – allows for online registration licensing of health professionals, unlike the old system, where they had to be physically present in Kampala. Several functionalities of the new systems to ease licensure and registration include (14):

- Personal Identification Number.
- Tracking function to see where the application is in the approval process.
- Online appointment for the facility inspection and online payment of fees.
- Built-in interface with Uganda's Self-Regulatory Quality Improvement System (SQIS).

Strengths:

- Cuts down on time and costs associated with registration and renewal of licenses incurred by health workers especially those with private practice outside of Kampala.
- Reduces regulatory agencies costs and process is more efficient leading to faster turnaround time.
- Links licensing to quality assessment and allow regulators to undertake targeted risk-based inspections and develop closer relationships with providers and consumers.
- Communities can question or validate license or registration through the platform (14).
- Links registration and licensing with Continuous Professional Development (CPD) as part of the license renewal requirements.
- The platform informs health workers what training is available, where and automatically tracks their CPD hours (14).

Limitations:

- Requires a change in regulations to compel all private providers to transition from paper-based processes to eLicensing platform.
- Takes a long time (still in the process) to enroll and train all providers and facilities in the platform.
- Although the platform is a more cost-effective mechanism, it still requires additional resources and staff to ensure enforcement.

Reinforcing Factors

In addition to institutional factors that relate to how management is delivered, community and client-level approaches reinforce these enabling factors for supporting QoC for FP delivered through the private sector.

Community Level

Engaging the community in QA/QI processes is a way to make contraceptive services more responsive to local needs and increase community ownership of the services. Key reinforcing drivers of QoC at the community level include community engagement, collaborative accountability, and stewardship. The study identified five community engagement approaches for reinforcing FP QoC (See Box 5 for an overview of QoC approaches at this level).

BOX 5: COMMUNITY LEVEL APPROACHES

- Community outreach
- Community in-reach
- Community-facility/provider accountability
- Community-Institutional accountability
- Community inclusion in Stewardship

The assessment found the following gaps/challenges at this level:

- Limited private sector presence at the community level overall.
- Entrenched social and gender norms continue to limit access to contraceptive services in some contexts.

To address these gaps/challenges the following recommended approach was identified:

- Ensure participation of community health committees, community leaders, and community members in QoC processes at sub-national and local levels based on collaborative social accountability tools/processes (e.g., community scorecards, facility walk-throughs, membership on facility QA/QI Committees, etc.).

Case study 5 is an example of a community-driven accountability practice in the public and private sectors and points to the need for more jointly designed public/private/community solutions for engaging the community in private sector QA/QI mechanisms. Making contraceptive services more responsive to local needs and increasing community ownership of the services entails collaborating with sub-county chiefs, local council (LC) chairpersons, health unit management committee (HUMC) chairpersons, village health team (VHT) members, community development officers (CDOs), community health workers, and sub-county councilors and volunteers to identify local innovative ways of dealing with the health service delivery and utilization challenges that they face.

CASE STUDY 5: INFLUENCE OF COMMUNITY SCORE CARDS (CSC) ON MATERNAL AND NEONATAL HEALTH SERVICES IN UGANDA

CSCs have been used on a small scale in Uganda and other countries to improve social accountability and quality of health services. Despite the potential positive impact on social accountability and quality of care their use in improving FP and maternal and newborn health (MNH) services remains limited in LMICs which still bear the heaviest burden of maternal mortality (15). An empirical study was conducted by the Future Health Systems Research Program Consortium in Uganda from 2017-2018 at four public health facilities and one private health facility to explain the routes through which CSCs work to improve QoC and provide explanations for any changes. The CSC intervention was implemented by sub-county chiefs, local council (LC) chairpersons, health unit management committee (HUMC) chairpersons, village health team (VHT) members, community development officers (CDOs), and sub-county councilors and volunteers.

Five rounds of scoring were implemented on a quarterly basis based on a stepwise process (e.g., preparatory groundwork, health facility identification and scoring of indicators, community identification, prioritization and scoring of indicators, interface meeting for stakeholders to discuss scores and solutions, and community advocates following-up on actions, conducted regular meetings and lobbied for support from partners.) At the community-level, respondents noted perceived improvements in birth preparedness and access to care due to improved information flow, increased citizen demand and collaborative problem solving and more responsive community leaders (15). At the facility level there was an improvement in availability of mid-wives, maternity beds, and drugs, as well as health worker attitudes (15). These changes were attributed to holding stakeholder accountable for their actions and top-down pressure from leaders for improved performance (15).

Strengths:

- Attracts the attention of other implementing partners and the support of the sub-county and district councils which control local budgets.
- Improves information flow and increased awareness among stakeholders about their roles, standards, and expected services.
- Improves trust and working relations with district stakeholders, health workers and the community in addition to facilitating more political involvement and support for maternal health services.
- The above changes can also influence health seeking behavior leading to increased uptake of services (15).

Limitations:

- Lacks a mechanism for communicating stakeholder concerns and recommendations from the process to effective governance structures which can identify, and harness locally existing solutions and resources needed to address the problems identified in addition to holding providers accountable for their performance (15).

Client Level

Key reinforcing factors of QoC at this level, identified by the study, include positive provider-client interactions, shared decision-making frameworks/tools, client access to information to advocate for and manage their own care, and client engagement in QA/QI mechanisms. (See Box 6 for an overview of QoC approaches at this level).

BOX 6: CLIENT LEVEL APPROACHES

- Client empowerment and accountability
- Client feedback systems and clients' perceived quality of care

The main gaps/challenges from the assessment included:

- Information asymmetry often characterizes interpersonal clinical encounters, where healthcare providers possess more knowledge than clients. This knowledge gap can lead to a lack of client awareness regarding available service options and their rights, as well as a limited understanding of what constitutes "good quality" healthcare. Addressing these disparities is crucial for empowering clients to make informed decisions about their health and ensuring they receive the highest standard of care.
- Client feedback channels (e.g., third-party exit interviews, client participation in QoC assessments, including client representation on QA/QI committees or organizational Boards, engaging clients in designing/redesigning services, etc.) are lacking in the private sector.
- Although traditional satisfaction surveys are relatively common, they have limitations because they are prone to expectancy disconfirmation, courtesy bias, and response bias. These biases can distort responses, resulting in an unreliable portrayal of service quality and potentially impeding the utility of survey outcomes in guiding decision-making processes, making it challenging to enhance service delivery quality.

The recommended approaches/practices that emerged included:

- Provision of adequate information on contraceptive methods for shared decision-making, including balanced counseling approaches, and tiered effectiveness counseling that focuses on method efficacy including LARCs.
- Expansion of the method mix offered by community-based services.
- Public display of charter of patient rights.
- Use of automated alerts and reminders for clients regarding their care.
- Use of online mechanisms to provide information and support for clients, their family and other caregivers, and their clinicians in encouraging self-management.
- Augment traditional surveys and complaint processes through the fuller engagement of clients in reviewing and improving the quality-of-service delivery in institutions and the community.

At this level, clients, clients' spouses/partners, caregivers, and families need to be engaged in any practices to make the quality of care more person-centered, improve patient efforts to manage their own care, and integrate patients in efforts to improve or redesign service delivery by incorporating client experience. Case story 6 provides an example of how the quality of care is adapting to the shift from information, products, and services previously offered by health

providers to being directly accessed by clients playing a greater role in their own care through self-care interventions.

CASE STUDY 6: QUALITY OF CARE FRAMEWORK FOR SELF-CARE

Self-care interventions (e.g., self-injectable contraception, human papillomavirus self-testing, HIV self-testing, etc.) are evidence-based health actions that can be provided fully or partially outside of formal health services and can be used with or without the direct supervision of health care personnel (16). As self-care becomes more prevalent and accessible, QoC mechanisms must adapt to support the individual's engagement in their own care while ensuring quality, equity, and accountability (16).

Population Services International (PSI) and the Family Planning 2020 Self-Care Trailblazers Working Group, developed the Quality-of-Care Framework for Self-Care aligned with the WHO Consolidated Guideline on Self-Care Interventions for Health. The new framework shifts the focus of QoC from provider and facility quality to QoC elements relevant to self-care. Drawing from the Bruce-Jain Framework and the WHO Conceptual Framework for Self-Care Interventions the following five domains form the core of the new framework (16):

- Technical competency
- Client safety
- Information exchange
- Interpersonal connection and choice
- Continuity of care.

A total of 41 standards comprises the framework and each can be adapted for any self-care intervention. Instead of assessing a provider's competency to provide quality health care the self-care standards assess the client's capacity to manage their own care with safety and competency. However, the standards do assess health worker capacity to support person-centered self-care, whether offered directly or with a digital application. Several standards also address the capacity of the health sector to assess if a client has access to information that is responsive to their needs regarding the benefits, risks, and side effects of the self-care intervention. (16)

Strengths:

- The framework complements existing QoC frameworks.
- Helps implementing partners or a MoH augment current quality of care system for self-care or to integrate self-care interventions more effectively and efficiently.
- Helps identify the QoC features that a self-care intervention requires of the health system that need further strengthening.
- Facilitates measurement of the quality of an individual's experience with self-care more effectively and determine effective responses.

Limitations:

- The framework's effectiveness in improving client capacity to manage their own care with safety and competency hasn't been formerly evaluated.

Predisposing Factors

QoC solutions that address predisposing factors were described as approaches at a facility level or approaches directly focusing on private providers.

Facility Level

The study identified strong management, adequate infrastructure, robust information systems, available supplies/commodities, CQI process, and client and community engagement and feedback processes as predisposing drivers of functional QA/QI mechanisms at the facility level. See Box 7 for QoC approaches at this level based on these predisposing factors).

BOX 7: FACILITY LEVEL APPROACHES

- Facility management
- Facility Infrastructure
- Facility information systems
- Availability of commodities
- FP QoC functions and mechanisms at facility level
- Client engagement and feedback mechanisms
- Community engagement and feedback mechanisms

Gaps/challenges that emerged from the assessment included:

- Poor monitoring of contraceptive product quality, especially Emergency Contraceptives.
- Lack of appropriate equipment and stockouts limits IUD provision
- Facilities usually do not have robust mechanisms in place for routinely assessing whether services align with principles of person-centered care (PCC)[6]. Where client exit surveys are undertaken, monitoring usually covers client satisfaction and PCC performance is rarely monitored.
- High attrition among trained QA/QI personnel

Recommended practices to address these gaps/challenges included:

- Use of comprehensive and participatory QI approaches such as Total Quality Management and the Bruce/Jain framework.
- More emphasis on ongoing monitoring of quality to reduce reliance on annual audit cycles,
- Harmonizing/simplifying contraceptive service quality measurement tools to enable routine facility-level monitoring in low-resource and community settings.
- Inclusion of performance objectives and targets relating to QoC in staff job descriptions.

[6] Person-centered care (PCC) prioritizes client needs, preferences, and values, emphasizing collaboration between healthcare providers and clients to tailor information and services accordingly. PCC monitoring entails obtaining client reported measures, such as client preferences, client perceptions of the quality of provider counseling, and perceptions of provider attitude towards the client, are widely regarded as effective means to assess person-centeredness, as they allow persons served to evaluate whether care aligns with their values, preferences, and needs. By incorporating person-centered measures in client exit surveys at the facility level institutional implementers, facility managers, and service providers can better ensure that care delivery is truly centered around the person, enhancing overall quality and satisfaction. Please see Case Study 8 for a description of PCC monitoring in the Beyond Bias project.

- Engaging private logistics providers to manage deliveries from regional levels to local health facilities.
- Establishing separate spaces to ensure privacy for contraceptive services/counseling.

Improving readiness and access to quality care of facility - and community-based health services and self-care interventions throughout the continuum of care entails engagement of managers, supervisor Facility Health Management Committees, Community Health Committees, quality supervisors, health and non-health staff, community members, and clients. Case study 7 is about a QI process that helps facility staff continuously improve the quality and efficiency of services provided at their facility and make services more responsive to clients' needs. Please see Case Study 8 for a description of PCC monitoring in the Beyond Bias project.

CASE STUDY 7: CLIENT ORIENTED PROVIDER-EFFICIENT (COPE) FAMILY PLANNING AND REPRODUCTIVE HEALTH SERVICES

Effective approaches to improving QoC at the facility level require engaging clients, the community, facility staff, and sub-national MoH officials in QA/QI processes. COPE is an evidence-based joint quality improvement approach for engaging multiple stakeholders. COPE was developed by EngenderHealth to provide facility supervisors/managers and health and non/health facility staff a practical, participatory approach to identifying problems with QoC and developing solutions using local resources, thus building commitment to CQI.(17) Drawing from global standards of care COPE promotes a client centered care approach, based on seven clients' rights and acknowledges the administrative support and critical resources facility staff require to provide quality care, based on three providers' needs (17).

The COPE process includes the following steps (17):

- Information-gathering and analysis: Using self-assessments based on standards of care, client interviews, record review, and a client flow analysis to identify problems.
- Action Plan development and prioritization: Refining a problem, prioritizing, recommending solutions, and deciding by whom and by when the problem will be addressed.
- Implementation of the Action Plan: Supervisors and staff share decision-making and responsibility for implementing actions.
- Follow-up and evaluation including discussion of the progress made on the Action Plan: This includes evaluation of successes and failures, further information gathering, and development of a new Action Plan, with new problems and solutions identified, and completing the process by beginning again with Step 1.

COPE exercises are led by two types of facilitators using the above set of complementary tools. (e.g., self-assessment guides. The external facilitator introduces COPE to the facility, guides the staff through the COPE process during the first COPE exercise, and trains one or more staff members to be site facilitators. The site facilitator organizes and facilitates subsequent COPE exercises, to establish a continuous QI process at the facility. At the end of the facility's first COPE exercise, the external facilitator helps the staff establish a COPE Committee. This committee—composed of staff members, supervisors, and site managers—plays a critical role in making QI an ongoing responsibility and the focus of the daily work of staff at all levels.(17)

Strengths:

- Evidence-based practice used in the public and private sectors in more than 45 countries and translated in 15 languages.
- Promotes teamwork and a sense of ownership of CQI by engaging all facility staff, community health workers, community members, and clients to identify local solutions based on local resources.
- Helps communicate service standards and improve performance.
- Helps facility managers work more effectively.
- Includes Community COPE, a companion handbook for engaging the community to improve QoC.

Limitations:

- Requires an initial investment of resources to train the on-site facilitator and orient facility staff to the process.
- Given high turnover of trained QA/QI staff can be challenging to sustain the facility QI team.
- If not institutionalized in a country's QA/QI system and linked to a supportive supervision process upstream QoC problems are challenging to solve at the facility level.
- COPE has seen widespread adoption in both public and private sectors across numerous countries. After an initial investment, integrating COPE into routine quality audits and training mechanisms in private sector facilities appears to be feasible. However, for large-scale implementation in the public sector, greater investment is required, necessitating political commitment to ensure sustainability.

Service Provider Level

To ensure service providers continuously improve the quality and efficiency of services provided at their facility and make services more responsive to clients' needs, they require clinical competence and skills, behavioral competence and counseling, supervision, monitoring support, in-service continuous professional development, and FP QoC data to inform service provision. (See Box 8 for relevant QoC approaches based on these predisposing factors).

BOX 8: SERVICE PROVIDER LEVEL APPROACHES

- Clinical competence and skills of service providers
- Behavioral competence and counseling skills of providers
- Supervision and monitoring support
- In service continuous professional development uptake
- FP QoC data reporting and sharing

With respect to these predisposing factors, the assessment found the following gaps/challenges:

- Health workers are not updated on current clinical guidelines.
- Job aids are not routinely used by health providers,
- Limited number of trained providers on IUD insertion is a missed opportunity for scaling up PPFP services.
- Service providers favor methods that take less time to provide to clients
- Service providers are judgmental toward the needs/preferences of adolescents.

Based on the assessment, recommended practices to address these gaps/challenges include:

- Training and supervision to improve interpersonal aspects of care should be integrated into future PPFP initiatives and PP and PAC visits.
- Investment in midwives' education, regulation, management, and work environment is paramount.
- Capacity building initiatives should prioritize training of master trainers, training on aspects of PCC, supervision of the health workforce, and skills-building through simulations.
- Acknowledging the best-performing service providers in front of their peers reinforces behavior change.
- Use QI collaboratives to bring together health professionals from across facilities to learn and apply CQI methods.

Case story 8 provides an example of a training intervention to address bias among providers. Key market actors to engage at this level include District Health Management Committees, Facility Health Management Committees, Community Health Committees, facility supervisors/managers, pre-service and in-training institutions, community midwifery and community health nursing education schools, trainers, and health providers.

CASE STORY 8: BEYOND BIAS PROVIDER BEHAVIOR CHANGE MODEL

Research shows that provider bias and judgmental behavior is a major barrier to the use of contraception by young people, including newly marrieds and first-time parents. (18,19). Decades of training and supervision have been insufficient in addressing biases held by sexual and reproductive health providers. Recognizing this, the Beyond Bias Project identified 11 key global drivers of bias through a comprehensive literature review and formative research process involving 900 providers, youth, and community leaders in Burkina Faso, Pakistan, and Tanzania. (20) In collaboration with Camber Collective, YLabs, and RAND, they designed the Beyond Bias approach for shifting providers' negative attitudes and behaviors.

The Beyond Bias behavior change model is based on Six Principles of unbiased care operationalized through three pillars (20):

- **Summit** - if providers are supported by a community of peers and trusted experts to activate their motivation and self-awareness of bias.
- **Connect** – if providers apply knowledge and motivation toward eliminating bias from their work.
- **Reward** – if providers achieve recognition for improved performance, then the quality of FP/SRH care they deliver to youth clients will improve. Together the three prongs reinforce each other across the continuum of care.

The model entails a stepwise process that includes introducing the Six Principles to providers, case study discussions to deepen the understanding of the Six Principles, action plans aligned with the Six Principles, quarterly report cards outlining data on how well facilities are performing on each of the Six Principles, and regular reviews of performance (20).

It is also links to the client level of the CQI Framework by addressing client experience of quality, including person centeredness of Method Information and Provider Interaction, with three sub domains (Verbal Interaction, non-Verbal Interaction, and Perceived Disrespect and Abuse). Each of these perceptual domains is mapped to specific sets of Principles of Person Centeredness of FP Care (PPCP) described in the Six Principles (20). These can be measured reliably during client exit interviews. using the PPCFP Scale and Sub Scales included in the Beyond Bias package. The scales are designed to yield validated client-assigned scores to providers which reliably reflect how well providers adhered to principles of person-centered care. Scores were included in report cards that were given to providers every quarter and linked to the Rewards pillar.

Strengths:

- Based on an evaluation of the approach in Burkina Faso, Pakistan, and Tanzania, Beyond Bias led to a significant reduction in biased attitudes and beliefs among public and private providers in all three countries and to more comprehensive counseling and better perceived treatment of young family planning clients in Tanzania and Pakistan (20).
- Creates a safe supportive environment free of blame or fear of punishment,
- Focuses on feasible actions providers can take to address biases in their practice.
- Rewards providers' progress towards standards of unbiased care, connecting bias to what providers care about, and celebrating providers' knowledge, experience, and commitment.
- Many opportunities exist to incorporate Beyond Bias solutions within existing programs, even if it is not currently feasible to adapt the entire model in each context.

Limitations:

- Responding to provider bias requires linking with facility level QoC interventions (e.g., strong management, adequate infrastructure, available supplies/commodities, etc.) to address provider needs and incentivize their performance.
- In addition, it requires linking with community level (e.g., community engagement, social accountability, etc.) QoC interventions to promote unbiased contraceptive services for clients in the community.
- Measuring provider bias is difficult due to challenges in obtaining unbiased feedback from clients at the facility level.

Conclusion

Through the lens of CQI, this report highlights how QoC in the private sector is a balancing act involving multiple market actors and using different policy/regulatory mechanisms and QA/QI approaches at multiple levels. Although this report found that most literature focuses on the private sector's capacity to deliver quality healthcare services in general, many of the lessons learned are applicable to strengthening of the private sector's ability to deliver quality FP services and products.

To create an enabling environment for strengthening QoC in the private sector, donors, policymakers, FP program planners/implementers, facility managers, for-profit and not-for-profit private operators, professional associations, non-governmental organizations (NGOs), advocacy groups/networks, and community leaders should consider the following recommendations:

- Deploy a systematic and multi-level CQI framework for assessing, applying, and evaluating a blend of evidence based QoC approaches based on local context. The FHM Engage Expanded Framework for FP QoC Solutions presents an FP QoC ecosystem that identifies a comprehensive set of approaches and solutions for strengthening QoC drivers across three levels of influence and six operational sub-levels. The Framework was conceptualized to provide a guiding roadmap for exploring and mapping the FP QoC ecosystem in any given context.
- Prioritize and ensure that QoC regulations, standards, and guidelines are developed and adopted at policy and institutional levels that support and sustain QA/QI systems/practices at facility, provider, community, and client levels.
- Adopt a supportive versus punitive approach to regulatory oversight of the private sector based on greater public/private collaboration.
- Strengthen individual and institutional capacity for proactive and effective stewardship to ensure that market actors' incentives, capacities, and accountability structures are aligned to achieve improved health outcomes.
- Improve access to timely and relevant QoC data and information to support evidence-based decision-making throughout the CQI cycle.
- Institutionalize periodic supportive supervision in QA/QI systems to reinforce quality standards at facility, provider, community, and client levels.
- Strengthen private provider capacity based on a step-wise approach that rewards person-centered care that is free from bias.
- Incentivize private providers by supporting clinical training in the latest methods, along with certification.

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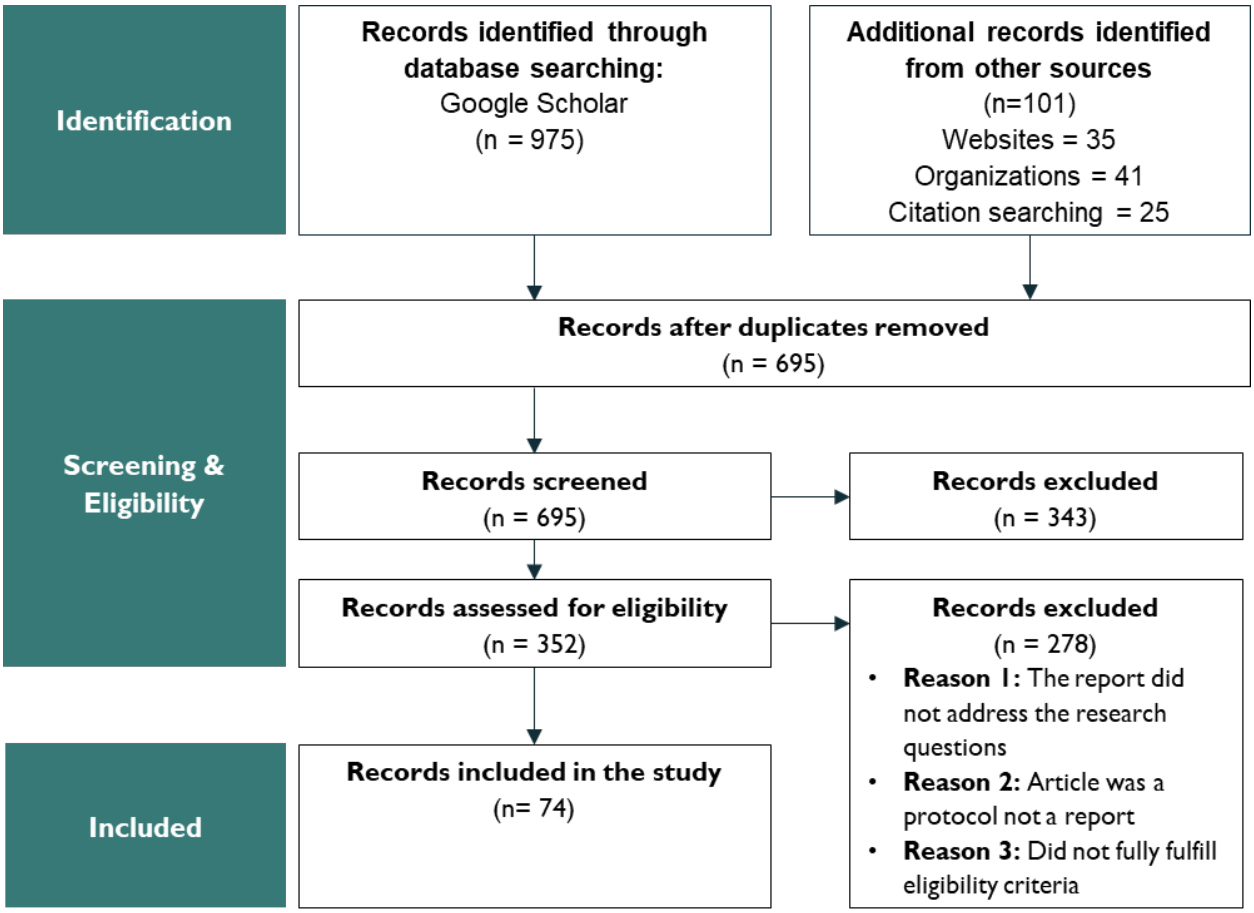
Annex 1. Identification, screening, and selection of records for desk review



Annex 2. List of Key Informants Interviewed for the Study

S/No.	Name	Designation & Organization	Country / Location
1	Mr. Heem S. Shakya	Sr. Consultant, Health Systems, Procurement, and Supply Management, Nepal	Nepal
2	Mr. Uttam (Raj) Regmi	Programme Manager- NHSSP 3/UKAID, Options-Nepal	Nepal
3	Dr. Norhan Bader	Medical Doctor | SRHR Specialist in Egypt	Egypt
4	Mr. Charles Nwaigwe	Monitoring & Evaluation Advisor, JSI	Nigeria
5	Mr. Kajura Ronald	Manager Origin team Micro labs	Uganda
6	Mr. Ivan Kayondo	Senior Quality Improvement and Knowledge Management Officer at TASO Uganda	Uganda
7	Mr. Victoire Medi Muhigirwa	Supply Chain Advisor, Global Health Supply Chain - Technical Assistance Francophone Task Order, Chemonics International	Democratic Republic of the Congo
8	Mr. Munyaradzi Dhodho	Member Board of Directors at Doctors Without Borders-Southern Africa	Zimbabwe
9	Dr. Tukaram Khandade	State Lead - Health System Design, JHPIEGO	India
10	Dr. Mahlet Berhanu	Capacity Building and Education Advisor, JHPIEGO	Ethiopia
11	Dr Eva Lathrop	Medical Director, PSI	USA
12	Dr. Lydia Murithi	Senior Global Technical and Strategy Advisor, Pathfinder International	USA
13	Ms. Pari Chowdhary	Senior Technical Advisor, Health Equity and Rights, CARE	USA
14	Dr. Hifsa Altaf	Ob/Gyn Clinician, SRHR and QoC consultant	Pakistan
15	Dr. Were Job	Pharmacist, Ministry of Health	Uganda
16	Dr. Victor Igara	Director, Private health facility	Uganda
17	Dr. Toko Rashid	Director, Private health facility	Uganda
18	Dr. Mayeya Paul	District Health Director at Ministry of Health	Zambia
19	Ms. Rotimi Oladira	Former Commercial Director, MSI Reproductive Choices	Nigeria
20	Dr. Jean Jose (Jimmy) Nzau	Global Medical Director, Pathfinder International	USA

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.

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