

# Incentives and barriers to implementing national hospital standards in Uganda

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## Abstract

**Objective.** The objective of this study was to elicit hospital staff's knowledge, attitudes, and current practices regarding hospital standards and to assess the level of motivation for staff and hospitals to meet new standards.

**Design.** This was a qualitative study using in-depth interviews and focus group discussions with staff in four hospitals. There was no intervention.

**Setting.** Four rural public and private not-for-profit hospitals in central Uganda.

**Participants.** Medical superintendents and other staff of four hospitals in Uganda who were familiar with the use of standards and had participated in a previous Uganda national accreditation program (Yellow Star).

**Results.** All staff expressed strong support for the development and implementation of hospital standards, but also said they would need more recognition and ongoing motivation. They cited the need for technical assistance, funding, and training as the main obstacles. Key areas requiring standards were: infection control, cleanliness and hygiene, infrastructure and medical records.

**Conclusions.** There was strong support for the development and implementation of hospital standards. The main perceived obstacles to the implementation of hospital standards are resource limitations and technical capability. There is a need to develop and implement preliminary standards for hospitals in Uganda.

**Keywords:** accreditation, developing countries, standards, hospitals, Uganda

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## Introduction

Improving the quality of hospital care in developing countries can contribute to the attainment of health-related Millennium Development Goals [1], especially the reductions in maternal and child mortality. Many factors negatively affect the quality of hospital care, including weak governance and management, health workforce shortages, pharmaceutical shortages, malfunctioning equipment, inadequate record-keeping and diagnostic capabilities, the absence of quality improvement programs and the poor coordination of care with other facilities [2–4]. These factors are magnified in sub-Saharan Africa, which has only 2% of the world's health-care workers, but 24% of the global disease burden [5].

Notable social and economic changes in Uganda have led to improvement in primary health care emphasizing disease prevention, controlling common diseases, health education

and promotion and rehabilitation of people with disabilities. About 30% of health facilities in Uganda are run by the government's Ministry of Health (MOH), 45% by private not-for-profit facilities and 25% by private-for-profits [6].

However, a recent national survey has identified serious shortcomings in hospital care [6]. Most hospitals lacked regular water supply, electricity and basic patient amenities. Only 6% of hospitals had all the necessary basic infection control elements (i.e. soap, running water, disinfectant and latex gloves) in all service areas. Essential supplies and medications were lacking in several areas. These findings suggest that new strategies such as introducing hospital standards, quality improvement committees, patient safety initiatives and continuing professional education are needed to improve the quality of hospital care in Uganda. Standards provide a uniform approach to the minimum requirements needed to provide safe effective care. They can be used to identify deficiencies,

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setting the stage for prioritizing budget allocations and implementing continuous performance improvement.

Uganda has made some previous attempts at implementing hospital standards, for example, the United States Agency for International Development (USAID) supported the 'Yellow Star' program (July 2000) as part of the Delivery of Improved Services for Health (DISH) II Project. This project involved the MOH, health districts and other development partners. Its focus was on improving the quality of primary health care through supervision, certification and reward, promotion of facilities use and client satisfaction measurement. Despite its early success and potential to improve the quality of services, as well as to create a more efficient and effective supervision of health facilities, the government had difficulty sustaining it when donor funding ended in 2005 [7].

Currently there is no uniform standard or accreditation process on which to judge hospital performance in Uganda despite evidence that accreditation has been associated with the improvement in quality of health care in other settings [8–11]. It should be noted, however, that not all hospital accreditation processes have yielded significant quality improvement [12–14]. Comparing accreditation programs in developing countries or examining outcomes from single disease-focused accreditation programs is difficult because different indicators and methods are used [15, 16].

In anticipation of launching an accreditation program in Uganda, we wanted to elicit hospital staff's knowledge, attitudes and practices regarding hospital standards, and to identify the incentives and disincentives related to implementing those standards and accreditation system.

## Methods

### Design

To assess the potential barriers and incentives for implementing hospital standards, we used a qualitative research approach including in-depth interviews and focus group discussions. We selected a convenience sample of four hospitals within 200 km of Kampala, the capital of Uganda. Two were medium-sized private hospitals and two were government hospitals. We met with medical superintendents (or their designees) from the hospitals to introduce the survey, set up appointments for the interviews and obtain permission to conduct focus groups with staff. In our first meeting, an information form detailing the study aims was given to each interviewee and verbal consent was obtained to record the interview. Following the initial interview, we asked the hospital superintendent or designee for permission to conduct focus group discussions with clinicians, hospital heads of department and nursing staff. Dates were selected for a return visit to the hospital for these discussions. Similar consent procedures were held before the focus group discussions.

Interviews and focus discussions covered the following areas: hospital's current use of standards, attitudes about using or having additional standards, priority areas for

standards, opinions about draft national standards, self-assessment, motivation for hospitals to meet standards, hospital collaboratives and suggestions for improving quality. We gave respondents an opportunity to review the draft national standards brought by the research team but developed earlier by a working group composed of members from the Ministry, Makerere University and selected staff representing private hospitals who were not included in the current study. We conducted the interviews and focus group discussions over a 2-week period in July 2008, each lasting less than an hour to minimize interruption to patient care.

### Data analysis

We described participating hospitals in terms of bed capacity and location. All focus group discussion notes and interview recordings were transcribed and analyzed by the study team. We identified and tabulated themes, and illustrated them with representative quotations. We analyzed transcripts from individual interviews and focus groups together and summarized common themes. We combined focus group and individual interview data because (i) the same questions were posed to the focus groups and in individual interviews; (ii) in some cases, because of short staffing, focus groups devolved into a series of serial interviews; and (iii) information received from the two methodologies did not differ in any systematic way. We obtained Institutional Review Board approvals from the University of Washington and Makerere University. All data were collected without attached names, and audio recordings were deleted after being transcribed.

## Results

### Characteristics of participants

The four hospitals in our study were separated from each other by at least 50 km. They each had a built capacity of 100–120 beds. At the time of the study, each reported having more patients than their official number of beds. We conducted interviews with four medical superintendents and one hospital chief nursing officer. Four of the interviewees were males and one female. All had clinical duties in addition to management roles. One had post-graduate training, while others were medical officers (a cadre of medical school graduates without specialty training). One of the interviewees was also in charge of the health sub-district that was part of the hospital catchment area. Focus group participants included clinicians (doctors and clinical officers, a mid-level cadre equivalent to physician assistants in the USA), nurses, midwives and heads of hospital departments. Table 1 illustrates study participants by their roles.

*Use of hospital standards.* Representatives from all four hospitals in our study said they were familiar with a precursor Ugandan hospital standards improvement program known as 'Yellow Star,' and were still using its components even though there was no longer a national support system for the program. None of the focus group participants had

**Table 1** Focus group participants in a study of Uganda hospital staff's knowledge and attitudes towards hospital standards for accreditation

Hospital	Doctors	Nurses	Heads of department	Total staff
1	5	8	10	23
2	1	4	1	6
3	2	5	3	10
4	7	7	5	19
Total	15	24	19	58

Source: primary data collection, standards research team, July 2008.

seen any representatives from the Yellow Star program in the prior 3 months. In addition, one superintendent stated, 'We are following some informal guidelines. We are collaborating with a foreign hospital on developing some guidelines and ways to improve care.' All hospitals mentioned following treatment guidelines for specific medical problems from the MOH, such as for human immunodeficiency virus (HIV) care and World Health Organization's Integrated Management of Childhood Illness.

*Attitudes about using or having additional standards.* Attitudes toward standards were almost all positive. One medical superintendent stated, 'I think standards are good in that they help people work together in a common direction.' Others noted that since society and technology were constantly changing, new standards are frequently needed. Many focus group participants felt the standards needed to be aligned with the MOH. Participants expressed the desire for more adherence to existing standards. For example, one participant said, 'If people adhere to them, it would be much better than simply doing what they think is right.' The participants cited numerous obstacles hampering the implementation of standards, such as staff shortages, overcrowding of patients due to limited physical space, limited supplies, limited drugs and shortage of resources and technical assistance.

When a draft set of standards was shown (see Table 2), most participants cited infection control, quality improvement, support services and other issues related to human resources as those they could potentially implement within current resources [17]. Half the respondents thought their hospitals had enough staff to implement some standards. Participants doubted that they could implement standards related to physical infrastructure without significant additional resources. As one staff member noted, 'These hospitals have been around for over 40 years.' Three of four medical superintendents felt they would be able to adopt some new standards, but they could not implement many without additional financial and technical support.

When asked if they want additional standards, the majority (three out of four medical superintendents) agreed there was need for additional standards, but also felt that 'standards without resources to implement them are useless.' One medical superintendent stated that the hospital had adequate

**Table 2** Categories of hospital standards

Category	Details of standards
1	Governance, management and leadership
2	Quality improvement and patient safety
3	Physical infrastructure
4	Human resource management establishment
5	Medical records
6	Infection control and waste management
7	Equity

standards and additional ones would not improve care, since 'we have covered all areas.' Participants repeatedly raised concerns over the implementation of new standards given the current situation of the lack of running water, absence of gloves and frequent stock-outs of crucial medications. One medical superintendent vowed that he would resign if he was compelled to implement new standards without additional resources.

*Priority areas for standards.* Most medical superintendents said they could use standards in infection control, cleanliness and hygiene, infrastructure (running water and functioning equipment) and medical records in order of importance. They also supported having financial standards and regular external audits. The single medical superintendent who thought all areas were covered by existing standards did acknowledge the need for better standards in infection control. He felt protocols were only needed for 'less common occurrences such as trauma following road traffic accidents,' because for common occurrences, current management standards would cover the situation and would not necessitate additional protocols.

There was consensus that having standards in areas that could only be improved with significant new funding, such as physical infrastructure, would not be fruitful. As one medical superintendent explained, 'It will just increase our stress. Scoring less on such a standard (over which we have little control) would only demoralize staff.' A focus group participant stated, 'This hospital was built over 30 years ago with 100 beds. Now we have 150 or more patients including some on the floor. This makes implementation of standards difficult.' Participants mentioned infrastructural problems such as the lack of piped water and space, which meant that HIV patients were exposed to infectious diseases such as tuberculosis. As one participant stated, 'Water affects everything.' In one hospital, water sourced from a swamp had ruined a new autoclave. Participants also said they were exposed to diseases such as Hepatitis B, but had never been immunized.

Understaffing was another constraint mentioned frequently. One medical superintendent said 'We are only 60% staffed and doctors mostly are missing.' The hospitals further from the capital city reported difficulty in retaining doctors. They also reported that most doctors outside of Kampala were paid \$300 per month, whereas non-governmental

organizations paid \$1000 per month to Kampala-based physicians. This pay differential and preferential location in Kampala presents a serious challenge to recruiting and retaining physicians, a pattern repeated in other developing countries [18].

*Hospital self-assessment.* Two of the medical superintendents said they could implement a self-assessment, and the other two would prefer an external audit if funds were available. All-said hospitals were willing to self-assess, although some opined the results of the self-assessment should not be used to compare hospitals because of the obvious inherent disincentives to identify deficiencies. Participants also expressed concern over whether they had the expertise to self-assess physical infrastructure, and then plan for renovations.

*Motivation for staff and hospitals to meet standards.* All agreed that rewards rather than penalties would be more successful in motivating staff. Many indicated striving to meet standards was part of their professional duty. Most said it would be counterproductive to penalize in the absence of sufficient resources to meet the standards. As one participant stated, 'I don't have gloves. How can you penalize me?' Another participant commented, 'At this hospital they (the MOH) are supporting 50% of what's required to meet standards, and that is the level we should meet.' 'I don't think the government needs to come in and punish us.' 'We want to be helped and not be punished.' There was strong support for positive reinforcement. The consultative nature and feedback provided by Yellow Star was viewed positively. For example, one participant mentioned, 'Yellow Star motivated us. Everyone asks how many points we got. Did we reach 80 of the 100 possible points?'

*Performance improvement mechanisms.* In every focus group and interview, the need for additional resources and technical assistance was emphasized. Technical assistance included consultation and feedback on how standards could be met, as well as specific training in financial management, infection control and quality management. Hospital staff also desired continuous professional education to improve clinical skills. In addition, technical consultation was considered necessary to improve the physical infrastructure, including new construction, or renovation or replacement of critical mechanical systems such as water systems.

Participants were also queried about whether they felt forming hospital collaboratives would assist them in meeting standards. A collaborative is where facilities within a geographic region (for logistical reasons) work together to coordinate care of patients referred between them, to share strategies to address needs such as infection control, to coordinate purchasing and delivery of supplies and pharmaceuticals and to participate collectively in continuous professional education. In principle, having collaboratives appealed to medical superintendents. They noted they often feel isolated and would benefit from more interaction with colleagues from other hospitals, sharing of specialty consultants and visits to other hospitals to observe better practices. Collaboratives might improve recruitment and retention of staff at hospitals more remote from Kampala.

However, they also noted that individual hospitals have differing procurement systems and levels of resources. Faith-based hospitals are already supported by the Uganda Catholic Medical Bureau or Uganda Protestant Medical Bureau, which provide a form of collaborative. A limitation of collaboratives was that such alliances could be one sided, since facilities with chronic shortages would not benefit the others. In view of this limitation, the medical superintendents in non-governmental hospitals would not be willing to set up collaboratives with their public hospital neighbors, as they felt it was unlikely to benefit them. The medical superintendents in public hospitals, however, welcomed the idea of collaboratives. One said, 'A collaborative could be a mechanism to implement (the standards) and advocate for more resources.'

Overall, while there was broad support for hospital standards, this support was tempered by the constraints under which these hospitals operate. All are critically dependent upon the resources supplied by the MOH and, for the non-profits, the added support of the medical bureaus. Because of this dependency, some participants wished also to establish standards for the MOH regarding the kinds of technical and financial support the Ministry provides to hospitals.

## Discussion

While all hospitals face serious challenges to provide high-quality, affordable and appropriate care, those in resource-limited settings like Uganda struggle with major barriers to making progress and improvements [19]. This study explored whether staff in selected Ugandan hospitals felt that an accreditation program could be a useful tool to improve the quality of care.

The results indicate nearly universal support and enthusiasm for adopting standards and working to improve the quality of care and working conditions. Yet there was palpable concern over the desperate lack of supplies, running water, drugs and other needs that directly and adversely affect care. The dedication of health workers in the four facilities to high-quality patient care was evident. Upgrades required to improve quality of patient care would also improve working conditions for health-care providers, which in turn would lead to improved morale and job satisfaction. Previous research in Uganda and other resource-limited settings suggests that non-financial incentives and working conditions are key to health worker intent to stay [20–22].

Because hospital improvement will take time, participants preferred to set the stage for an effective program, with surveys, plans for improvement and access to resources and technical assistance. They wanted an improvement program that minimized penalties as motivators and instead recommended the use of positive approaches such as recognition, consultation, technical assistance and additional resources. Participants strongly supported the concept of a two-way partnership between the MOH and the local hospital, with the expectation that each partner would meet standards. In this model, the hospital would need to meet

standards of care, and the Ministry would need to provide technical assistance and resources.

The early success of the 'Yellow Star Program' was mentioned often. This program was a motivator for improvement and provided needed consultation [7, 18]. Participants seemed disappointed the Yellow Star Program was in abeyance and that survey teams had not recently visited. This experience suggests that now may be an opportune time to introduce a more comprehensive program of hospital improvement in Uganda. It was also noted that collaboration and coordination between hospitals and other components of the health system is poor. A program that developed mutually beneficial collaboratives to achieve standards and improve patient referrals and care might be promising.

There was strong support for the development and implementation of hospital standards among the staff and hospitals queried. In addition, about half the hospital personnel believed they had the skills and knowledge to perform self-assessments. The success of accreditation programs in resource-poor settings depends on the time and commitment of health-care workers who are overworked and poorly remunerated. Standards alone, without resources for additional staff and renovation or technical assistance, are unlikely to improve care. As with any major change, achieving broad acceptance and ownership of standards by stakeholders is crucial to long-term success. However, resource limitations are currently so severe that many of the commonly accepted standards could not be addressed without additional support.

This study had some limitations. Only four hospitals were included and they may not represent the situation in more deprived parts of the country. Hence, it is possible that the need for resources and technical assistance is even more severe elsewhere in Uganda. Also, it is possible that focus group participants were concerned that their answers to questions would be reported back to the hospital leadership, which could have introduced a bias. However, the facilitators had been trained to build rapport and the participants seemed to speak candidly.

On the basis of the results, we recommend that preliminary standards for hospitals in Uganda be developed building on previous experience, and pretested for eventual national implementation. These standards should be developed in concert with a plan of improvement to address the gaps. The plans for improvement should be linked to the provision of new resources and technical assistance. Also, it may be appropriate to develop a hospital association or collaborative for government hospitals to begin interaction with each other, and to share best practices. As noted, such associations already exist with the faith-based hospitals, and appear to be beneficial.

## Acknowledgements

The authors also wish to acknowledge the contributions and support of Dr. Francis Runumi, Commissioner of Health Planning, the Quality Assurance Committee, Makerere

University and the Stakeholders Committee of the MOH for reviewing and revising the preliminary standards.

## Funding

This work was supported by the Puget Sound Partners in Global Health.

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Accepted for publication 13 September 2009