Ministry of Health

HEALTH SECTOR QUALITY IMPROVEMENT FRAMEWORK AND STRATEGIC PLAN 2010/11 – 2014/15

Ministry of Health
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FOREWORD

The Health Sector Strategic and Investment Plan 2010/11 – 2014/15 focuses on achieving universal coverage with quality health, and health related services through one of the strategic objectives **"To accelerate quality and safety improvements for health and health services through implementation of identified interventions".**

The development of National Quality Improvement Framework and Strategic Plan has been largely informed by lessons from the Quality of Care Evaluation study, 2009, Quality Improvement situation analysis in 2010 and Quality Improvement stakeholders meeting held in Kampala in March 2011. It has also been developed in alignment with the Second National Health Policy and Health Sector Strategic and Investment Plan 2010/11 – 2014/15. The process of development of the National Quality Improvement Framework and Strategic Plan was highly consultative, participatory and transparent. Stakeholders from Development Partners, MoH and related institutions, Local Governments, Civil Society, Health Consumers, private sector and academia were consulted during the development process.

The National Quality Improvement Framework and Strategic Plan provides a common framework for all public and private health institutions, partners and stakeholders to coordinate, plan, mobilize resources, implement, monitor and evaluate quality improvement initiatives in Uganda in order to **"ensure provision of high quality health services and contribute to the attainment of good quality of life and well-being at all levels of health care".**

It is envisaged that the target audience for this framework which includes: policy makers, planners, program managers, programs and projects implementers, DPs, health service providers, partners in public and private sectors, CSOs, CBOs and health consumers in the health sector shall subscribe to it to ensure responsiveness, transparency and accountability for service delivery.

I wish to express my appreciation to all partners but more specifically Uganda Capacity Program, USAID Health Care Improvement Project and all who participated in the development of the National Quality Improvement Framework and Strategic Plan. I look forward to expedited operationalisation of the National Quality Improvement Framework and Strategic Plan towards attainment of our national and international health goals.

For God and My Country

DR. D.J. CHRISTINE ONDOA
MINISTER OF HEALTH

EXECUTIVE SUMMARY

The Second National Health Policy (NHP II) puts the client and community at the forefront and adopts a client-centered approach with consideration of both the supply and demand side of healthcare. Good quality of care enhances clients' satisfaction and their use of services. It increases job satisfaction and motivation among service providers, leading to effective and efficient utilization of resources.

Over the years the MoH in collaboration with Development Partners has built capacity for establishment of internal quality assurance at all levels. Due to increasing number of districts and demand for improved quality of services the Quality Assurance Department (QAD) is faced with the challenge of ensuring that it is able to address this demand across the country.

A situation analysis of QI initiatives in Uganda conducted by Uganda Capacity Program in November 2010 identified that; there are many QI initiatives in the country mostly donor driven; some of the initiatives are disease specific mainly focusing on HIV/AIDS, while others are program oriented. The differences between the initiatives were in the approach to implementation but the concepts and principles were largely similar. There were weak mechanisms to coordinate the many QI initiatives both at the central and Local Government levels. A 2010 formative evaluation of the HIV/AIDS QoC program in Uganda had also recommended strengthening the QAD for harmonisation and institutionalisation of QI initiatives in Uganda.

The National Quality Improvement Framework (QIF) and Strategic Plan has been developed in recognition that the health sector needs to institutionalize, harmonize and coordinate Quality Management interventions in Uganda. The National QIF and Strategic Plan provides a common framework for all public and private health institutions, partners and stakeholders to coordinate, plan, mobilize resources, implement, monitor and evaluate quality improvement initiatives in order to **"ensure provision of high quality health services and contribute to the attainment of good quality of life and well-being at all levels of health care".** The framework has two sets of objectives. The first set of objectives and the related interventions are designed to improve the capacity of the health system to provide high quality services. The second set of objectives contributes to improvement of health outcomes in the priority areas set out in the HSSIP 2010/11 – 2014/15.

Districts and partners involved in QI shall develop their own plans and implement evidence based QI interventions which apply the principle of an iterative cycle of improvement – Plan, Do, Study, Act (PDSA cycle) in addition to the 5S-CQI-TQM methodology as a fundamental background to continuous quality improvement. A QI coordination structure has been created to enhance the QI policy, strategy development, communication and capacity building activities in a coordinated manner. QI committees / team meetings, supervision / monitoring visits and periodic performance reviews will be carried out for monitoring QI initiatives at the various levels.

Acronyms

CSO	Civil Society Organisation
DGHS	Director General Health Services
DHO	District Health Officer
DHT	District Health Team
DP	Development Partner
GoU	Government of Uganda
HC	Health Centre
HCI	USAID Health Care Improvement Project
HMIS	Health Management Information system
HPAC	Health Policy and Advisory Committee
HRH	Human Resources for Health
HSD	Health Sub-District
HSS	Health Systems Strengthening
HSSIP	Health Sector Strategic and Investment Plan
HSSP	Health Sector Strategic Plan
HUMCs	Health Unit Management Committees
JICA	Japan International Cooperation Agency
LC	Local Council
LG	Local Government
MDGs	Millennium Development Goals
MoH	Ministry of Health
NRH	National Referral Hospital
NHP	National Health Policy
PDSA	Plan, Do, Study, Act
PDQ	Partnerships Defined Quality
PHP	Private Health Practitioners
PNFP	Private Not-for-Profit Providers
PPPH	Public Private Partnership for Health
QA	Quality Assurance
QAD	Quality Assurance Department
QAP	Quality Assurance Programme
QI	Quality Improvement
QIF	Quality Improvement Framework
QM	Quality Management
QoC	Quality of care
RRH	Regional Referral Hospital
SME&R	Supervision, Monitoring, Evaluation and Research
SWOT	Strengths Weakness Opportunities Threats
TCMP	Traditional and Complementary Medicine Practitioners
TWG	Technical Working Group
UCMB	Uganda Catholic Medical Bureau
UCP	Uganda Capacity Programme
UMMB	Uganda Moslem Medical Bureau
UNHCO	Uganda National Health Consumers Organisation
UNMHCP	Uganda National Minimum Health Care Package
UPMB	Uganda Protestant Medical Bureau
VHT	Village Health Team
WHO	World Health Organisation
YSP	Yellow Star Programme

Operational Definitions

Best Practice	A way or method of accomplishing a function or process that is considered to be superior to all other known methods. In health care, it is often used to refer to tools, materials, models of care, organizational arrangements, and other practices that have been shown in multiple settings to facilitate compliance with evidence-based standards of care.
Benchmarking	The continual and collaborative discipline of measuring and comparing the results of key work processes with those of the best performers to identify and recognise 'good' and 'best' practice.
Coaching	A form of training where the supervisor/manager models or demonstrates a behaviour or task and uses feedback to guide the employee while s/he practices the behaviour or task to ensure successful performance
Continuous Quality Improvement	An approach to health care based on evaluation of a product or the outcome(s) of a process, and on understanding the needs and expectations of the consumers of these products or processes.
Quality Assurance	A system to support performance according to standards. It implies a systematic way of establishing and maintaining quality improvement activities as an integral and sustainable part of systems or organizations. This includes all activities that contribute to the design, assessment, monitoring of standards agreed upon by all stakeholders and improving quality of service delivery, client satisfaction and effective utilization.
Quality Improvement	A management approach to improving and maintaining quality that emphasizes internally driven and relatively continuous assessments of potential causes of quality defects, followed by an action aimed either at avoiding decrease in quality or correcting it at an early stage.
Quality Management	The Application of management practice to systematically maintain and improve organization-wide performance.
Improvement Collaborative	A time-limited strategy for quality improvement based on shared learning that brings together a large number of teams to work together to rapidly achieve significant improvements in processes, quality, and efficiency of a specific area of care, with intentions of spreading the intervention package resulting in these improvements to other sites.

Indicator	A measurable variable (or characteristic) that can be used to determine the degree of adherence to a standard or the level of quality achieved.
Mentoring	Mentoring is a developmental partnership through which one person shares knowledge, skills, information and perspective to foster the personal and professional growth of someone else.
Quality	There are many definitions, but for our purposes, quality is defined as the extent to which health care, services, systems, and programs conform to national or international standards/ requirements/ specifications. According to Institute of Medicine (IOM), health care is of high quality if it is safe, effective, patient-centered, timely, efficient; and equitable.
Quality Improvement Initiatives	Cycles of interventions that are linked to assessment and that have the goal of improving the process, outcome, and efficient of complex systems or simply put: interventions for assessing, measuring, defining and resolving health care delivery issues with an aim to improving the safety, timeliness, equity, access, and appropriateness of health care services.

1 Introduction

1.1 Background

Quality of Care (QoC) is one of the key elements of the right to health. As the country population grows there is parallel growth in the health care needs and expectations. During implementation of the Health Sector Strategic Plan (HSSP) I (2000/01 – 2004/05) and HSSP II (2005/06 – 2009/10) emphasis was focused on access to health services, both geographical and financial and less on the quality of services provided. There has been shift in the Health Sector Strategic and Investment Plan (HSSIP) which now emphasizes quality and patient safety in order to ensure efficient and effective utilization of resources at all levels of healthcare (HSSIP 2010/11-2014/5).

The Second National Health Policy (NHP II) puts the client and community at the forefront and adopts a client-centered approach with consideration of both the supply and demand side of healthcare. The following social values, as detailed in the Constitution of the Republic of Uganda and Uganda's Patients' Charter, 2010 guide the implementation of the NHP II[1]:

The right to highest attainable level of health: The Constitution guarantees rights of all people in Uganda to access basic health services.

Solidarity: Government will give due consideration to pursuit of national solidarity in its attempt to achieve health-related Millennium Development Goals (MDGs) with special focus on social health protection for vulnerable groups.

Equity: Government shall ensure equal access to the same health services for individuals with the same health conditions.

Respect of cultures and traditions of the people of Uganda: Stakeholders shall respect promotive health aspects of cultures and traditions of the peoples of Uganda. Negative practices and behaviours shall be discouraged.

Professionalism, integrity and ethics: Health workers shall perform their work with the highest level of professionalism, integrity and trust as detailed in the ethics guidelines enforced by professional bodies to which they are affiliated.

Client's responsibilities: Individuals are ultimately responsible for lifestyle decisions they adopt. Clients have the responsibility of seeking care, adhering to treatment and mutual respect for health providers.

[1] The Second National health Policy, MoH, Uganda 2010

Accountability: A high level of efficiency, effectiveness, transparency and accountability shall be maintained in the development and management of the national health system. The health service will be accountable for its performance, not only to the political and administrative system, but, above all, to its client communities.

QoC is an important component of the HSSIP 2010/11 – 2014/15. Good quality of care enhances clients' satisfaction and their use of services. It increases job satisfaction and motivation among service providers, leading to effective and efficient utilization of resources. The responsibility for health primarily lies with individuals, households and communities. The Government of Uganda (GoU), as part of its commitments to the right to health and gender equality, has put in place an elaborate structure of the National Health System to facilitate the individuals, households and communities (as rights holders) to attain and sustain good health. The individuals, households and communities therefore need to be empowered to take their due role as health producers and consumers[2].

The overall goal of the health sector during HSSIP 2010/11 – 2014/15 is ***"To attain a good standard of health for all people in Uganda in order to promote a healthy and productive life".***

To achieve this goal, the health sector shall focus on achieving universal coverage with quality health, and health related services through addressing the following strategic objectives.

1. Scale up critical interventions for health, and health related services, with emphasis on vulnerable populations.
2. Improve the levels, and equity in access and demand to defined services needed for health.
3. **Accelerate quality and safety improvements for health and health services through implementation of identified interventions.**
4. Improve on the efficiency, and effectiveness of resource management for service delivery in the sector.
5. Deepen stewardship of the health agenda, by the MoH.

The Health Sector Quality Improvement Framework (QIF) and Strategic Plan are aligned to strategic objective 3 above. The health sector aims to provide services of an acceptable level of quality, to ensure the clients are able to maximize the health benefits from available care.

[2] Health Sector Strategic and Investment Plan 2010/11 – 2014/15, MoH, Uganda 2010

1.2 The Development Process

The Health Sector QI Framework was developed by the MoH with active support and participation of various stakeholders and experts involved in QI locally and internationally. These included: service providers, program managers, Development Partners (DP), International Quality Improvement experts, and CSOs in the health sector. These provided technical support and relevant strategic information for the framework.

The process for the development of the framework involved four phases:

- The first phase involved literature and document analysis to conceptualize QI issues from a global and national perspective. It involved a rigorous review of published journals, Health Sector Strategic Plans, technical program strategies and reports, NHP II, and WHO documents on quality of health care among others.

- The second phase involved conducting a situation analysis of existing QI initiatives in the country based on available literature and stakeholder interview responses. Although the focus was mainly on the national level stakeholders, they also support QI initiatives at national regional, district, health facility and community level. The situation analysis identified existing QI initiatives, experiences and lessons. It also analyzed the strengths and weaknesses as well as the existing opportunities and impending threats for the QI initiatives. This phase provided a significant basis for the framework.

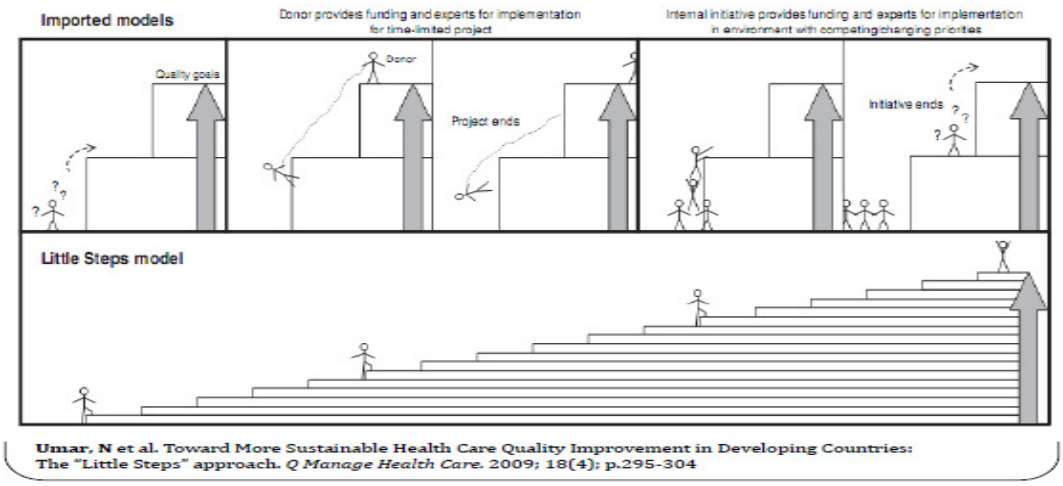
- The third phase involved a national health care quality improvement strategy meeting which was convened in Kampala, Uganda from March 21 to 22, 2011. This meeting provided a forum for various departments within the MoH, selected partners, and international QI experts to share experiences, clarify the role of government partners, and discuss lessons learned from implementing health care QI initiatives at national and local levels.

- The last phase involved a series of meetings by the QIF Task Force and Supervision, Monitoring, Evaluation & Research Technical Working Group. A final stakeholders meeting was held to incorporate technical inputs and generate consensus on the framework.

The major recommendation was for the QAD to accelerate its efforts in developing the National Quality Improvement Framework (QIF) based on the “little steps approach”. The "Little Steps" approach begins by defining QI concepts, goals, and processes in a manner congruent with the target setting and that builds upon existing systems, structures, and values. Despite immediate short-term needs, an approach emphasizing incremental QI achievements may be more effective in yielding sustainable improvements in health care quality at the national or regional level[3].

[3] Toward more sustainable health care quality improvement in developing countries: the "little steps" approach. Umar N, Litaker D, Terris DD.

Figure 1: The Little Steps approach



Umar, N et al. Toward More Sustainable Health Care Quality Improvement in Developing Countries: The "Little Steps" approach. *Q Manage Health Care.* 2009; 18(4); p.295-304

1.3 Situation Analysis

The trends in overall health status in Uganda show slow progress in the already poor health status evidenced by; Under five Mortality Rate of 137 deaths per 1,000 live births, Infant Mortality Rate of 75 deaths per 1,000 live births, Maternal Mortality Ratio of 435 deaths per 100,000 live births, (Uganda Demographic Health Survey, 2006). Community surveys and media reports indicate that the quality of services in public sector in Uganda leaves a lot to be desired. (1) Ugandans do not receive the services they need in terms of missed opportunities, leading to waste and inefficiency; delayed care leading to dissatisfaction and ineffective services or systems; (2) Ugandans receiving services they do not need; (3) Ugandans are harmed by the services they receive e.g. medical errors generate additional costs and waste, leading to inefficiency and dissatisfaction.

Over the years the MoH in collaboration with Development Partners has built capacity for establishment of internal quality assurance at all levels. Due to increasing number of districts and demand for improved quality of services the Quality Assurance Department (QAD) is faced with the challenge of ensuring that it is able to address this demand across the country.

Quality Assurance (QA) in the health sector in Uganda started in 1994 as the Quality Assurance Program (QAP) which was created to support health service delivery in a decentralized system. As roles devolved to the districts, the MoH had to ensure quality of health service provision was maintained at the same level as before. The QAP transitioned to the QAD under the Directorate of Planning and Development in 1998.

Between 2000 and 2005 the major Quality Management (QM) intervention supported by MoH was the Yellow Star Program (YSP) which focused on minimum service standards for a range of primary health care services in the districts. The YSP was implemented as project rather than program in that it had its own project staff, supervisory structure, reporting mechanisms, and meeting schedule. When YSP ended, it had not been integrated into the existing district health structure and it was not sustained in most districts.

Other QM interventions in the sector to support the improvement of health service delivery in both the public and private sector include; support supervision, Results Oriented Management, Continuous Medical Education for Professional Development, Staff Motivation and Retention Strategy; accreditation, professional registration, licensing, Infection Control and Prevention; Quality Control in Central Public Health Laboratories; Maternal and Perinatal Death Audits; Reach Every District (RED) for immunisation program; Client Charter which highlights the commitments of the service providers to their clients; and Patients Charter specifying the patients' rights and responsibility in care. Each of these is implemented by the respective programs with no correlation and therefore difficult to attribute successes (see Table 1). Most of them were designed to be implemented periodically by supervisors, managers or trainers.

Support supervision is a QM intervention that is currently applied at all levels of health service delivery. The HSSP II (2004/05 – 2009/10) mid-term review study carried out in 2008 by MoH to assess the various supervision mechanisms in the country identified the following pertinent gaps in the mechanism. The review indicated that the full cycle of supervision as a QI and motivation strategy for health sector performance is not followed and therefore limits the effectiveness of supervision.

Accreditation of health facilities is one of the QM interventions previously implemented more by the private sector specifically the faith-based medical bureaus and has been applied by the public sector in accrediting health facilities for anti-retroviral therapy provision and laboratory services. The MoH will develop a more comprehensive accreditation system as part of a comprehensive national QM plan and strategy.

Registration of health professionals and licensing of private clinics is a role delineated to the Health Professional Councils (Uganda Medical and Dental Practitioners Council, Uganda Nurses and Midwives Council, Pharmacy Council and the Allied Health Professionals Council). The Councils are expected to ensure that all practising health professionals are legally registered and renewal practising licenses annually with evidence of continuous medical education / professional development. Annual licensing of private health facilities is carried out based on minimum service delivery standards.

Since 2005, there has been a paradigm shift to QI as an approach for realizing sustained performance improvement, effective and efficient utilization of resources at service delivery level. The MoH started the HIV/AIDS Quality of Care Program with the purpose of ensuring

quality HIV/AIDS services and rapid roll out of ART throughout the country. Since then a number of QI initiatives have been introduced to address specific programmatic areas.

Table 1: Quality Management Interventions in Uganda 2010

Quality Improvement interventions	Lead Department / Agency	Area of Focus	Status
Support supervision (Area Teams)	MoH / QAD	Integrated	Ongoing in all districts
Technical supervision	MoH / Departments / Programs / Projects	Program specific	Ongoing in all districts
Yellow Star Assessment	MoH / QAD	Integrated	By HSSP II midterm review (2008) was implemented in 50% of districts
Result Oriented Management	MoH / HRM	Human Resource	Ongoing in all districts
Injection safety and waste care management	MoH / MMIS / AIDSTAR-One	Patient safety	Ongoing in all districts
Implementation of the Patient Charter	MoH	Patients rights, roles and responsibilities	Ongoing nationally in public and private sectors
Implementation of the Client Charter	MoH	Roles and responsibilities of the service providers	Ongoing at national level
Maternal and Perinatal Death Audit	MoH / RH Department	RH	Ongoing in all public and private health facilities
Reach Every District	MoH / UNEPI	Immunization	Ongoing in all districts focusing on unreached or hard-to-reach populations
Systems Strengthening, Continuous Assessments, Training, Accreditation systems, Human Resource Quality Measurements, Performance Based Financing	Uganda Catholic Medical Bureau Uganda Protestant Medical Bureau	Multiple	Ongoing in UCMB and UPMB facilities
HIV/AIDS Quality of Care	MoH / HIVQUAL	HIV/AIDS	Ongoing in all districts
Quality of Care in HIV/AIDS	USAID Health Care Improvement (HCI) Project	HIV/AIDS	In selected facilities in 45 Districts
Palliative care	HCI Project	HIV	Ongoing 2 districts
Chronic care model (Pilot)	HCI Project	HIV/AIDS, Diabetes, Hypertension	Pilot in 1 district (Buikwe)
Maternal, Child and Neonatal Care (Pilot)	HCI Project	RH	Pilot in 2 districts (Masaka & Luwero)
Registration and Licensing of health facilities	Health Professional Councils	Private clinics	Ongoing in all districts
Performance Improvement	Uganda Capacity Program	Human Resources	Ongoing in 13 districts
Capacity Building and Training	Stop Malaria Uganda	Malaria	Ongoing in 34 Districts
5S-CQI-TQM Systems strengthening	JICA	Infrastructure	15 Districts
Standard Based Management	Jhpiego	Infection control &	Isingiro and Mbarara districts

Quality Improvement interventions	Lead Department / Agency	Area of Focus	Status
and Recognition (SBMR)		prevention Maternal and Child Health	
QI in HIV/AIDS care (Coaching, mentoring, peer learning, and involving patient)	STAR East, South West and East Central Projects	HIV/AIDS	Regional based (east, south-west, east-central Uganda)
QI in HIV/AIDS care	NUMAT	HIV/AIDS	Regional based (northern Uganda)
Accreditation	Central Public Health Laboratories	Laboratory services	National
Fellowship Training	MUK - SPH	HIV/AIDS	National
Training	MUK – Regional Center for Quality of Health Care	Post graduate training	East African Region
Promotion of health as a human right Advocacy for Patient safety	Uganda National Health Consumers Organisation (UNHCO)	Consumers/Users of health services	National

A 2010 formative evaluation of the HIV/AIDS QoC program determined that the initiative was successful in improving the quality of HIV/AIDS services, rapidly scaling up Anti-retroviral Therapy (ART), and establishing a national structure for roll out and scaling up quality HIV/AIDS services. While the HIV/AIDS QoC program did increase collaboration between partners in some areas, there remained weak coordination of partners at the national and district levels. Other major gaps identified include insufficient managerial involvement in services, lack of incentive for workers to continue the program, and reliance on external support e.g. PEPFAR. The QI interventions frequently focused on high-impact/immediate change rather than on program sustainability.

A situation analysis of QI initiatives in Uganda conducted by Uganda Capacity Program in November 2010 identified that;

- There are many QI initiatives in the country mostly donor driven with shared vision and common purpose of improving quality of healthcare.
- Some of the initiatives are disease specific mainly focusing on HIV/AIDS, while others are program oriented.
- The differences between the initiatives are in the approach to implementation but the concepts and principles are largely similar.
- The current QI management system is not well developed and needs to be reviewed and improved.
    - There are weak mechanisms to coordinate the many QI initiatives both at the central and LG level.
    - There are inadequate linkages between the different QI implementers and MoH supervision, monitoring and evaluation system.

- QI is not well institutionalized in the health service delivery chain in the country as such each quality actor has their own standards and approach.

The lack of coordination and the obscure reporting mechanisms tend to weaken the intended result of the initiatives and also raise concerns of effectiveness and sustainability of such initiatives especially when donor funding dwindles. It is even very difficult to assess, evaluate and measure quality improvement after an intervention has been initiated. This status elucidates the urgent need for the institutionalization, harmonization and coordination of QI initiatives in the country[4].

It is against this background that the QAD, under its mandate, developed the National Quality Improvement Framework (QIF) and Strategic Plan to guide and harmonize all QI initiatives in the health sector in line with the NHP II and HSSIP 2010/11 – 2014/15.

[4] Draft Report Quality Improvement Situation Analysis in Uganda, MoH, 2011

2 The National QIF and Strategic Plan

This section describes the QIF and strategies for improving quality of care by the health sector in Uganda.

2.1 Purpose of the National QIF and Strategic Plan

The National QIF and Strategic Plan has been developed in recognition that the health sector needs to institutionalize, harmonize and coordinate QM interventions in Uganda. The National QIF and Strategic Plan provides a common framework for all public and private health institutions, partners and stakeholders to coordinate, plan, mobilize resources, implement, monitor and evaluate **quality improvement initiatives** in order to **"ensure provision of high quality health services and contribute to the attainment of good quality of life and well-being at all levels of health care".** This should be done while ensuring responsiveness, transparency and accountability for service delivery.

The target audience for the National QIF and Strategic Plan include: policy makers, planners, program managers, programs and projects implementers, DPs, health service providers, partners in public and private sectors, CSOs, CBOs and Health Consumers.

2.2 The National QI Framework

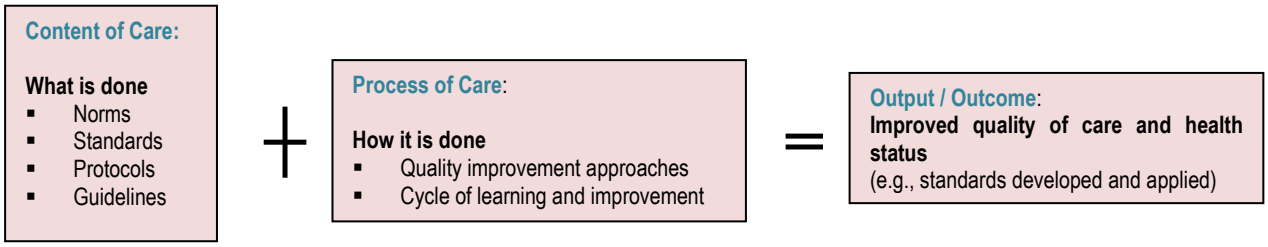
It is envisaged that the National QIF will encourage stakeholders and health workers at all levels to appreciate the role of QI in the health sector. QI has the potential to optimize the use of limited resources available from governments and global initiatives targeted at achieving shared aims. Demonstrable improvements in quality encourage greater investment in health systems by increasing stakeholder confidence that resources are being effectively and efficiently utilized.

The framework for improving quality of care in Uganda will be based on the framework for improving clinical quality adapted from (P.B Batalden and P.K Stolz)[5], Figure 2. In this framework improvement looks at two major components: what is done (content) and how it is done (process of care). Either component could lead to improvement, but the most powerful impact occurs by addressing both simultaneously. This framework requires evidence based norms, standards, protocols, and guidelines to be in place and these are used to identify gaps and measure performance improvement. The QI initiatives adopted by the MoH shall operate within this framework.

[5] A framework for the continual improvement of healthcare: Building and applying professional and improvement knowledge to test changes in daily work. P.B. Batalden and P.K. Stolz 1993.

Existing national standards, protocols and guidelines will be used and where lacking will be developed and disseminated. QI approaches will be implemented at all levels using applicable initiatives with a cycle of learning and improvement.

Figure 2: How QI Integrates Content of Care and the Process of Providing Care



2.3 The Quality Improvement Strategic Plan

The QI Strategic Plan 2010/11 – 2014/15 has been developed to provide a common strategic framework for QI in Uganda during the five year period. The plan will guide all QI initiatives by all parties at all levels in the health sector. As such, achievement of its targets is a collective responsibility of all stakeholders and service providers.

The Strategic Plan introduces two sets of objectives meant to achieve broad ranging improvement in the five year period. The first set of objectives and the related interventions are strategic objectives designed to improve the capacity of the health system to provide high quality services. Thus the first set of objectives and interventions (see table 2) prepare the ground for improving the quality of health care and as such contributes to the achievements of the second. The second set is specific objectives (see table 3) to contribute to improvement of health outcomes in the priority areas set out in the HSSIP 2010/11 – 2014/15.

2.4 Goal and Objectives

The goal and objectives of the National QI Strategic Plan are derived from Strategic Objective 3 and respective strategic interventions in the HSSIP 2010/11 – 2014/15.

2.4.1 Goal

The goal of the National QIF and Strategic Plan is to **"ensure provision of high quality health services and contribute to the attainment of good quality of life and well-being at all levels of health care".**

2.4.2 Strategic QI Objectives for Health Systems Strengthening

The strategic objectives for health systems strengthening are;

1. To provide a harmonized and integrated approach to quality improvement in health service delivery throughout the health sector

2. To improve quality of health care and patient safety at all levels including the private sector while ensuring efficient utilization of available resources.

3. To provide client centered services with the aim of improving the quality and responsiveness (including gender responsiveness) of health services provided.

2.4.3 Strategic Interventions

Operationalisation of the National QIF and Strategic Plan will be through implementation of selected priority interventions for QI (Figure 3) at various levels of service delivery. Interventions will be geared towards;

1. Building local capacity to implement QI at the facility level, including developing permanent QI structures as appropriate;
2. Strengthening national, sub-national and facility level capacity for implementation, supervision and monitoring of quality and QI activities;
3. Increasing government and civil society participation in QI initiatives to create a broad base of stakeholders and advocates for high quality health care;
4. Raising motivation and providing incentives for health care providers to implement QI, improve compliance with national and international standards, and achieve improved outcomes through reward and recognition mechanisms;
5. Promoting the development of a permanent culture of quality practice for all including the MoH, professional bodies, pre-service training institutions, regional and district health authorities, CSOs, facility managers, and practitioners.
6. Addressing the quality of non-clinical aspects of service, including availability, accessibility, strengthening leadership and management, improving health worker productivity, improving the work environment, implementation of standards for medical equipment and their maintenance, implementation of health facility structure standards, health promotion and prevention, sanitation and environmental health, feedback / complaint management system and improving client satisfaction.
7. Addressing the quality of clinical care including; accreditation, occupational safety, pharmaceutical safety, patient safety, risk management, reporting of medical errors, accidents and mistakes, clinical audit and peer reviews, infection prevention and control, coordination and continuity of care including referrals, case management and discharge planning.

Figure 3: Results framework for QI Objectives for Health Systems Strengthening

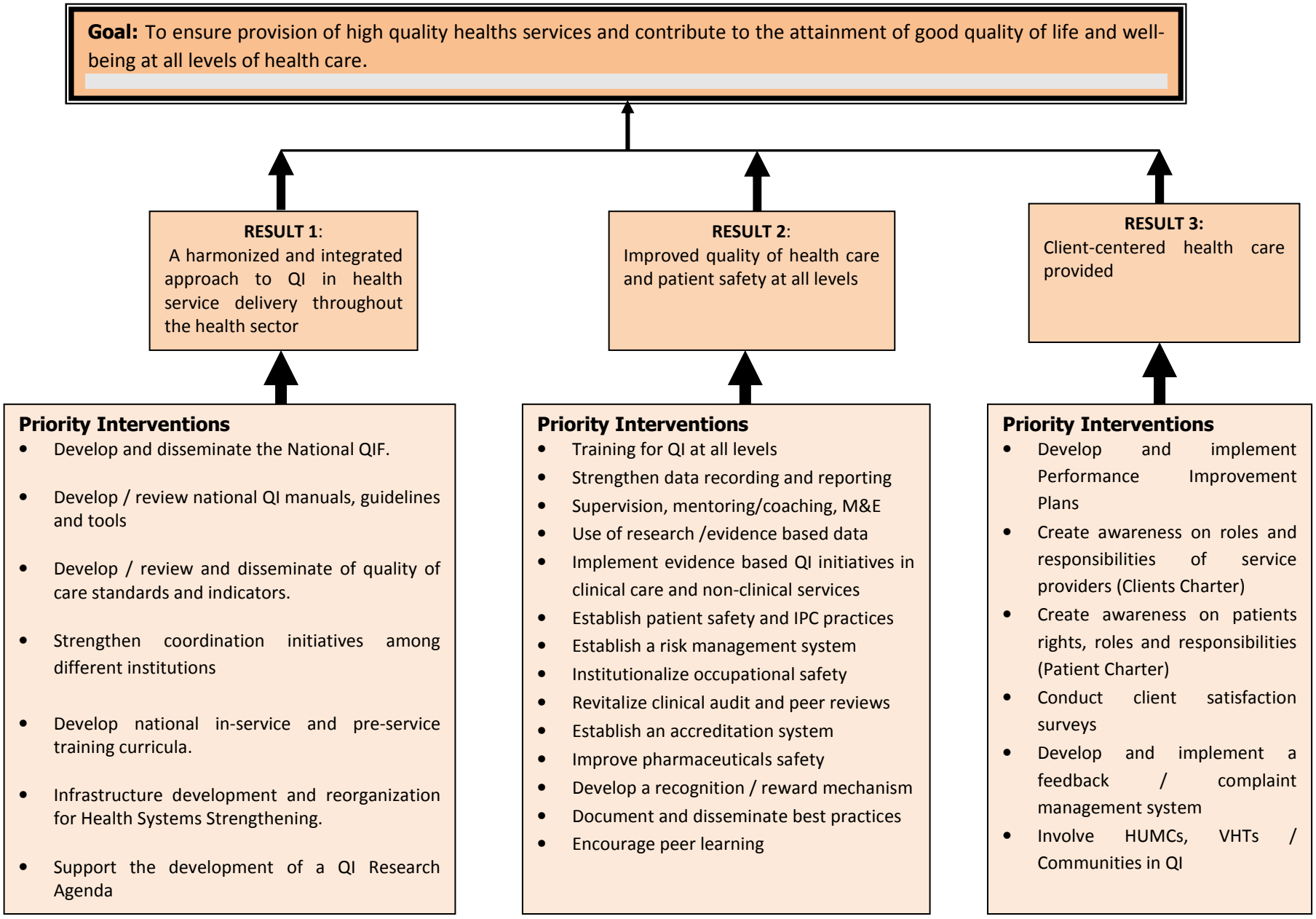


Table 2: Five Year Strategic Plan 2014/15 for the QI Strategic Objectives for Health Systems Strengthening

Interventions	Actions	Responsibility	Financial Year					Output Indicators	Means of Verification
			10/11	11/12	12/13	13/14	14/15		
Strategic Objective 1: To provide a harmonized and integrated approach to quality improvement in health service delivery.									
Development and dissemination the National QI framework	Conduct consultative meetings	MoH / QAD	X					No. of meetings	Reports
	Print and binding of the QIF & SP	MoH / QAD		X				No. of copies printed	Supervision
	Dissemination of the QIF & SP			X				No. of copies disseminated	Reports
Planning for QI	Development of QI annual workplan	All levels	X	X	X	X	X	Annual workplans	Workplans
Development of national QI manuals, tools and standards	Conduct consultative meetings	MoH / QAD		X				No. of meetings	Reports
	Print and disseminate the manuals, tools and standards	MoH / QAD		X				No. and types of guidelines, tools and standards developed	Availability and use of guidelines, tools and standards
	Develop a QI Communication strategy	QAD			X			Communication Strategy developed	Communication Strategy
Develop a national in-service QI training manual	Develop TORs for Consultancy	QAD		X				Terms of Reference developed	Terms of Reference
	Procure Consultancy services for development of training manual	QAD / DP		X				Consultant procured	
	Consultative meetings for consensus building	QAD		X				No. of Meetings	Minutes
	Printing and binding of National In-service QI training manual	QAD		X				National in-service QI training manual	In-service QI training manual
Liaise with academic institutions for review and update of the pre-service QI	Make recommendations for review and update of the pre-service QI training curriculum	MoH / HRD / MoES		X	X			No. of Training Institutions with modules incorporating QI	Concept note

Interventions	Actions	Responsibility	Financial Year					Output Indicators	Means of Verification
			10/11	11/12	12/13	13/14	14/15		
training curriculum									
Infrastructure development and reorganization for Health Systems Strengthening	Clarify and document implementation structures, roles and responsibilities for all stakeholders	MoH / QAD		X				Documentation of mandate and roles of various stakeholders	Records
	Facilitation and coordination of QI activities at the national, regional, district and health facility levels	MoH / DPs / Regional Committees / District Committees	X	X	X	X	X	No. of functional regional and district coordination structures	Reports
Strengthening coordination initiatives among different institutions to improve quality and responsiveness of health services	Review and establish QI coordination committees and teams at all levels	QAD / Managers	X	X	X	X	X	% of institutions with functional QI Committees / teams	Reports
	Conduct coordination meetings	Chairpersons	X	X	X	X	X	% of planned meetings conducted	Minutes
Support the development of a QI Research Agenda	Conduct intervention and operational QI research	DPs / Research Institutions		X	X	X	X	No. and types of QI Researches carried out	Study Reports
	Gather, develop and disseminate the continuum of medical care to promote effective models of care that are responsive to the needs of patients	Researchers / Managers	X	X	X	X	X	No. of publications	Reports Newsletters Journals
	Use of researched data/evidence base for planning QI interventions	Policy Makers	X	X	X	X	X	No. of QI policy statements / policies made	Policy statements / documents
Strategic Objective 2: To improve quality of health care and patient safety at all levels including the private sector while ensuring efficient utilization of available									

Interventions	Actions	Responsibility	Financial Year					Output Indicators	Means of Verification
			10/11	11/12	12/13	13/14	14/15		
resources.									
Build capacity for QI at all levels of the health service that include planning and self assessment with participation of both internal and external clients.	Conduct QI Training Needs Assessment	QAD		X				Training Needs Assessment conducted	Report
	Training of National / Regional QI Trainers	MoH / DPs	X	X	X	X	X	No. of QI trainers	Reports
	Training of health workers at all levels	MoH / DPs	X	X	X	X	X	No. and cadre of health workers trained by level and district	Reports
	Establish a database for QI trainees	QAD		X	X	X	X	No. of QI trainers and trainees registered in data base	Data base
	Establish a Quality Facilitator Certification program	QAD / DPs			X	X	X	No. of facilitators certified	Reports
	Mentoring and coaching for QI at all levels of health care system	MoH / DPs	X	X	X	X	X	No. of mentoring / coaching activities	Reports
	On/off site technical assistance opportunities by a pool of QI experts as well as experienced program staff	MoH / DPs	X	X	X	X	X	No. of health providers participating in QI activities	Reports
Strengthening data recording and reporting system	Revise HMIS guidelines to include QI indicators and their use	MoH – Resource Centre					X	QI indicators incorporated in the HMIS	Revised HMIS
	Develop standardized data formats for data collection and reporting with the HMIS and M&E plan to avoid duplication of efforts	MoH – Resource Centre	X					Standardized formats for data collection	Formats available and utilized
	Provide technical assistance for QI data collection process and utilization at the facility level through district and regional	MoH – Resource Centre	X	X	X	X	X	No. of supervision / mentoring visits	Reports

Interventions	Actions	Responsibility	Financial Year					Output Indicators	Means of Verification
			10/11	11/12	12/13	13/14	14/15		
	Timely share individual and comparative performance data and reports with internal and external stakeholders	Managers	X	X	X	X	X	No. of reports submitted timely	QI reports
	Provide routine feedback using findings to improve activities	Health Facility Managers	X	X	X	X	X	No. of feedback reports	Reports
	Analyze data on the national, regional, district and facility level to identify opportunities, gaps, priorities and programmatic decision making	Managers at all levels	X	X	X	X	X	Performance report with analytical data	Observations
Improve availability and access of health inputs	Establish a Supply Chain Management System	Pharmacy Division	X	X	X	X	X	% of health facilities without stock out of essential medicines and health supplies	Reports
Strengthening leadership and management	Training in leadership and management skills	HRD	X	X	X	X	X	% of Health managers trained in leadership and management	Reports
Improving the work environment	Implementation of 5S-CQI-TQM	QAD	X	X	X	X	X	% of facilities implementing 5S-CQI-TQM % of health workers satisfied with work	Reports
Establish standards for medical equipment and their maintenance	User training	Infrastructure Division	X	X	X	X	X	% of functional medical equipment	Reports
Improve health facility infrastructure	Review and implement health facility structure standards	Infrastructure Division / LGs		X	X	X	X	No. of health facilities constructed	Designs Supervision

Interventions	Actions	Responsibility	Financial Year					Output Indicators	Means of Verification
			10/11	11/12	12/13	13/14	14/15		
								according to standards	
Improving health worker productivity and quality of care	Conduct regular supervision, monitoring and mentoring	QAD Program / Project Managers	X	X	X	X	X	No. of planned supervision, monitoring and mentoring visits conducted	Reports
	Routinely evaluate QI interventions based on standardized tools to reflect progress towards stated goals		X	X	X	X	X	No. of evaluation studies	Evaluation Reports
	Create a system of recognition and awards for achievements in QI and performance measurement through involvement of providers and consumers	Managers		X	X	X	X	No. of providers recognized and rewarded	Reports
Implement evidence based quality improvement initiatives	Scale up QI initiatives for clinical care and non-clinical services at all levels	Managers DPs	X	X	X	X	X	No. of facilities by level implementing QI interventions % improvement in health outcomes (coverage indicators for specific program areas e.g. HIV, RH, EPI, Malaria, TB, Env. Health, HP&E, Mental Health, Chronic Care, Palliative care, etc.)	Reports
	Integrate QI activities at Service Delivery Points	Managers / DPs	X	X	X	X	X	No. of facilities implementing an integrated QI approach	Reports
Establish patient	Identify and adopt patient safety goals	QI Committees		X	X	X	X	Patient safety goals	Reports

Interventions	Actions	Responsibility	Financial Year					Output Indicators	Means of Verification
			10/11	11/12	12/13	13/14	14/15		
safety practices								identified annually	
	Train staff on patient safety practices	CHS CS			X	X	X	No. of staff trained	Reports
	Establish an adverse events and near–miss reporting system	CHS CS		X	X	X	X	Reporting system established	Observation
	Develop active networks of patients and providers	Health Consumer Organizations	X	X	X	X	X	No. of networks developed	Reports
	Empowering and educating patients and the public, as partners in the process of care	CSOs	X	X	X	X	X	No. of sessions and people educated	Reports
Risk management system	Establish a risk management system in all health facilities	Managers			X	X	X	No. of facilities undertaking annual risk appraisal	Reports
Establish safe surgery checklists	Introduce the WHO's safe surgery checklist in all NRH, RRH and General hospitals	Clinical Services			X	X	X	No. of hospitals using the checklist	Availability of the checklist
Revitalize clinical audit and peer reviews	Develop and disseminate guidelines for clinical audits	Clinical Services	X	X	X	X	X	% of hospitals with clinical audit guidelines	Supervisory visits
	Establish Clinical Audit Committees in all hospitals	Clinical Services	X	X	X	X	X	% of hospitals with Clinical Audit Committees	Reports
	Carry out clinical audits and peer reviews	Hospital Managers			X	X	X	No. of hospitals carrying out clinical audits and peer reviews	Reports
Strengthen infection prevention and control mechanisms	Integrate the National Infection Prevention and Control Guidelines	QAD	X	X				IPC guidelines integrated	Guidelines
	Printing and binding of IPC Guidelines	QAD		X				Guidelines printed	Guidelines
	Disseminate IPC guidelines to all health facilities	QAD			X			Availability of IPC guidelines at all facilities	Supervision reports Inventory
	Provision of adequate amounts of	NMS / Managers	X	X	X	X	X	Quantity of IPC	Stock cards

Interventions	Actions	Responsibility	Financial Year					Output Indicators	Means of Verification
			10/11	11/12	12/13	13/14	14/15		
	infection prevention and control supplies							supplies procured and distributed	
	Improve hospital waste handling and management	CHS CS		X	X	X	X	% of health facilities with proper waste handling and management systems	Supervision
Strengthen referral system	Functionalise HC IVs	Clinical Services / LGs	X	X	X	X	X	% functional HC IVs	Reports
Improve case management	Develop and distribute Clinical guidelines and Standard Operating Procedures at facilities	Program Managers	X	X	X	X	X	% of HUs using guidelines and SOPs	Supervision
Improve pharmaceuticals safety	Develop system for identifying and controlling high hazard medication (e.g. narcotics and anticoagulants).	Pharmacy Division		X	X	X	X	Narcotics and anticoagulant controlled	Mechanism in place
Establish accreditation systems	Define service standards, criteria, implementation arrangements and tools	QAD		X	X			Accreditation system developed	Criteria and tools in place
	Orientation of hospitals on the accreditation system	QAD		X	X			No. of hospital staff oriented	Reports
	Accreditation of public and private hospitals	Accreditation Body			X	X	X	No. of hospital accredited	Reports
	Accreditation of laboratories	CPHL	X	X	X	X	X	No. of laboratories accredited	Reports
Documentation and dissemination of best practices	Print and disseminate newsletters and journal articles	Implementers	X	X	X	X	X	No. of QI implementers with up to date journals	Reports
	Provide opportunities for peer learning through learning networks, clinic-to-clinic mentoring and newsletters	Managers	X	X	X	X	X	No. of learning sessions, mentoring sessions and newsletters	Documentation journals Reports
Strategic Objective 3: To provide client-centered health care services.									
Conduct surveys	Conduct client satisfaction surveys	QAD DPs	X	X	X	X	X	No. of surveys conducted	Reports

Interventions	Actions	Responsibility	Financial Year					Output Indicators	Means of Verification
			10/11	11/12	12/13	13/14	14/15		
		Managers						periodically	
Development and implementation of a feedback / complaint management system at MoH, LG Offices, and Health facilities	Identification and establishment of appropriate methods for obtaining client feedback / complaints (Complaints management plan)	All Managers	X	X	X	X	X	% of institutions with functional complaint management system	
Develop and implement Performance Improvement Plans	Conduct performance assessment	All Managers	X	X	X	X	X	No. of staff meeting performance targets	Reports
Create awareness on roles and responsibilities for providers	Customize and roll out client charters in the health sector	All Managers	X	X	X	X	X	No. of service delivery level charters developed	Copies of client charter
Create awareness on rights, roles and responsibilities	Translate and disseminate patient's charter	QAD	X	X	X	X	X	No. of Patient charter translated and disseminated	Copies of translated charters
Strengthen the Health Unit Management Committees	Review HUMC guidelines to capture QI issues	Clinical Services	X	X				Revised HUMC guidelines	Reports
	Induction of HUMCs	Clinical Services LGs / Partners		X	X	X	X	% of facilities with functional committees	Reports
Involvement of Village Health Teams / Communities in QI	Develop Partnership Defined Quality manual for QI interventions	Partners / MoH			X			PDQ manual developed	Manual
	Training & follow up of CBOs, and VHTs/Peers on QI principles and community responsiveness	HPE Division / CSOs / CBOs		X	X	X	X	% trained	Reports

Interventions	Actions	Responsibility	Financial Year					Output Indicators	Means of Verification
			10/11	11/12	12/13	13/14	14/15		
	Conduct community dialogue	HP&E Division / QI Implementers		X	X	X	X	No. of community dialogues	Reports
Monitoring and Evaluation									
Performance Indicators	Review and identify QI indicators	QAD / Managers	X	X	X	X	X	No. of QI indicators identified	Indicator booklet
Reporting	Compile and submit QI performance reports	Managers Implementers	X	X	X	X	X	% of QI reports submitted timely	Reports
Performance Review	Conduct QI stakeholder meetings at different levels	QAD / Managers	X	X	X	X	X	% of planned meetings conducted	Minutes
Annual QOC Program Assessment	QOC Program Assessment	Consultants	X	X	X	X	X	% of assessment done timely	Reports
Evaluation	Mid-term and End Evaluation of the QIF & SP	Consultants			X		X	Evaluations carried out	Reports

2.5 Specific QI Objectives for Health Outcomes

The specific QI objectives for health outcomes will be identified by the respective programs, depending on key priorities. Table 3 shows some of the specific QI interventions and quality indicators.

1. HIV/AIDS including prevention, treatment, care and support
2. Tuberculosis
3. Malaria
4. Maternal care
5. Newborn care
6. Child and Adolescent Health
7. Non-communicable Diseases e.g. mental health, diabetes, hypertension, cancer
8. Health Promotion and Education
9. Environmental Health and Sanitation

Table 3: Specific Quality Improvement Interventions and Indicators

Priority Area	Leading causes of morbidity and mortality	Highly recommended evidence–based interventions	Potential QI interventions	Indicators
HIV/AIDS prevention, treatment, care and support	Late case detection and initiation of treatment Risky ehavior	HCT Targeted interventions for HIV most at risk population Treatment with highly active antiretrovirals (HAART)	Collaboratives to help develop new models for PMTCT and HIV services Supportive supervision and monitoring Treatment guidelines Multisectoral approach	HIV Prevalence rates No. / % eligible patients receiving HAART % pregnant women receiving HCT % at risk populations aware of HIV prevention No. / % exposed children receiving ARVs
Tuberculosis	Multi-drug resistance Poor patient compliance Late detection Domestic overcrowding	Treatment using second/third line medication in cases of resistance Directly Observed Therapy Short Course (DOTS) Improved sanitation	Collaboratives Access to quality assured laboratory services Systems for active surveillance and follow-up for TB	TB smear positive case detection rate TB cure rate TB default rate Proportion TB cases on supervised DOTS
Malaria	Late detection Non-standard	Parasitological diagnosis, antimalarial drugs as indicated by parasite and	Reliable provision of standard equipment, supplies and high quality	No. of malaria confirmed cases per 1,000 population per

Priority Area	Leading causes of morbidity and mortality	Highly recommended evidence–based interventions	Potential QI interventions	Indicators
	treatment	severity of illness	medicines Access to quality assured laboratory services Treatment guidelines Competency based training (initial and refresher) for health workers and those involved in malaria control Supportive supervision and monitoring	year % of laboratory-confirmed malaria cases % of malaria patients received treatment according to guidelines % of <5s who slept under a LLITN the previous night
Maternal care	Intrapartum and postpartum hemorrhage	Manual extraction of the placenta, removal of retained products, stemming bleeding, management of hypovolemic shock, blood transfusion	Competency –based training (initial and refresher) Reliable provision of standard equipment, supplies and medicines Job Aids / monitoring checklists including partographs Maternal death reviews and audits Infection prevention committees Improve referral system including transportation Good record keeping Review of performance (use of UNICEF quality assessment for Emergency Obstetric care services	Maternal mortality ratio % of pregnant women who received 4 ANC sessions by skilled attendant % of deliveries attended by a skilled birth attendant Caesarian section rates % of pregnant women who received TT2 plus % of women knowing at least 3 danger signs of pregnancy related complications
	Sepsis	Diagnosis, isolation and treatment initially with broad spectrum antibiotics, management of septic shock		
	Pregnancy-induced hypertension	Anticonvulsants and antihypertensive drugs, induction or caesarean section		
	Obstructed labour	Skilled birth attendance Reduced delay in seeking care Partograph use Assisted delivery Caesarian section		
	Unsafe abortion			
Newborn care	Newborn asphyxia	APGAR to assess	Competency based	Neonatal Mortality

Priority Area	Leading causes of morbidity and mortality	Highly recommended evidence–based interventions	Potential QI interventions	Indicators
		management Up to date resuscitation skills and availability of the necessary supplies	training (initial and refresher) on assessment of neonate Resuscitation of asphyxia newborn (e.g. Helping Babies Breathe) Essential newborn care and Kangaroo Mother Care	Rate
	Newborn sepsis	Antibiotics and shock therapy Post natal monitoring Mother's awareness of danger signs		
	Low birth weight	Early breastfeeding, kangaroo mother care		
	Birth trauma	Advanced newborn care		
Child and Adolescent Health	Diarrhea with severe dehydration	Resuscitation as required Rehydration therapy Zinc Feeding	Competency based training (initial and refresher) on Integrated Management of Childhood Illness (IMCI) & community based IMCI (CIMCI). Expansion of Hospital Pediatric Initiative including establishment of emergency triage assessment and treatment system Reliable provision of standard equipment, supplies and medicines. Training to enable basic assessment of common conditions by teachers	Under five mortality rate % of children receiving ORS and zinc when presenting to CHW or health facility with severe diarrhea % of babies fed exclusively with breast milk until 6 months old % of babies receiving complementary food and breast milk after 6 months of age % of pregnant women receiving iron and folate supplementation
	Severe pneumonia	Resuscitation as required Antibiotic therapy, oxygen, antipyretics		
	Severe malnutrition	Resuscitate as required Vitamin A and antibiotics for corneal ulceration, glucose or sucrose, warming, regular feeding, antibiotics, magnesium, potassium, zinc and copper supplements, multivitamins, folic acid and iron		
Non-communicable Diseases Mental health (Severe Mental disorder)	Schizophrenia Depression	Mental health awareness at community and health facility level Counseling Psycho-social support	Competency based training (initial and refresher) on therapeutic counseling Recognition & treatment of priority mental health conditions	No. of CHWs trained on recognition, referral and follow up of mental health problems No. of health facilities providing mental health

Priority Area	Leading causes of morbidity and mortality	Highly recommended evidence–based interventions	Potential QI interventions	Indicators
		Psychotropic medication (antipsychotics, antidepressants)	Reliable provision of standard supplies and medicines Use of treatment protocols & mental health service delivery checklist Partnership Defined Quality	services as defined in minimum health care package including psychosocial care (basic counseling) Availability of minimum range of psychotropic drugs No. of patients presenting with mental health problem attending follow-up appointments
Diabetes, Hypertension and Cancer	Low awareness Late detection Poor adherence to treatment Obesity Complications	Community sensitization Screening and early treatment using the recommended regimen Diet Treatment support Adherence to treatment	Easy to read brochures, Peer education programmes Reliable provision of standard equipment, supplies and high quality medicines Access to quality laboratory services Availability of treatment guidelines for NCDs Competency based training of the staff involved in NCD treatment Empower patients to manage their conditions through provision of skills in self-management Availability of registers patient care cards and other tools Maintenance of longitudinal patient	% of screened patients found to have NCDs % of patient put on treatment % of patient with good clinical outcome (stable and controlled blood sugar / blood pressure

Priority Area	Leading causes of morbidity and mortality	Highly recommended evidence–based interventions	Potential QI interventions	Indicators
			records for ease of follow up Community support	
Emergencies, injuries / trauma	Haemorrhage	Resuscitate as required Treatment as per type of injury Early / timely referral	Emergency supplies and medicine kits located at all areas in a health facility Job aids/monitoring checklists Improve referral systems, including transportation	% of facilities without stock outs of emergency supplies Emergency care SOPs No. of facilities with functional referral system
Epidemic responses	Low awareness Late detection Delayed response	Community sensitization Early detection Rapid response	Functional surveillance system Empower health workers in early case definitions Establish functional epidemic response teams	% of suspected disease outbreaks responded to within 48 hours of notification
Environmental Health, Hygiene and Sanitation	30% of population has no access to sanitary latrines Poor hand washing practices after visiting toilets and before preparing / eating meals	Use of latrines Proper hand washing practices	Enforcement of Public Health Act Innovative hand washing technologies	Latrine coverage % of households with hand washing facilities and soap

3 Themes and Methodologies for QI in Uganda

3.1 Guiding Themes for QI

The following themes should be recognized and adopted to guide designing, planning and implementation of QI in Uganda.

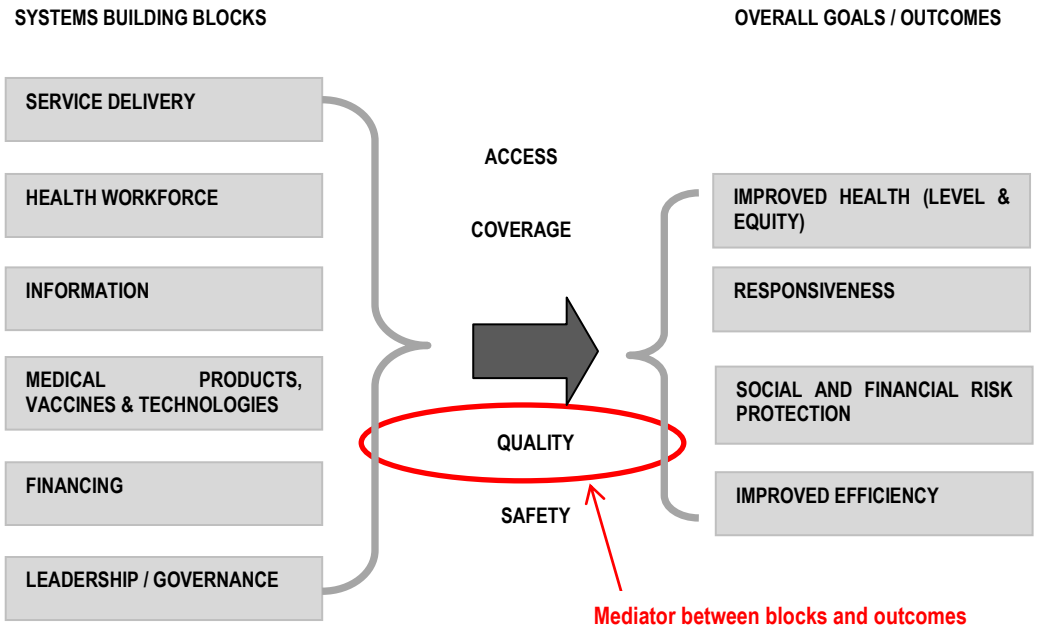
1. **A *culture of safety and improvement*** that rewards improvement and is driven to improve quality is important. The culture is needed to support a quality infrastructure that has the resources and human capital required for successfully improving quality.
2. QI Committees need to have the right ***stakeholders*** involved.
3. QI Committees and stakeholders need to ***understand the problem and root causes*.** There must be a consensus on the definition of the problem. To this end, a clearly defined and universally agreed upon metric is essential. This agreement is as crucial to the success of any improvement effort as the validity of the data itself.
4. Use a ***proven, methodologically sound approach*** without being distracted by the jargon used in QI. The importance given to using clear models, terms, and process is critical, especially because many of the quality tools are interrelated; using only one tool will not produce successful results.
5. ***Standardizing care processes*** and ensuring that everyone uses those standards should improve processes by making them more efficient and effective—and improve organizational and patient outcomes.
6. ***Evidence-based practice*** can facilitate ongoing QI efforts.
7. Implementation plans need to be ***flexible*** to adapt to needed changes as they come up
8. Efforts to change practice and improve the quality of care can have ***multiple purposes***, including redesigning care processes to maximize efficiency and effectiveness, improving customer satisfaction, improving patient outcomes, and improving organizational climate.
9. ***Appropriate use of technology*** can improve team functioning, foster collaboration, reduce human error, and improve patient safety.
10. Efforts need to have ***sufficient resources***, including protected staff time.
11. ***Continually collect and analyze data and communicate results*** on critical indicators across the organization. The ultimate goal of assessing and monitoring quality is to use findings to assess performance and define other areas needing improvement.
12. ***Change takes time***, so it is important to stay focused and persevere.
13. Health system interventions are usually multimodal; ***concurrently addressing providers, patients and system level interventions.***

Health Systems Strengthening (HSS) will specifically include QI. Quality is a mediator between the six World Health Organisation (WHO) HSS building blocks and achieving desired health outcomes[6]. The WHO HSS building blocks are:

[6] Strengthening Health Systems to improve health outcomes WHO, Geneva

1. **Service delivery:** QI closes the gap between actual performance and achievable practice.
2. **Health workforce:** QI enhances individual performance, satisfaction and retention.
3. **Information:** QI enhances the development and adoption of information systems.
4. **Medical products and technology:** QI improves the appropriate, evidence-based use of limited resources.
5. **Financing:** QI helps optimize the use of limited resources and reduces the cost of financial transactions.
6. **Leadership and governance:** QI strengthens measurement capacity, stewardship, accountability and transparency.

Figure 4: WHO HSS Building blocks



3.2 Methodology for QI in Uganda

Situation analysis and literature review of the various QI methodologies indicates that although the presentation of various modern QI methodologies seems different, the content and basic principles are very similar and in most cases complement each other.

In Uganda, districts and partners involved in QI shall implement evidence based targeted QI models and interventions which apply the principle of an iterative cycle of improvement – Plan, Do, Study, Act (PDSA cycle). The MoH recommends initiation of QI interventions in health facilities to start with the 5S which is the initial component of the 5S - Continuous Quality Improvement (CQI) – Total Quality Management (TQM) methodology as a fundamental background to CQI and then introduce appropriate QI interventions which;

- apply the principle of an iterative cycle of improvements;
- apply systematic assessment of service delivery processes;
- use data measurement and statistics in daily work;
- recognize the organizational dimension of improvement; and
- recognize the need for commitment from leadership as well as active engagement of frontline clinical staff;
- involve patients / clients.

The combination of 5S and other evidence based QI interventions is a concerted effort to address the needs and expectations of both the internal and external clients in a systematic way. Internal clients are the health staffs and external clients are the health service users and communities. Each of these groups may expect different things from health services.

The health provider (Internal Client) can provide quality care if he/she has:

- Adequate knowledge and skills.
- Enough resources- staff, drugs, supplies, equipment and transport etc
- Safe and clean workplace.
- Opportunity to regularly improve himself/herself.
- Is well paid and rewarded for good work.

The health care manager (Internal Client) sees quality care as:

- Managing efficiently the resources of the health facility.
- Health staff achieving set targets.
- Health staff being regularly supported and supervised.
- Having adequate and competent staff to provide care.
- Staff being disciplined.
- Providing enough resources for work.

The Patient/Client (External Clients) want services that:

- Are delivered on time by friendly and respectful staff;
- Are safe, produce positive result and that they can afford;
- Provide them with adequate information about their condition and treatment;
- Provide them with all the drugs they need;
- Give privacy.
- Are within their reach (distance) and given in a language they can understand.

In addition programs will provide logistical management and financial support; technical support; support community participation; supporting favourable local team climate at (national, district, facility or community); and establishment of peer support linkages between or among the agencies or programs. Also, interventions may focus on any health related problem (e.g. Performance Improvement for Health Workforce, Quality of Care in HIV/AIDS, Systems Strengthening, Occupational safety, etc). By implementing their interventions, programs or agencies shall be creating solutions to quality issues within the

health sector, as long as their priorities lie within the national health goals and framework. As much as possible, program specific interventions should try to use the Health Systems Strengthening approach in designing interventions in coordination with existing QI partners.

3.2.1 5S Method

In order to set the best stage for health personnel to make maximal use of their skills and knowledge, the MoH recommends the 5S method as the foundation for all QI initiatives in the country. 5-S is a management tool, which originated in Japanese manufacturing sector. It is used as a basic, fundamental, systematic approach for productivity, quality and safety improvement in all types of organizations.

Usually, improvement of work processes often is sustained only for a while, and workers drift back to old habits and managers lose the determination and perseverance. 5-S in contrast involves all staff members in establishing new disciplines so that they become the new norms of the organization i.e. internalization of concepts and development of a different culture.

Although the 5-Ss originated in the manufacturing environment, they translate well to other work situations including hospitals, general offices, telecommunication companies etc. 5 Ss are abbreviations of the Japanese words **Seiri, Seiton, Seiso, Seiketsu, and Shitsuke.** In English, 5Ss were translated as **Sort, Set, Shine, Standardize, and Sustain**. In practical context, local language words are more effective for people to understand easily thus, facilitators of 5S-CQI-TQM in some countries have translated 5-S English words into local language e.g. in Swahili these are: **Sasambua** (Sort), **Seti** (Set), **Safisha** (Shine), **Sanifisha** (Standardize) and **Shikilia** (Sustain).

5-S is the initial step towards establishing TQM. There will be no conflict in the implementation of 5-S activities even though organizations are already implementing other QI interventions. 5-S will support all QI interventions to move forward.

3.2.1.1 Objectives of 5S

1. **Improved productivity:** Health workers being diverted from service delivery to look for equipment, medicines, registers, and so on is the most frustrating form of lost time in any health facility. With 5S often-needed items are stored in the most accessible location and correct adoption of the standardization approach means that they are returned to the correct location after use.
2. **Improved work environment / infrastructure maintenance**: Health workers taking responsibility for keeping work place clean and tidy can take ownership for highlighting potential problems before they have an impact on performance.
3. **Improved Health & Safety:** Clear pathways between workbenches and storage racks can minimize accidents, as can properly-swept floors. An environment in which the

workforce has pride in their workplace can contribute to a considerable extent in a number of ways including customer service. Improving the layout of the facility merges with the concept of visual management; if health workers can see the status of unit and of work in the facility, thus removing the need for complex tracking and communication systems, then benefits will accrue. 5S can also be a valuable marketing tool when potential customers visit; a well-organized, clean and tidy facility sends a message of a professional and well-organized service provider.

Implementation Modalities

1. 5S activities will be used as tools to prepare the obtainable best stage for health personnel to make maximal use of their knowledge and skills.
2. The 5S principles will be implemented starting with a few targeted areas and use the results from these areas to win support from the remaining areas to implement them.
3. The following steps will be followed in the implementation of 5S;

1. Sorting

- Elimination of all unnecessary stuff from venue of work and reduce clutter.
- Go through all tools, materials, and so forth in the work area.
- Keep only essential items and eliminate what is not required, prioritizing things as per requirements and keeping them in easily-accessible places.
- Everything else is stored or discarded.

2. Setting in order or Straightening / Stabilize

- Organize everything needed in proper order for ease of operation.
- There should be a place for everything and everything should be in its place.
- The place for each item should be clearly labeled or demarcated.
- Items should be arranged in a manner that promotes efficient work flow, with equipment used most often being the most easily accessible.
- Workers should not have to bend repetitively to access materials.
- Each tool, part, supply, or piece of equipment should be kept close to where it will be used – in other words, straightening the flow path.

3. Shining or Cleanliness / Systematic Cleaning

- Maintain high standard of cleanliness.
- Clean the workspace and all equipment, and keep it clean, tidy and organized.
- At the end of each shift, clean the work area and be sure everything is restored to its place.

4. Standardizing

- Set up the above three S's as norms in every section of the workplace.
- Work practices should be consistent and standardized.
- All work stations for a particular job should be identical.

- All employees doing the same job should be able to work in any station with the same tools that are in the same location in every station.
- Everyone should know exactly what his or her responsibilities are for adhering to the first 3 S's.

5. Sustaining the discipline or self-discipline

- Train and maintain discipline of the personnel engaged.
- Once the previous 4 S's have been established, they become the new way to operate.
- Maintain focus on this new way and do not allow a gradual decline back to the old ways.
- While thinking about the new way, also be thinking about yet better ways.
- When an issue arises such as a suggested improvement, a new way of working, a new tool or a new output requirement, review the first 4 S's and make changes as appropriate.

On improvement of the work environment/infrastructure from 5S implementation; then other QI initiatives can now come in to improve various aspects of quality in health services including technical issues.

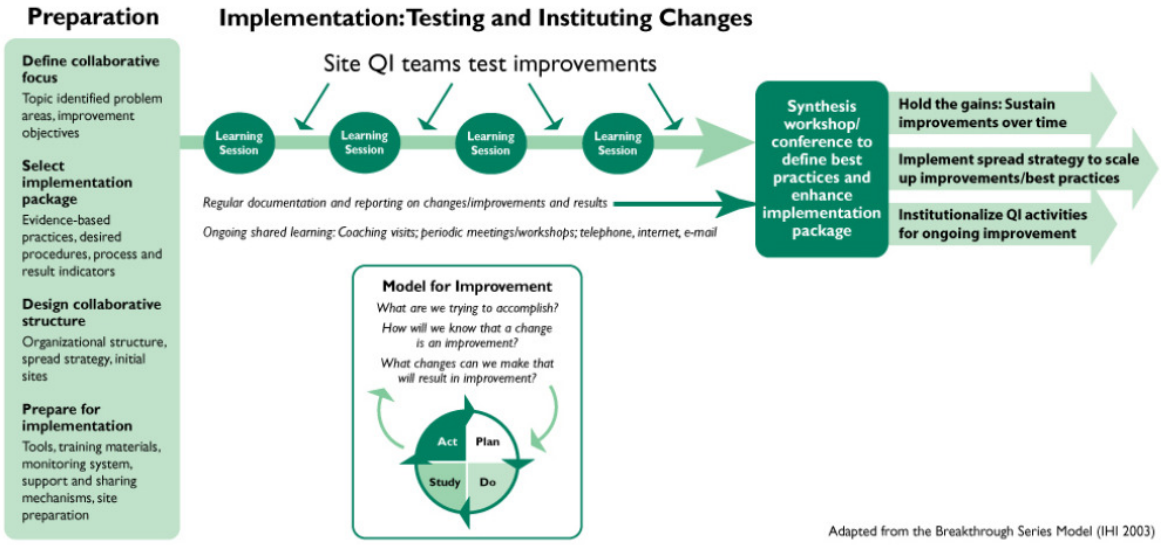
All QI initiatives shall be implemented based on the "Improvement Collaborative" Model ensuring application of the principle of an iterative cycle of improvement (PDSA cycle).

3.2.2 Improvement Collaborative

An "improvement collaborative" is shared learning system that brings together a large number of teams to work together to rapidly achieve significant improvements in processes, quality, and efficiency of a specific area of care, with intention of spreading these methods to other sites / units. The collaborative approach combines traditional QI methods of team work, process analysis, introduction of standards, measurement of quality indicators, training, job aids, and coaching with techniques based on social learning and diffusion of innovation[7].

[7] International Journal for Quality in Health Care 2009; Volume 21, Number 3

Figure 5: HCI Improvement Collaborative Model



- Initiatives should conduct assessments of the current situation (current quality standards) to identify critical gaps and trace their root causes. By this process, it becomes easier to determine and plan for what is to be done to improve the current quality situation (desired quality standards). Depending on what has been identified as of critical need by the MoH or districts, partnering shall determine what to prioritize on supporting and initiate programs that contribute to providing solutions at any level.
- A collaborative will focus on a single technical area (for example prevention of mother-to-child transmission of HIV, ART, family planning, immunization, neonatal-newborn care, etc) and seek to rapidly spread existing knowledge or best practices related to that technical topic to multiple settings, through systematic improvement efforts of a large numbers of teams. Also, interventions may decide on their priorities on any health related problem (e.g. Performance Improvement for Health Workforce, QoC in HIV/AIDS, Systems Strengthening, Occupational safety, etc). By implementing their interventions, programs or agencies shall be creating solutions to quality issues within the health sector, as long as their priorities lie within the national health goals and framework.
- The teams shall work together for a 10 – 12 month period to achieve significant improvements in a specific area of care and then focus on another technical area.
- Teams of health care providers will work independently to test out changes in how they deliver care that seek to implement best practices and accepted standards for the collaborative's topic area.
- Teams shall use a common set of indicators to measure the quality of the care processes the collaborative is trying to improve and, where possible, the desired health outcomes.

- The teams will organize regular sharing of results among teams through learning sessions in which teams learn from each other about which changes have been successful and which were not. This results in a dynamic improvement strategy in which many teams working on related problem areas can learn from each other in a way that facilitates rapid dissemination of successful practices.
- Learning and improvements to new sites will be spread through a spread collaborative. A spread collaborative uses the collaborative structure of a network of sites, a common (enhanced) implementation package and indicators, and learning sessions and other mechanisms for shared learning to spread proven improvements to a significantly larger number of facilities and/or practitioners.
- Spread collaboratives will rely on QI-experienced staff and "quality champions" from the demonstration collaborative to provide support based on their own experiences and who can motivate new facilities as living proof that improvement can happen.
- Dissemination of improvements will be in the form of;
    - guidelines or policy decrees focusing on increasing the perceived legitimacy of the improved intervention and alignment with the institutional values;
    - cascade training, supervision and endorsement by training institutions, development partners, or individuals, alone and in combination focusing in developing technical competency; and
    - extension agents and campaigns focusing on building commitment and political will.
- A change package of best practices that have been demonstrated to be successful and can be adapted by other implementing agencies.
- Sustainability of the achievements of the collaboratives will be demonstrated when the gains in the quality of care are maintained and the health system has incorporated an ongoing process to continually improve quality of care. Evidence of achievements should be generated through performance reports and reviews, documentation and sharing of best practices during learning sessions, evaluations and research. Sustainability should be ensured through deliberate strategies including;
    - incorporation of aspects of the collaborative's refined implementation package into the national service delivery policies and standards
    - advocating for changes in pre-service curriculum and bringing training institutions up to date
    - incorporating quality indicators into routine monitoring and reporting systems and performance based management agreements
    - adding quality monitoring to supervisory functions

This approach's central innovation is the structured, shared learning among many teams working on the same problem area, a feature that promotes rapid dissemination of successful practices.

Regional Learning sessions

Each region is encouraged to hold an inter-facility learning session whereby each site QI team presents what improvement they made and how they approached it. This kind of exchange or sharing is meant to sell ideas to other teams who may not have tested that particular change. We recommend that learning sessions are organized by the Regional QI Committees and held bi-annually for at least 2 days. It should be attended by all implementing health facilities in the region with 2 health workers per facility. In attendance should be some members of the District QI Committees. The district political and technical leadership including; Resident District Commissioners (RDCs), Local Council (LC) V Chairpersons, Secretaries for Health and Chief Administrative Officers (CAOs) could attend the last day when action plans are made and for sharing resolutions.

Exchange Visits

Another valuable way of learning is by having exchange visits of poor performing health workers visiting good performing health facilities to learn from them.

3.2.3 Other QI Methodologies

The MoH of Uganda will continue exploring and adopting different methods based on the Science of Improvement.

It is important to have continuous education about maintaining standards. When there are changes that affect the QI program such as new equipment, new products or new work rules, it is essential to make changes in the standards and provide training. Organizations embracing QI should use posters, signs and Standard Operating Procedures as a way of educating employees and maintaining standards.

3.2.4 Planning and Implementation of QI Initiatives

Planning and implementation of QI initiatives will be done utilizing the inherent organizational knowledge of the facility team as well as factual data. Implementation and results will be measured to ensure success.

Team leaders should aim at ensuring that their organizations:

- Focus on a shared goal
- Communicate that goal to all leaders
- Involve all leaders in planning to achieve the goal
- Hold participants accountable for achieving their part of the plan

Organizations must understand and use structured rapid problem solving tools which include histograms, pareto charts, cause-and-effect diagrams, check sheets, scatter diagrams, flowcharts and control charts, affinity diagram, relations diagram, tree diagram, matrix diagram, prioritization matrix, arrow diagram, and process decision program chart, etc.

The planning process should involve everyone and include the following steps;

1. Creating a vision or goal of the future.
2. Developing innovative ideas about the steps taken to achieve the goal.
3. Grouping ideas into specific strategies.
4. Analyzing the strategies using structured problem solving tools.
5. Formation of cross-functional teams to further investigate the viability of each strategy and to flesh - out an action plan if appropriate.
6. Reviewing and approving the final strategies and action plans.
7. Identifying Action Teams members
8. Implementation of strategies.

The full planning team meet should meet regularly to review and measure progress on each initiative, and to make any adjustments in the plan that are needed. Management and the employees must work together by reporting and providing feedback to one another. This is then followed by a Plan-Do-Study-Act cycle. The cycle of PDSA involves measuring the progress to the goal that was set in the beginning of the year, to record the actual results-to-date, to take note of all the problems between the results and the plan, and lastly state the impact on the strategy for the coming year.

4 Implementation Arrangements

This section presents the implementation arrangements for the QI activities. The implementation arrangements will provide institutional and structural systems that will contribute to the attainment of the HSSIP 2010/11 – 2014/15 objective of accelerating quality and safety improvements. It is important that the implementation of QI programs and interventions utilizes the existing structures and systems of MoH. This will minimize utilization of resources and ensure that QI issues are mainstreamed and integrated within the health system. QI activities will be implemented at national, regional, district, health facility and community levels and incorporated into activities of Private Health Providers and CSOs.

4.1 Political and Administrative Environment

Administratively, Uganda is divided into districts which are further sub-divided into lower administrative units namely counties, sub-counties and parishes. Overtime, the numbers of districts and lower level administrative units have increased in number with the aim of making administration and delivery of social services easier and closer to the people. This has however placed increased strain on delivery of health services, as numbers of management and administrative units and functions increase. This has led to the development of the concept of regional structures to enhance coordination and supervision functions of the center.

As a way of improving the efficiency and effectiveness of service delivery, the GoU decentralized delivery of services guided by the Constitution of the Republic of Uganda (1995) and the Local Government Act (1997). Both NHP I and II support the decentralization of services to districts and Health Sub-Districts (HSDs). Each level of the decentralized health delivery system has specific roles and responsibilities.

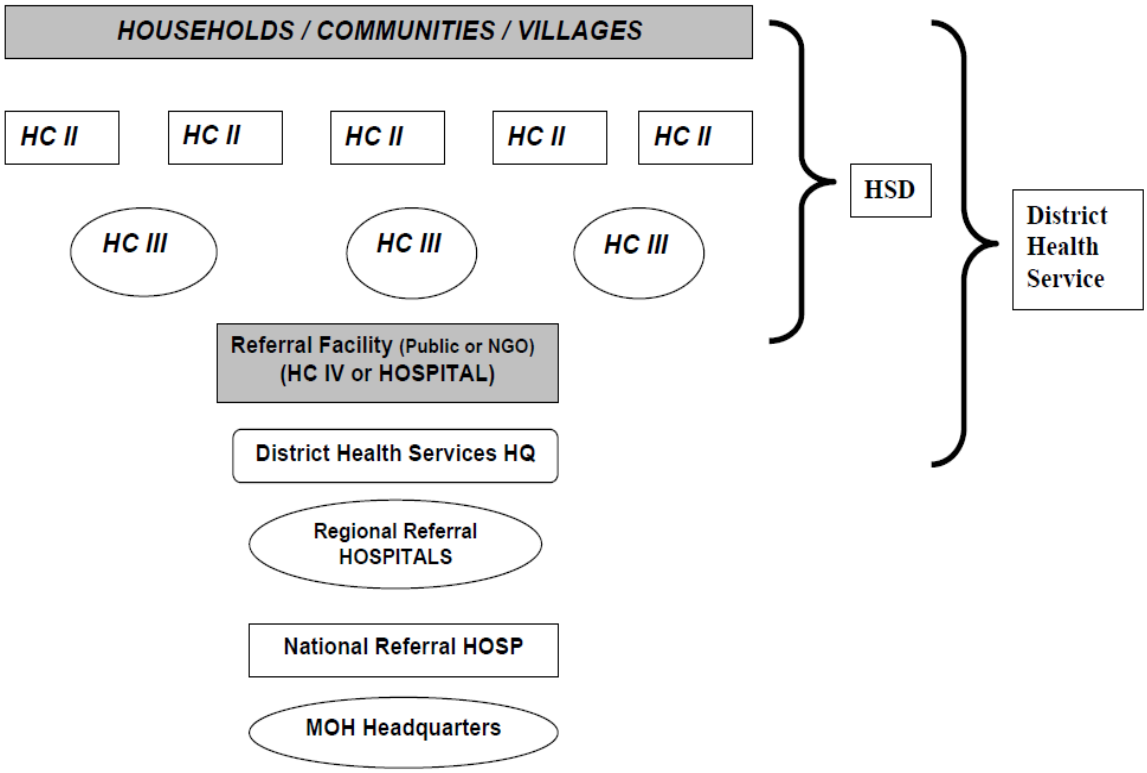
4.2 The National Health System

The National Health System (NHS) is made up of the public and the private sectors. The public sector includes all GoU health facilities under the Ministry of Health, health services of the Ministries of Defense (Army), Education, Internal Affairs (Police and Prisons) and Ministry of Local Government (MoLG). The private health delivery system consists of Private Not-for-Profit (PNFPs) providers, Private Health Practitioners (PHP), and the Traditional and Complementary Medicine Practitioners (TCMPs).

The National Health System is comprised of households / communities / Villages with the Village Health Teams (VHTs) as the lowest structure (Health Centre (HC) I), HC IIs, HC IIIs, HC IVs, General Hospitals, Regional referral Hospitals (RRHs) and National Referral Hospitals

(NRHs). See Figure 6. The provision of health services in Uganda is decentralized with districts and HSDs playing a key role in the delivery and management of health services at those levels.

Figure 6: The National Health System



4.3 Health Service Delivery in Uganda

The delivery of health services in Uganda is by both public and private sectors with GoU being the owner of most facilities. Table 2, shows the number of health facilities by ownership and level in the year 2010 (with a target to have every person house hold accessing a health facility within 5 kms radius).

Table 4: Health Facilities 2010

Level	Government	PNFP	Private	Total
Hospital	64	56	9	129
HC IV	164	12	1	177
HC III	832	226	24	1,082
HC II	1,562	480	964	3,006
Total	2,622	774	998	4,394

Source: HSSIP 2010/11 – 2014/15

4.4 The Public Health Delivery System

Public health services in Uganda are delivered through VHTs, HC IIs, HC IIIs, HC IVs, general hospitals, RRHs and NRHs. The range of health services delivered varies with the level of care. In all public health facilities curative, preventive, rehabilitative and promotive health services are free, having abolished user fees in 2001. However, user fees in public facilities remain in private wings of public hospitals. Although 72% of the households in Uganda live within 5km from a health facility (public or PNFP), utilisation is limited due to poor infrastructure, lack of medicines and other health supplies, shortage of human resource in the public sector, low salaries, inadequate accommodation at health facilities and other factors that further constrain access to quality service delivery.

A study conducted in 2008 on user's satisfaction and understanding of client experiences showed that in general clients were satisfied with physical access to health services (66%), hours of service (71%), availability and affordability of services including the providers' skills and competencies among other things. However, they were dissatisfied with a wide range of issues such as long waiting times, unofficial fees in the public sector, quantity of information provided during care and other behavioural problems relating to health workers. The clients were also more satisfied with community health initiatives because they provide free services and it gives them an opportunity to participate in health services management[8].

4.5 The Private Sector Health Care Delivery System

The private sector plays an important role in the delivery of health services in Uganda covering about 50% of the reported outputs. The private health system comprises of the PNFPs, PHPs and the Traditional and complementary Medical Practitioners (TCMPs); however, the contribution of each sub-sector to the overall health output varies widely. The PNFP sector is more structured and prominently present in rural areas. The PHP is fast growing and most facilities are concentrated in urban areas. TCMPs are present in both rural and urban areas. The services provided are not consistent and vary from traditional practices in rural areas to imported alternative medicines, mostly in urban areas. The GoU recognizes the importance of the private sector by subsidizing the health facilities, PNFP training institutions and a few private hospitals.

4.6 Organisation and Management of Health Services

The Government possesses both service delivery, and stewardship functions in health. The stewardship function is exercised by the management, while the service delivery function is exercised by the facilities, and coordinated by the HSD's and districts. The management structure of the MoH lays emphasis on responsiveness to the requirements of the NHP and

[8] *Jitta, J., J. Arube-Wani and H. Muyiinda. (2008). Study of Client Satisfaction with Health Services in Uganda.*

the health sector strategic plan. The organization is such that there is a clear communication linkage among the national, regional and district level for ease of planning, operations, monitoring and evaluation.

At the district level the District Health Officer (DHO) is in charge of health services with his/her team, addressing both the management and governance issues at the district. At the proposed regional level, the management function will be held by the Hospital Director of the RRH, where they focus on coordination, support to district planning, supervision and monitoring of health services in the region on behalf of the Director General of Health Services (DGHS).

Management Structure and Functions at the Sub-national Level

The DGHS coordinates management functions at the national level with those at the sub-national level. These management structures are in place at district level, and will be established at regional level during the implementation of the HSSIP 2010/11 – 2014/15.

Management at the Regional Level

The detailed structure at the regional level will be outlined after it has been determined through an authentic and agreed process. The Team will have the overall objective of coordination of health, and health related service provision in the region, by ensuring the following functions:

- liaising between national level, and the districts on health, and health related issues;
- supporting the development and implementation of the annual operational plans of the districts and regional referral hospitals in the region;
- supervising, monitoring and reviewing the implementation of the annual operational plans in the region by compiling and analysing quarterly and annual reports; and
- initiating and supporting research activities.

Management at the District Level

District health services are coordinated by the District Health Team (DHT). The DHT has the overall objective of coordinating the provision of health services by both public and private sector in the district under their responsibility, by ensuring the following functions:

- liaising between regional level and the HSD's on health services issues;
- planning for delivery of health services in the district through development of annual operational plans for HSD's and the DHT;
- monitoring and reviewing the delivery of health services in the district by compiling and analysing quarterly and annual reports;
- coordinating integrated supportive supervision for health services in the district.

Management at the Health Sub-District Level

HSD health services are coordinated by the HSD Team. The HSD Team has the overall responsibility of coordinating health services provision in the HSD under their jurisdiction, by ensuring the following functions:

- liaising between district level and the health facilities within on health services issues;
- planning for delivery of health services in the HSD through development of annual operational plans for health facilities and the HSD;
- monitoring and reviewing the delivery of health services in the HSD by compiling and analysing quarterly and annual reports;
- coordinating integrated supportive supervision for health services in the HSD.

The Health Unit Management Committee (HUMC)

The HUMC brings together selected community representatives who are responsible for fostering improved communication with the public, thereby encouraging community participation in health activities within and outside the unit. The HUMC reports to the health facility any plans and decision to improve the quality of care within the health facility.

Specific Responsibilities for the HUMC include:

- Sensitizing community on health rights, roles and responsibilities (Patients Charter);
- Assessing work plans to ascertain that community needs are appropriately addressed;
- Community HIMS data collection and submission to health facility;
- Providing correct information to the community regarding performance of the health facility;
- Providing feedback to the health workers about the performance of the health facility.

4.6.1 Contextual considerations for existing structures and systems

Decentralization: QI initiatives in Local Governments shall be delivered within the framework of decentralization and any future reforms therein. This is because the LGs have the mandate to ensure delivery of quality health services and currently serve as the most appropriate level for coordinating top-down and bottom-up planning for organizing community involvement in planning and implementation; and for improving the coordination between government and private health care. Many key development sectors and partners are represented at this level.

Public Private Partnerships: The private sector shall be seen as complementary to the public sector in terms of increasing geographical access to quality health services, the scope and scale of QI initiatives implemented. In order to ensure standardized quality of services the public sector shall implement QI initiatives as guided by the national QIF.

Integrated health care delivery: QI initiatives shall be scaled up from disease specific interventions to an integrated approach aimed at health systems strengthening.

Harmonization of QI Initiatives: All QI implementers shall be guided by the National QI Framework. One of the gaps in QI efforts in the country has been that QI initiatives were fragmented and not coordinated. There were uncoordinated multiple initiatives, gaps in reporting and feedback, lack of clarity on roles and responsibilities of the different stakeholders as well as inadequate implementation of supervision and mentoring activities for quality.

Client-oriented: The client-oriented principle requires the MoH to design strategies focusing on both the internal and external clients. Most of the QI initiatives in the country have been disease specific mainly because of the urgency in need to improve new interventions like the rapid scale up of HIV care and treatment in the mid 2000s. The current drive is for a health systems strengthening approach which builds on the integrated service delivery approach spelt out in the NHP II.

Leadership: The MoH will provide overall leadership for QI in health care. The MoH will work closely with partners in mapping and defining, on a continuous basis, the roles of different institutions, desired quality outcomes of health care and the values that will guide actions. Leadership needs to empower staff, be actively involved, and continuously drive QI. All partners are to apply the QA principles of focusing on the client, use of data focusing on evidence based outcomes, systems thinking and effective communication with all stakeholders. Without the commitment and support of senior-level leadership, even the best intended projects are at great risk of not being successful. Champions of the quality initiative and QI need to be throughout the organization, but especially in leadership positions and on the team.

Multidisciplinary Teams: Due to the complexity of health care, multidisciplinary teams and strategies are essential. Multidisciplinary teams from participating centers/units need to work closely together, taking advantage of communication strategies such as face-to-face meetings, conference calls, and dedicated e-mail list servers. They need to also utilize the guidance of trained facilitators and expert faculty throughout the process of implementing change initiatives when possible.

Country-led monitoring and evaluation plan: The National Strategic Plan (HSSIP) core and program specific indicators shall provide a basis for the development of indicators for various QI initiatives. M&E activities will be guided by the national strategic plan M&E Plan.

Human Resources: The capabilities for implementing QI shall be addressed through a) in-service training, as well as b) pre-service education for all health professions, including physicians, nurses, pharmacists, laboratory personnel, health managers, etc. c) The possibility of embedding QI into job descriptions will be explored so that it is understood that everyone participates. The MoH will spearhead development of a national in-service QI training manual and liaise with training institutions in development of pre-service QI training curriculum. The expectations for facilities should be made clear at all levels of

training so that the expectation of minimum QI standards for organizations is well understood and disseminated throughout the entire health sector.

4.7 Relationship Structure

Quality improvement requires active and continuing support from top leadership. At the Ministry level it means the Minister himself/herself, the Permanent Secretary, and the Director General of Health Services (Top Management) give their full support. At district level, the Local Council Chairperson, the Chief Administrative Officer (CAO), the DHO and the Hospital Director / Medical Superintendant are involved in efforts to improve the quality of district health services by supporting application of quality improvement initiatives. Equally at sub-county level, the political and administrative leaders play an important role in sustaining the culture of quality.

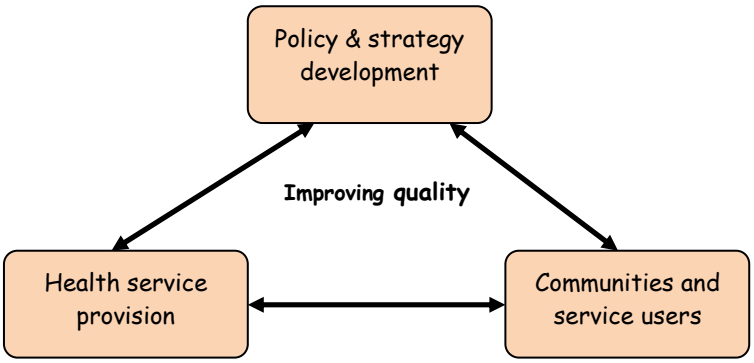
The main responsibilities of decision-makers and managers will be to keep the performance of the whole system under review, and to develop strategies for improving quality outcomes and equity across the whole system. Decision-makers will engage health-service providers, communities, and service users in developing and implementing new strategies for quality using evidence based data.

Providers may be seen as whole organizations, teams, or individual health workers. The core responsibilities of health-service providers for QI will be to ensure that the services they provide are of the highest possible standard and meet the needs of individual service users, their families, and communities. Health service providers also need to operate within an appropriate policy environment for quality, and should have proper understanding of the needs and expectations of those they serve so as to deliver the best results

Improved quality outcomes are not, however, delivered by health-service providers alone. Communities and service users are the co-producers of health. They have critical roles and responsibilities in identifying their own needs and preferences, and in managing their own health with appropriate support from health-service providers. Communities and service users need to influence both quality policy and the way in which health services are provided to them, if they are to improve their own health outcomes. This should be achieved through established mechanisms to address responsiveness like client satisfaction surveys, suggestion boxes, complaints desk, community meetings/dialogues, etc. Findings related to inequalities and vulnerabilities should be prioritized in subsequent plans.

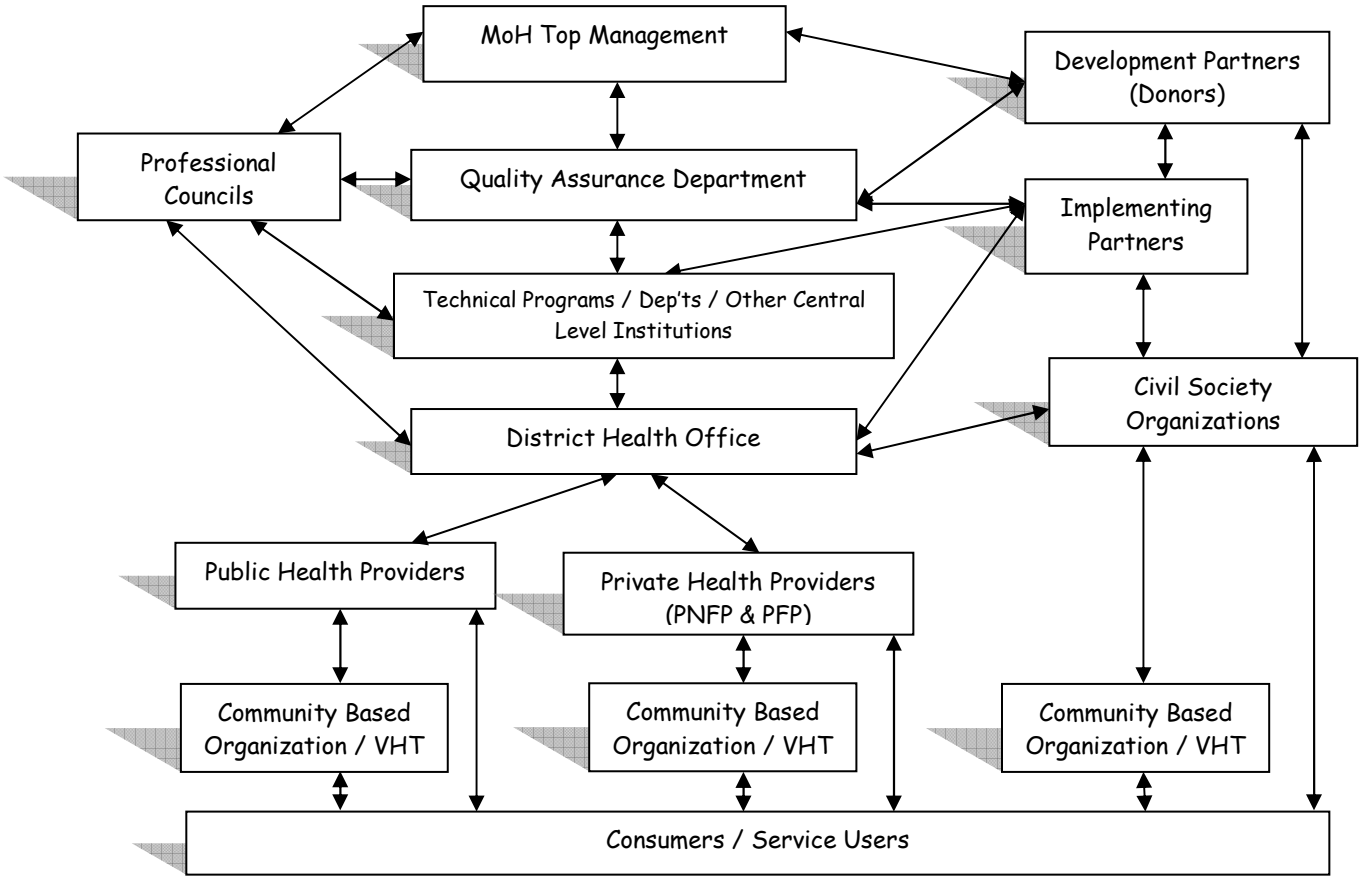
The MoH relationships in improving quality involve a number of stakeholders responsible for; policy and strategy development; health service provision; communities and service users

Figure 7: Stakeholder Roles in Quality Improvement



The MoH will ensure collaboration between the various stakeholders using the following QI implementation relationship structure.

Figure 8: MoH Quality Improvement Relationship Structure



The MoH Top management comprising of the Ministers, Permanent Secretary, DGHS, Directors, Heads of Departments and other Health Policy Advisory Committee (HPAC) members will be responsible for reviewing and approving QI policies and strategies guided by the QAD with input from the National QI Coordination Committee.

The Quality Assurance Department

The mandate of the QAD is to ensure that the quality of services provided is within acceptable standards for the entire sector, both public and private health services. This is to be achieved through the departmental strategic objective of **"Facilitating the establishment of internal quality assurance capacity at all levels".**

The responsibilities of the QAD will include overall operational oversight and coordination. Specifically the QAD will help build a sound quality program that establishes performance measures and data collection systems; develop written QM plans and annual goals; and oversee the progress of QI activities in the health sector. At the provider level, steps include building capacity and capability for QI among providers through training and technical assistance.

The QAD will coordinate the planning, resource mobilization, monitoring and evaluation of QM/QI interventions within the various MoH departments, programs, projects, health institutions and the entire health care delivery system. Implementation of the various QM interventions including QI initiative will be the responsibility of specific programs/projects, departments and institutions which shall have designated QM/QI officers.

The QAD will be the secretariat of the National QI Coordination Committee. QAD will receive, synthesize and present any strategic plans and decisions, to maintain and improve the quality of care within the sector to the Supervision, Monitoring, Evaluation and Research Technical Working Group (SME&R TWG). The SME&R TWG will discuss and present relevant QI strategies and policy recommendations to the Senior Management Committee and the HPAC for action.

The specific responsibilities for QAD are:

- Developing national standards and guidelines for QI.
- Ensuring the dissemination of the guidelines to the regions, districts and stakeholders.
- Coordinating and supporting training at all levels (national, regional, district, health centers and community); including pre-service and in-service health training institutions in new technological and QI issues.
- Overseeing execution of the national QI plan
- Facilitating implementation of regional and local QI activities
- Coordinating support supervision at all levels in regard to QI issues.
- Working with UNHRO to determine the quality improvement research agenda
- Working with training institutions to develop and implement the national QI training curriculum and training manual.
- Documenting quality of care best practices and share information with other interested stakeholders for adaptation.
- Compiling and disseminating national reports
- Convening national QI stakeholders meetings

- Recognizing and rewarding top performers.

The Professional Councils will be responsible for regulation of professional standards, ethics and code of conduct. They should be able to recognize and reward good performance and sanction or institute disciplinary measures for poor performance.

Development Partners will be responsible for offering technical and financial support to relevant levels in consultation with the MoH Top Management and guided by the QAD on the existing gaps, priorities and community needs. Also participate in supervision, monitoring and evaluation activities.

Program Managers / Heads of Departments/ Central Level Institutions including Regional Referral Hospitals will be responsible for offering technical support in terms of identifying QI priorities in specific program areas and presenting them to the QAD for discussion by the National QI Coordination Committee. In addition Program Managers / Heads of Departments will be responsible for identifying QI Focal Persons / Officers who will collaborate with the QAD in planning, resource mobilization, implementing, monitoring and evaluating QI activities in their programs. Program Managers / Heads of Departments will compile and submit performance reports to the QAD on a quarterly basis.

Implementing partners may be supported by the Development Partners to offer technical and financial support to public, private and community based service providers. This should be done in consultation with the QAD and guided by the existing gaps, priorities and community needs. Implementing partners will engage the DHOs in the day-to-day QI intervention operations. To ensure that all workplans and reports are submitted through the MoH reporting system with copy to the relevant stakeholders. Implementing partners may facilitate collection and synthesis of additional project data without replacing the MoH Health Management Information System (HMIS).

Health service providers including the private and public sectors and community based organizations will plan, implement, monitor and evaluate QI interventions in line with the national planning guidelines, National QIF and Strategic Plan, National supervision, monitoring and evaluation guidelines. Compile and submit periodic reports including documentation and sharing of best practices.

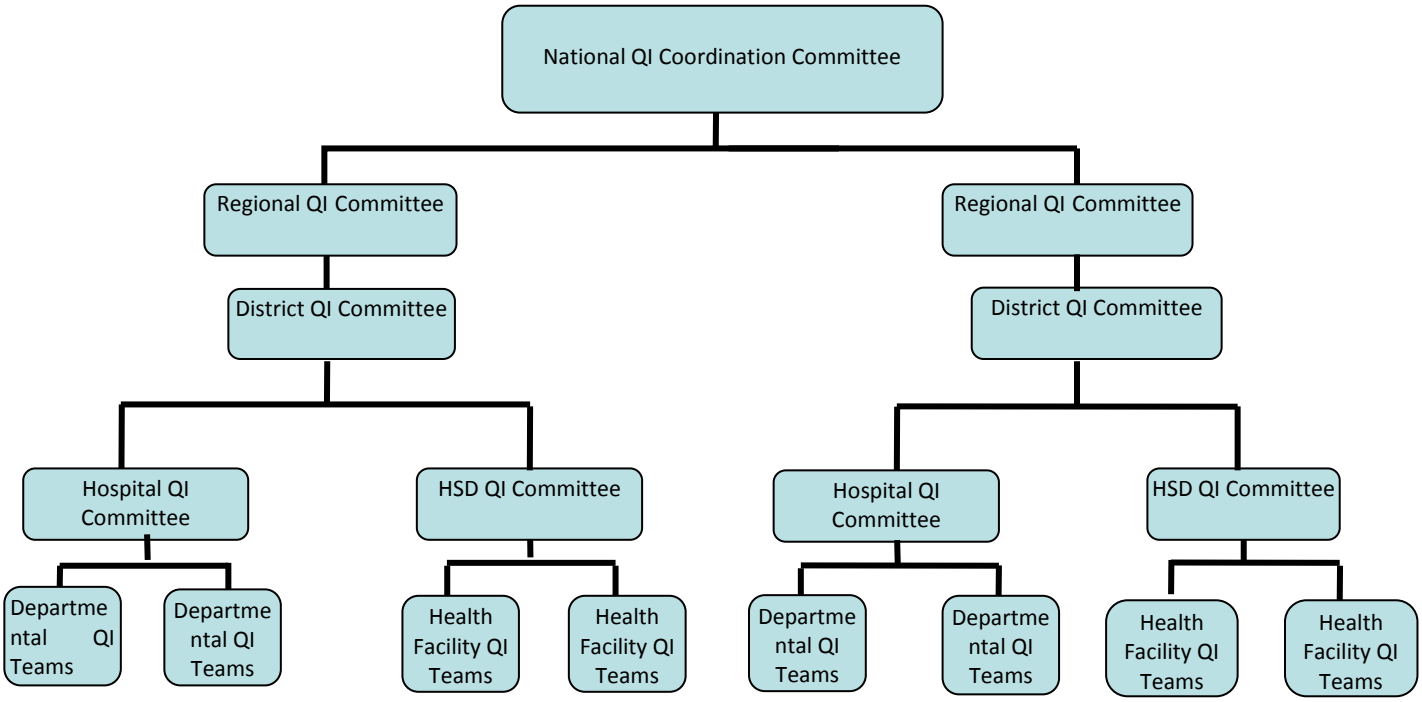
Communities and Service users will participate in identifying and planning for services needed, utilize the services provided and provide feedback on quality of services using established mechanisms.

Communication and reporting mechanisms for QI will follow the same structure.

4.8 QI Coordination Structure

The following QI coordination structure has been created to enhance the QI policy, strategy development, communication and capacity building activities in a coordinated manner.

Figure 9: National Quality Improvement Coordination Structure



4.8.1 Roles and Responsibilities

The National Quality Improvement Coordination Committee

The National QI Coordination Committee brings together major stakeholders such as the priority programs, Development Partners, PNFPs, CSOs and health consumers. The key responsibility of the National QI Coordination Committee is to identify opportunities and potential strategies to coordinate the QI initiatives in Uganda.

The Coordination Committee will report to the Quality Assurance Department any plans and decisions, to maintain and improve the quality of care within the sector.

Specific responsibilities include:

1. Participating in developing strategies for improving quality outcomes which apply across the whole system.
2. Supporting and participating in the formulation of national QI guidelines and standards.
3. Identifying key priority areas for QI and make recommendations to the SME&R TWG and relevant stakeholders.

4. Facilitating networking with partners in identifying problems and solutions at National, Regional, District and Sub-District levels.
5. Receiving and reviewing QI implementation reports.
6. Discuss recommendations and lessons learnt during implementation of QI initiatives.
7. Participating in building capacity of national, regional, district, HSD and facility personnel in the implementation of QI activities in health services.
8. Monitoring and evaluating performance of the Regional QI Committees.
9. Attending National QI Coordination Committee meetings.

Composition

The National QI Coordination Committee shall have a membership which shall include:

- Director Health Services, Planning and Development as Chairperson
- Technical staff from the QAD
- Representatives from MoH departments and programs implementing QI activities
- Representatives from Public and Private Institutions implementing QI activities
- Representatives from Health Development Partners supporting implementation of QI
- Representatives from CSOs supporting implementation of QI activities
- Representatives from health consumers organizations
- Representatives from tertiary training institutions

The National QI Coordination Committee shall meet quarterly.

Regional QI Committee

The Regional QI Committee brings together major stakeholders such as the PNFPs, priority programs and Development Partners supporting QI in the region. The Regional QI Committee will report to the National QI Coordination Committee any plans and decisions, to maintain and improve the quality of care within the catchment area.

Specific Responsibilities for the Regional QI Committee include:

1. Guiding implementation of QI activities in the region
2. Developing Regional QI plan and budget
3. Participating in building capacity of district personnel in implementation of QI activities.
4. Organizing regional learning networks
5. Identifying training needs within the region
6. Supervising, coaching and mentoring at district and health facility level
7. Monitoring and evaluating data results to determine regional priorities and presenting data at regional learning networks
8. Monitoring and Evaluating performance of the District QI Committees
9. Convening regional QI stakeholders meetings
10. Recognizing and rewarding top performers.

Composition

The Regional QI Committee shall have a membership which shall include:

- The Hospital Director of a Regional Referral Hospital as Chairperson.
- Regional QI Focal Person as Secretary
- Heads of Departments
- Head of Nursing in the RRH
- District Health Officers in the region
- Representatives from Health Development Partners supporting implementation of QI in the region
- Representatives from CSOs implementing QI in the region
- Community/Patient Representatives (one male, one female)

The Regional QI Committee shall select a Regional QI Focal Person from its members and the committee shall meet quarterly.

District QI Committee

The District QI Committee brings together major stakeholders such as the HSDs I/Cs, PNFPs, priority program managers / Focal Persons and Development Partners implementing QI in the district. The District QI Committee will report to the Regional QI Committee any plans and decisions, to maintain and improve the quality of care within the district.

Specific Responsibilities for the District QI Committee include:

1. Overseeing all QI activities in district
2. Developing district QI plan and budget
3. Participating in building capacity of HSDV / health facility personnel in implementation of QI activities.
4. Supervising, coaching and mentoring general hospitals and HC IV and reporting findings (Integrated)
5. Overseeing data collection process at hospital and HSD level and submitting facility level data to national level
6. Overseeing data analysis using control or run charts, synthesis and interpreting variation from patterns
7. Monitoring and evaluating QI implementation in the district
8. Communicating with regional and national level through specified reporting structure, forms, etc.
9. Convening District QI Committee meetings
10. Recognizing and rewarding top performers.

Composition

The District QI Committee shall have a membership which shall include:

- The District Health Officer as Chairperson
- District QI Focal Person as Secretary
- Selected DHT members including the District Biostastician
- In-Charges of Health Sub-districts

- QI Focal Person of the RRH in the district
- HSD QI Focal Persons if different from the HSD In-charge
- Representatives from Health Development Partners supporting implementation of QI in the district
- Representatives from CSOs implementing QI in the district
- Community/Patient Representatives (one male, one female)

The District QI Committee shall select a District QI Focal Person from its members and the committee shall meet quarterly.

HSD/HC IV QI Committee

The HSD QI Committee brings together major stakeholders such as the HSD Departmental Heads, Health Facility QI Focal Persons from all implementing facilities in the HSD, HC III In-charges, and QI partners in the HSD. The HSD QI Committee will report to the District QI Committee any plans and decisions, to maintain and improve the quality of care within the HSD.

Specific Responsibilities for the HSD QI Committee include:

1. Developing a QI Committee (or equivalent) to oversee all QI activities in HSD
2. Developing HSD QI plan and budget
3. Supervising (Integrated), coaching and mentoring lower level facilities and reporting findings
4. Overseeing data collection process at lower level facilities and submitting facility level data to district level
5. Monitoring and evaluating QI implementation in the HSD
6. Convening HSD QI Committee meetings
7. Communicating with district and regional level through specified reporting structure, forms, etc.
8. Recognizing and rewarding top performers

Composition

The HSD QI Committee shall have a membership of which shall include:

- The HSD In-charge as Chairperson
- HSD QI Focal Person as Secretary
- Health Inspector
- Nursing Officer
- In-Charges of HC IIIs in the HSD
- Records Officer
- Representatives from Health Development Partners supporting implementation of QI in the subcounty
- Representatives from CSOs implementing QI in the subcounty
- Community/Patient Representatives (one male, one female)

The HSD QI Committee shall select a HSD QI Focal Person from its members and the committee shall meet monthly.

Hospital QI Committee

Hospital QI Committee brings together various departments to participate in QI activities. The Hospital QI Committee shall bring together Hospital Managers, Departmental QI focal persons, service providers and consumer representatives in the hospitals. The Hospital QI Committee will report to the Regional QI Committee in case of Regional Referral Hospitals or District QI Committee in case of General Hospitals any plans and decisions, to maintain and improve the quality of care within the hospital.

Specific Responsibilities for the Hospital QI Committee include:

1. Developing hospital QI plan and budget
2. Leadership support for QI
3. Developing team-based QI projects
4. Supervising, coaching and mentoring QI activities in the hospital
5. Staff involvement in QI
6. Collecting and reporting facility data and submitting to district level
7. Use of data for QI
8. Organizing QI Committee meetings
9. Patient involvement in QI

Composition

The Hospital QI Committee shall have a membership which shall include:

- The Hospital Manager as Chairperson
- Hospital QI Focal Person as Secretary
- Hospital Administrator
- Heads of Departments
- Head of Nursing
- In-Charges of the various wards
- Medical Records Officer
- Representatives from Health Development Partners supporting implementation of QI in the hospital
- Representatives from CSOs implementing QI in the hospital
- Community/Patient Representatives (one male, one female)

The Hospital QI Committee shall meet monthly.

Departmental QI Teams

Departmental QI Teams should be established in major departments (Surgery, Medical, Pediatrics, Obstetrics and Gynaecology, Outpatient Department (Casualty, Pharmacy & Stores, Laboratory), Community, etc. Department QI Team will report to the Hospital QI

Committee activities and plans executed in departments. The Departmental QI teams will be about 3 - 5 in number per given hospital.

Specific responsibilities of Departmental QI Teams include:

- Testing and introducing improvement changes in departments
- Monitoring and evaluating QI results in the departments
- Identifying quality issues at department level
- Developing improvement objectives that are priority to the department and facility

Composition

The Departmental QI team shall have a membership which shall include:

- The Head of Department will serve as a Chairperson
- The Departmental QI Focal Person will be the Secretary
- Members of the department involved in QI activities
- Representatives from other departments closely linked/closely related to the department

Lower Level Facility QI Teams

The lower level facility QI Teams bring together player to participate in specific QI interventions at the various levels. This can be at national, sub-national and health facility or institutional level. The lower level Facility QI Teams shall bring together managers, QI focal persons, service providers and consumer representatives at a specific facility. The lower level Facility QI Team will report to the relevant QI Committee (national level QI Team reports to the National QI Coordination Committee, Regional QI team to the Regional Committee, district based team to the District QI Committee, general hospital QI team to Hospital Committee and Lower Level health facility teams to the HSD Committee) any plans and decisions regarding implementation of specific QI interventions within the health facility/institution.

Specific responsibilities for the Lower Health Facility QI Team include:

1. Developing health facility QI intervention plan and budget
2. Leadership support for specific QI interventions
3. Developing team-based QI projects
4. Supervising, coaching and mentoring specific QI activities
5. Staff involvement in QI interventions
6. Collecting and reporting and submitting facility data
7. Use of data for QI
8. Organizing QI team meetings
9. Patient involvement in QI

Composition

The Lower level Facility QI Team shall have a membership which shall include:

- The Facility Manager as Chairperson

- QI Focal Person as Secretary
- Representatives of service delivery areas
- Records Assistant
- Representative from Health Development Partners supporting implementation of a specific QI intervention in the facility
- Representatives from CSOs implementing the specific QI in the area
- Community/Patient Representatives (one male, one female)

The lower level Facility QI Teams shall meet monthly.

Village Health Teams / Health Consumers
A network of VHTs has been established in Uganda which is facilitating health promotion, service delivery, community participation and empowerment in access to and utilization of health services.

The VHTs are responsible for:

1. Identifying the community's health needs and taking appropriate measures;
2. Mobilizing community resources and monitoring utilization of all resources for their health;
3. Mobilizing communities for health interventions such as immunization, malaria control, sanitation and promoting health seeking behaviour;
4. Maintaining a register of members of households and their health status;
5. Maintaining birth and death registration;
6. Serving as the first link between the community and formal health providers.
7. Community based management of common childhood illnesses including malaria, diarrhoea and pneumonia; and management and distribution of any health commodities availed from time to time.

The Partnerships Defined Quality (PDQ) approach will be used to seek community ideas and expectations on quality of services through community dialogues facilitate by the VHTs or health consumers like under peers for chronic care. The PDQ process should be designed to encourage health care providers and communities to look beyond the health system for solutions to health care deficiencies at the community level.

5 Quality Assessment / Measurement

The rationale for measuring QI is the belief that good performance reflects good-quality practice, and that comparing performance among providers and organizations will encourage better performance. It is the only way of really knowing whether care is being provided at the population or group level. Performance measurement separates what we "think" is happening from what we "know", avoids putting ineffective solutions into place.

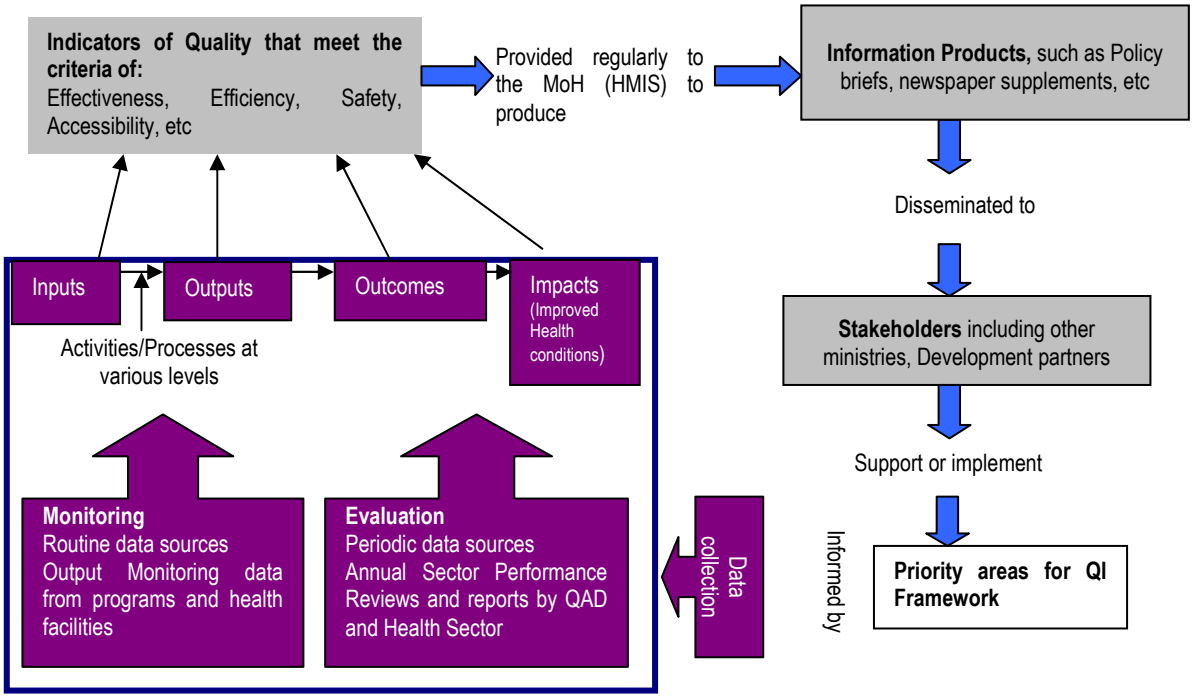
Efforts to improve quality need to be measured to demonstrate whether improvement efforts;

1. lead to change in the primary end point in the desired direction;
2. contribute to unintended results in different parts of the system;
3. require additional efforts to bring a process back into acceptable ranges

The measurement of quality of care shall be based on indicators that are linked to optimal clinical care and support service inputs, processes and outcomes. Specific aspects of clinical care will be selected by clinical leadership within the Ministry departments in conjunction with key stakeholders, patients and the community. From these designated priorities indicators that are relevant, measureable and improvable will be developed. Some indicators may apply to all patients entering the health care system and others will only apply to selected groups based on gender, disease and age.

Inputs shall be all those activities and processes at various levels while outputs shall be determined according to the inputs.

Figure 10: Quality Assessment Process



The portfolio of quality measures will be enhanced to include other strategic and externally required measures to ensure integration with donor requirements and other external requirements. These indicators will be reviewed and approved by the National QI Coordination Committee annually to assure continued relevance to current policy guidelines and current available care.

5.1.1 Quality Assessment Indicators

Performance standards shall be established for most dimensions of quality, such as technical competence, effectiveness, efficiency, safety, and coverage. Where standards are explicit for example coverage, quality assessment will measure the level of performance according to those standards. For dimensions of quality where standards are more difficult to identify, such as continuity of care or accessibility, quality assessment will describe the current level of performance with the objective of improving it.

The MoH – QAD shall facilitate the review of existing QI standards and indicators for various service areas for harmonization. The review and development of the quality assessment indicators in all service delivery areas will based on the following:

Structural Indicators

- Accessibility to health care services taking consideration of geographical coverage and location, distance to the health facility, continuity of services, etc;
- Availability of trained health workers
- Availability of medicines and supplies
- Work environment organization
- Logistics management
- Data management, use and dissemination

Process Indicators

- Availability and use of standards and guidelines
- Organizational management for implementing QI
- Risk and harm reduction to service providers and users
- Infection prevention and control practices
- Testing and documentation of changes
- Client participation
- Staff attitude to work

Outcome Indicators

- Balanced and equitable health care to reduce variations across different social characteristics
- Waiting time and crowding at service points
- Responsiveness in the institution health care system
- Community participation
- Level of utilization of services in priority area
- Extent to which health care is delivered in a manner which maximizes resource use and avoids waste
- Indicators for standardization
- Indicators for sustainability
- Client satisfaction

5.2 Sources of Data

Data for monitoring quality may be from the routine or periodic data that we collect in the facilities and in the communities. The data needs for QI intervention assessment shall be based on agreed performance indicators (QI framework and programme specific) to facilitate monitoring, evaluation, reporting and decision-making for specific interventions

1. The main routine data sources will include;

- **Facility generated data.** This will be collected by all public and private health service delivery facilities and community. This data will be collected routinely using established data collection methods and tools and aggregated at health facility, HSD, district and national level. In addition different programs and projects managed at the MoH/national level shall provide reports to the QAD on program/project specific activities. Health projects managed by implementing partners (DPs and CSOs) at district or community level shall provide reports through the district health system.
- **Administrative data sources** will provide information on health inventories, supervision, management meetings, logistics management, human resource, financial resource flows and expenditures at national and sub-national levels.
- **Population based health surveys** mainly carried out by Uganda Bureau of Statistics (UBOS) and other institutions that generate data relative to populations (population studies) as a whole. Research Institutions and academia that carry out health systems research, clinical trials and longitudinal community studies will also provide data for interpretation and possible use by the sector.
- **Civil registration and vital statistics system** is essential for providing quality data on births, death and causes of death. Efforts will be made to link this system to the Health Information System.
- **Population and Household Census** is carried out every ten years and will be the primary source of data on size of the population, its geographic distribution, and the social,

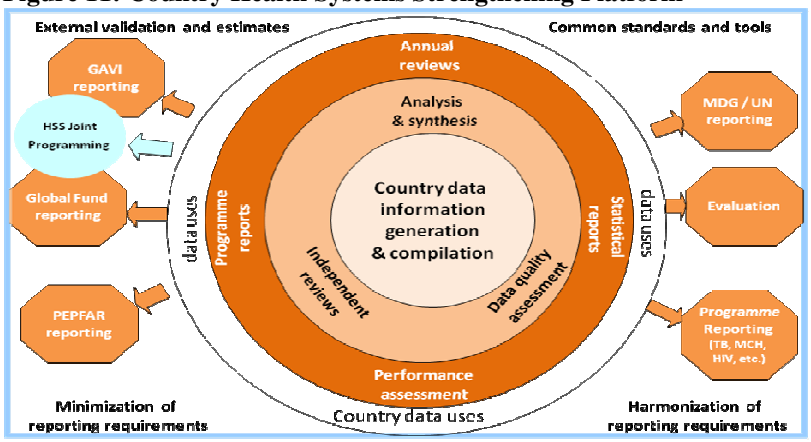
demographic and economic characteristics. Annual projections at national and sub-national level will be provided by UBOS.

2. Other sources of data for QI intervention assessment

Under the Country-led M&E platform all partners are expected to use the national HMIS for facility based primary data collection (Figure 9).

Other data needs for QI intervention assessment will be generated during improvement projects and PDSA cycles. These may be collected but not be synthesized under the routine HMIS. Partners supporting the QI intervention projects will be required to facilitate development and supply of additional data synthesis and analysis tools and logistics.

Figure 11: Country Health Systems Strengthening Platform



Overall, the sources of data will be guided by different information needs, particularly the Government, Parliament, Development Partners, private sector and the community.

5.3 Quality Assessment Methods and Tools

Quality assessment is often an initial step in a larger QI process which may include providing feedback to health workers on performance, training and motivating staff to undertake quality improvements, and designing solutions to bridge quality gaps.

The methods of data collection will be a combination of quantitative and qualitative methods. As far as possible, standardized data collection tools and techniques will be used. Most data in respect of some indicators will be collected annually, and any survey-based indicators will be collected at baseline, mid-term where possible and project end.

The specific tools and methods will among others include;

- The HMIS for review of routine health information e.g. OPD attendance, In-patient admissions and deaths, Immunization coverage, deliveries, ANC attendance, Family planning utilization, HCT uptake, ART uptake, etc.
- Project databases for project specific data;

- Human Resource Information System (HRIS) for staffing levels;
- Logistics Management Information System (LMIS);
- Output Budgeting Tool (OBT) under the Integrated Financial Management System (IFMS);
- Specific questionnaires will be designed for evaluation surveys (baseline, mid and end term), client satisfaction and relevant household surveys;
- Standardized checklist will be used to collect other quality measurement data e.g. audit of individual patient records, death audits and review, clinical audits, observation of service delivery, critical incidents –adverse events, mystery clients, peer reviews;
- Patient complaint system e.g. suggestion boxes, complaint's desk;
- Geographical Information System (GIS) shall be used to enhance documentation and accountability where applicable.
- Other proven tools and methodologies

5.4 Data Analysis and Synthesis

Data analysis and synthesis will be done at various levels of service delivery (National, sub-national to health facility) to enhance evidence based decision making. The results obtained will be summarized into a consistent assessment of the quality improvement and trends, using selected QI indicators and targets. The focus of analysis will be on comparing planned results with actual ones, understand the reasons for divergences and compare the performance at different levels.

Measures of quality and safety can track the progress of quality improvement initiatives using external benchmarks. Benchmarking in health care is defined as the continual and collaborative discipline of measuring and comparing the results of key work processes with those of the best performers in evaluating organizational performance.

Two types of benchmarking will be used to evaluate patient safety and quality performance.

- Internal benchmarking will be used to identify best practices within an organization / health facility, to compare best practices within the organization / health facility, and to compare current practice over time. The information and data may be plotted on a control or run chart with statistically derived upper and lower control limits.

- Competitive / External benchmarking will also be used to represent best practices elsewhere. Competitive / external benchmarking involves using comparative data between organizations / health facilities to judge performance and identify improvements that have proven to be successful in other organizations / health facilities.

5.5 Data Communication and Feedback

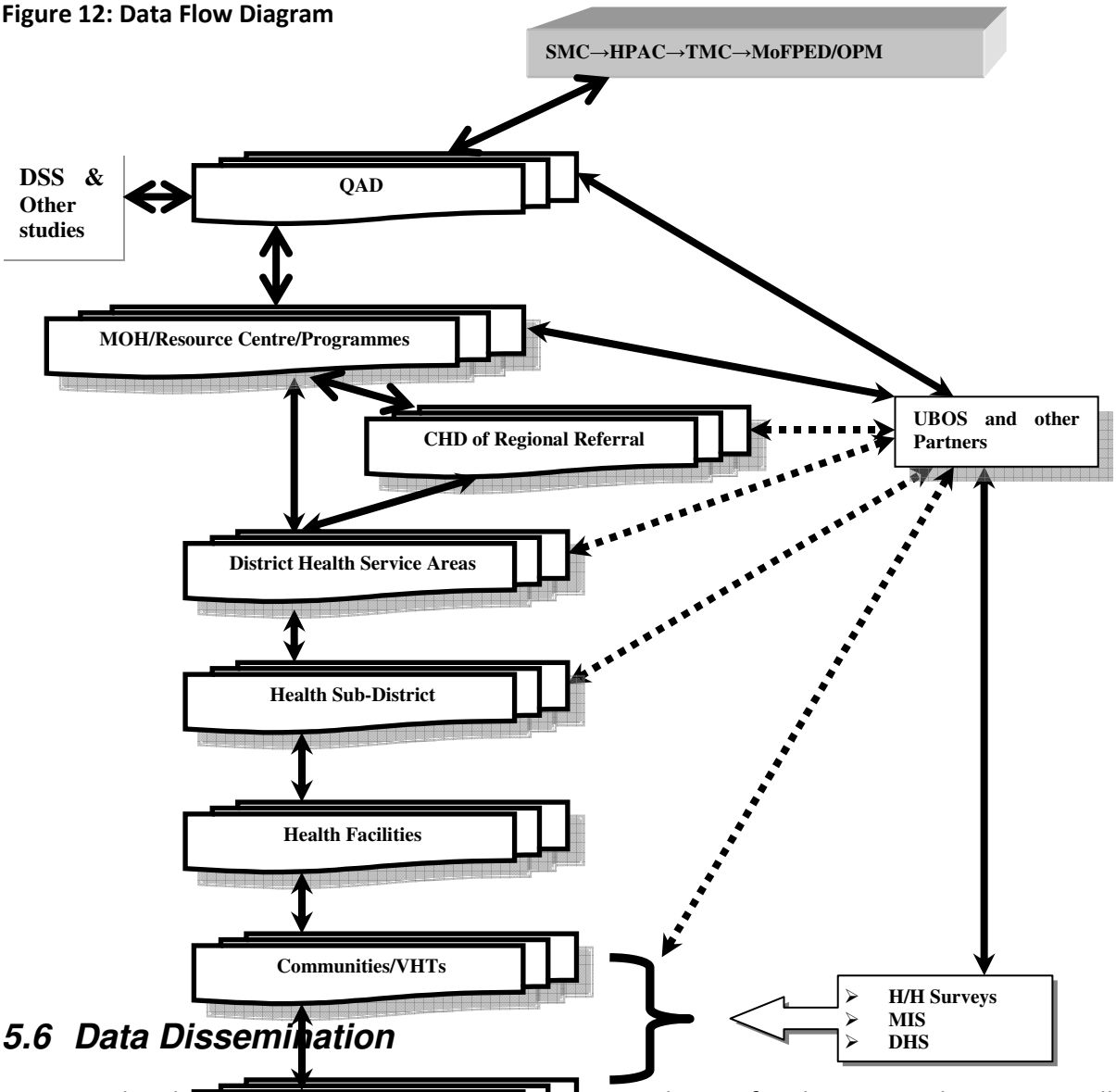
The MoH houses the central database for reporting on progress of the sector National Strategic Plan. The MoH Resource Center will serve as a repository and source for all service delivery data and information at national level. This implies that all health service delivery data and information should be routed through the MoH Resource Center (RC) for validation, analysis & synthesis, and dissemination.

At district level, the district / HSD database where established will service as a repository and source for all service delivery data and information at district level.

Programs and projects with specific data bases shall access service delivery data and information for the MoH Resource Centre of district/HSD databases. Systems shall be developed to link project, district and MoH databases for efficient flow of information.

In order to ensure routine data reporting and feedback on performance to sub-national and private providers, it is crucial that all service delivery and administrative structures adhere to the following data flow mechanism.

Figure 12: Data Flow Diagram



5.6 Data Dissemination

Data need to be [illegible] at is relevant for decision-making. Data will be packaged a[illegible] formats that are determined by management at the various levels. Service delivery data shall be packaged and displayed at the various health facilities using the HMIS formats already provided. The timing of information dissemination should fit in the planning cycles and needs of the users.

The MoH will use various communication channels in order to ensure general access to data and reports. Quantitative and qualitative data will be made publicly accessible through the MoH database under the Resource Center. The Local Area Network (LAN) installed at the MoH will facilitate inter-departmental communication. The public will also be able to access health information on the MoH website, www.health.go.ug.

Data will also be disseminated to the wider audience through meetings, conferences, journals and newsletters.

6 Monitoring and Evaluation of the National QIF and Strategic Plan

The monitoring and evaluation process will measure the extent to which the QIF goal and strategic objectives have been attained. This will be complemented by a stepwise analysis to assess which interventions and projects were successful; from inputs such as finances and policy/standards, to service access and quality, utilization, coverage of interventions, and health outcomes, and responsiveness to needs.

The QAD shall ensure that M&E of implementation of the national QIF and Strategic Plan is aligned with the M&E Plan of the HSSIP 2010/11 – 2014/15. The core HSSIP indicators related to coverage, availability, accessibility and quality of services will be used to monitor performance of this the QIF and Strategic Plan. Program/project specific quality indicators will be used to monitor implementation of the various QI initiatives.

Individual programs and institutions including districts and health facilities shall conduct their routine M&E, and among other issues pay attention to how each of the processes contributes to the achievement of core HSSIP indicators and national health care goals while providing evidence through routine reporting and updates.

Existing sector M&E structures will be used for monitoring implementation of the QIF. While the MoH spearheads the overall monitoring of various QI initiatives, local leadership (at various levels) and community (health consumers) will also be involved in action and monitoring of QI interventions to ensure acceptance, ownership and sustainability.

6.1 Monitoring Mechanisms

QI committees / team meetings, supervision / monitoring visits, periodic performance reviews, surveys and evaluations will be carried out for monitoring at the various levels as outlined below.

Monitoring at national Level:
The following activities will be conducted at national level to track progress on implementation of QI interventions:

1. Monthly QAD meeting will receive and address pertinent QI issues.
2. Quarterly National QI Coordination Committee meetings will be conducted to track progress.
3. Quarterly QI supervision visits to institutions, Referral Hospitals, Local Governments and implementing partners.

4. Quarterly QI progress reports compiled by program and project managers and submitted to QAD.
5. Quarterly QI performance review at the sector review meetings.
6. National QI stakeholders' meetings

Monitoring at Regional Level:
The following activities will be conducted at regional level to track progress on implementation of the regional QI plan:

1. Quarterly Regional QI Coordination Committee meetings.
2. Quarterly supervision visits to implementing facilities.
3. Quarterly QI progress reports compiled and submitted to QAD and National Program / Project Managers.
4. Quarterly QI performance review at the regional performance review meetings.

Monitoring at district Level:
The following activities will be conducted at regional level to track progress on implementation of the district QI plan:

1. Monthly District QI Committee meetings to track progress.
2. Quarterly supervision visits to Health Sub-Districts.
3. Quarterly QI progress reports compiled and submitted to the Regional QI Coordination Committee / Project Managers.
4. Quarterly QI performance review at the district performance review meetings.

Monitoring at Health Sub-District level:
The following activities will be conducted at regional level to track progress on implementation of the HSD QI plan:

1. Monthly HSD QI Committee meetings.
2. Quarterly supervision to health facilities.
3. Quarterly HSD QI progress reports compiled and submitted to the DHO.
4. Quarterly QI performance review meetings.

Monitoring at facility level:
The following activities will be conducted at health facility level to track progress on implementation of the facility QI plan:

1. Monthly health facility meetings.
2. Internal supervision within health facilities.
3. Quarterly facility QI progress reports compiled and submitted to the HSD.
4. Presented at HSD performance review meetings.

6.1.1 Meetings

Chairpersons will be responsible for holding planned meetings.

1. **Setting Objectives for the Meeting.** Before planning the agenda, the team should determine the objective(s) of the meeting.
2. **Provide an Agenda Beforehand.** The agenda needs to include a one-sentence description of the meeting objectives, a list of the topics to be covered and a list stating who will address each topic for how long. Follow the agenda closely during the meeting.
3. **Assign Meeting Preparation.** Give participants something to prepare and report for the meeting.
4. **Assign Action Items.** Don't finish any discussion in the meeting without deciding how and who to act on it.
5. **Examine Your Meeting Process.** Don't leave the meeting without assessing what took place and making a plan to improve the next meeting.

A format for writing minutes will be developed by the QAD for standardized documentation of meetings which will be filed and used as a measure of performance.

6.1.2 Supervision

Supervision is a process of guiding, helping and teaching health workers at their workplace to perform better. It involves a two-way communication between the one supervising (supervisor) and the one being supervised (supervisee). Adequate preparation should be made in terms of planning and budgeting before the visits.

At the end of the visit, the supervisor should make time to discuss with staff their findings and agree on what actions to take to improve on performance. A report must be written by the supervisor and feedback sent to the staff.

The MoH supervision system uses different approaches of supervision described below:

1. Facilitative Supervision: It is also called supportive supervision because the supervisor does not see himself as an inspector looking over the shoulders of his subordinates for faults. Instead, he sees himself as part of the quality team guiding the staff to identify their weaknesses and gaps in quality of service delivery. Together with the supervisee, they develop appropriate solutions to improve on their performance. This approach is applied in integrated, vertical and emergency types of supervision.

2. Inspectorate approach: The supervision here focuses on finding faults with punitive actions and has minimal interaction. It therefore leaves little or no learning experience to the one being supervised. This is mainly applied by the Health Professional Councils and inspectorate bodies like the National Drug Authority.

3. Self- assessment or peer-based supervision: This is where the supervisor's role is indirect. It is the type of supervision where staff belonging to the same team or professional group sets up a system whereby they meet regularly to discuss their own performance with little or no external role. The assessment is based on pre-determined performance targets.

The existing MoH supervision mechanism will be used whereby the national level carries out integrated support supervision to the Local Governments (Districts), hospitals and HC IVs using the Area Teams and Local Governments supervise the lower levels. Various aspects of QI will be incorporated in the quarterly supervision visits by the center and LGs. Under this supervision mechanism specific programs and projects also carry out technical (vertical) supervision. Relevant programs and projects will adopt this mechanism for specific QI interventions. The regional structures will be strengthened to ensure more efficient and effective supervision in the sector.

The MoH will spearhead development of the national QI supervision guidelines as part of the comprehensive supervision guidelines. The MoH will also be responsible for developing capacity building plans for supervision under the National Comprehensive Supervision, monitoring and inspection strategy.

6.1.3 Performance Reports

To monitor the compliance to the national standards and guidelines for QI, programs / projects and LGs shall regularly share performance reports with the QAD, MoH. These reports shall be shared and reviewed by the National QI Coordination Committee to identify gaps in consistence and alignment with national QI guidelines and goals.

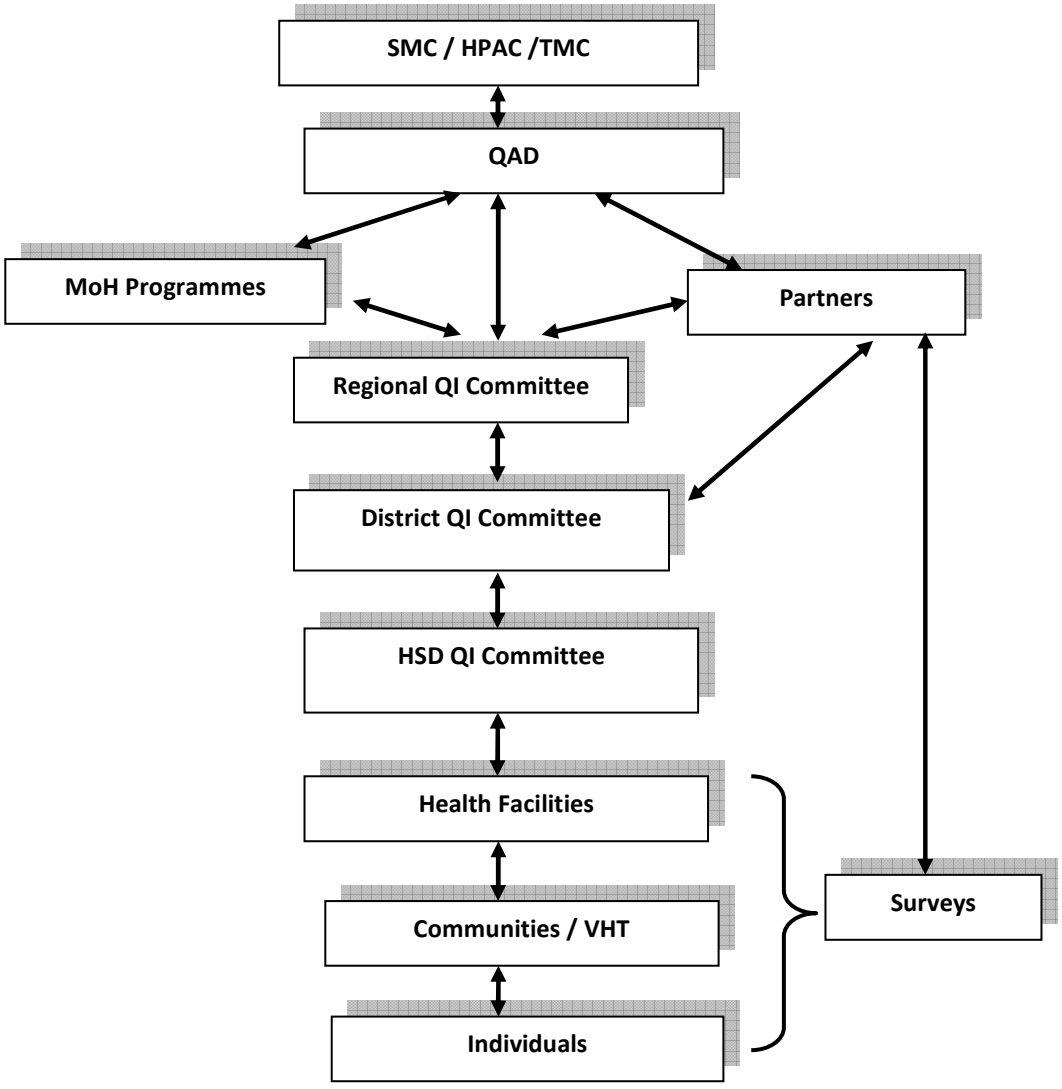
Global reporting requirements shall be based on ongoing country processes of data generation, compilation, analysis and synthesis, communication and use for decision making. This has been clearly spelt out in the Country Compact for implementation of the HSSIP.

Reporting on performance will follow the parameters and indicators that will be developed by the MoH. This is to ensure that QI activities and programs remain in consistence with national QI standards and priorities. Performance monitoring and feedback shall follow the QI implementation structure (Figure 10). The timing of reporting should follow the health sector M&E plan calendar and needs of the users.

A standardized reporting format will be developed by QAD for submission of periodic QI reports.

QI intervention data shall be packaged and displayed at the various health facilities using standardized formats.

Figure 13: Performance Monitoring Channel



6.1.4 QI Performance Review

The QI approach utilized by the MoH emphasizes systems of care rather than individual practitioners, a multidisciplinary team approach, and a continuing cycle of improvement activities and performance measurement. Providers are encouraged to analyze data and assess the internal factors that contribute to organizational performance which offers an opportunity to identify areas for improvement. Results generated through the review process will be shared with the national QI Technical Committee for bench marking to provide national, regional and district reports. The results will also used by MoH, programme managers, DQI Committees and other stakeholders to target providers for assistance and on-site coaching and mentoring.

6.2 Client Satisfaction Surveys

It is essential that Service Providers periodically review their performance to ensure they are effectively meeting the needs of their clients.

Client satisfaction surveys will be carried out at all levels of service delivery to determine the quality of services offered in the client perspective. A client satisfaction survey tool shall be developed by the Quality Assurance Department for incorporation into the HMIS. Facility client satisfaction surveys will be carried out biannually (December and June every year) and findings utilized for quality improvement.

6.3 Evaluation

Evaluation shall be carried out as part of monitoring and systematic investigation to provide baseline information, assess progress and impact of QI interventions. The results of the evaluation studies are supposed to inform decision making hence contribute to improving delivery of and access to health care.

All QI initiatives will be subjected to evaluation to follow up on whether the intended clinical outcomes are achieved. The type of evaluation to be planned for and conducted should reflect the nature and scope of the public investment. For example, pilot projects that are being conducted amongst a random group of participants shall be selected for impact evaluation to determine whether or not the investment should be scaled up.

As a minimum requirement, imported project based QI initiatives will be required to conduct the following:

I. baseline study during the preparatory design phase of the project;
II. mid-term review at the mid-point in the project to assess progress against objectives and provide recommendations for corrective measures;
III. final evaluation or value-for-money (VFM) audit at the end of the project.

The MoH – QAD in collaboration with the specific programme / project managers will be responsible for the design, management and follow-up of the programme and project evaluations (including baseline and mid-term reviews). All projects are required to budget for periodic project evaluations. All project evaluations will be conducted by external evaluators to ensure independence. QI project evaluation reports shall be disseminated during the sector quarterly and annual review meetings.

Findings will be disseminated in form of workshops and reports which will be circulated to relevant stakeholders in hard copy as well as on the MoH website, www.health.go.ug.

6.4 Recognition and Reward

Consideration should be given to providing incentives to facilities that meet goals and hold their gains. For example, modest financial incentives for successful teams have been used with success in other settings[9].

The recognition and reward criteria should be defined and established by all organizations / facilities clearly stating what performance or contribution constitutes rewardable behavior or actions.

The criteria should ensure that;

- all employees / facilities must be eligible for the recognition;
- the recognition must supply the employer and employee/institution with specific information about what behaviors or actions are being rewarded and recognized;
- anyone / facility that then performs at the level or standard stated in the criteria receives the reward;
- the recognition should occur as close to the performance of the actions as possible, so the recognition reinforces behavior the employer wants to encourage;
- managers are not the ones to "select" the people / facilities to receive recognition.

[9]Formative evaluation of quality ofcare initiatives by MoH – Uganda

7 Research

Research shall be carried out as part of systematic investigation to establish facts, solve new or existing problems in quality improvement, prove new interventions and initiatives, or develop new theories, using a scientific method, at all levels or by independent institutions or partners. The results of these studies are supposed to inform decision making hence contribute to improving delivery of and access to health care.

The MoH – QAD in collaboration with research institutions, programme / project managers will oversee the implementation of national level research activities. Institutional heads and DHOs will be responsible for follow-up of institutional and district based research activities respectively.

To ensure better understanding and use of research, the results shall be widely disseminated at different planning levels. Findings will be disseminated in form of workshops and reports which will be circulated to relevant stakeholders in hard copy as well as on the MoH website, www.health.go.ug.

8 Budget Estimate

Interventions	Actions	Responsibility	Output Indicators	Amount Ug. Shs '000					Total
				2010/11	2011/12	2012/13	2013/14	2014/15	
Strategic Objective 1: To provide a harmonized and integrated approach to quality improvement in health service delivery.									
Development and dissemination the National QI framework	Conduct consultative meetings	MoH / QAD	No. of meetings	30,000	15,000	0	0	0	45,000
	Print and binding of the QIF & Strategic Plan	MoH / QAD	No. of copies printed	0	15,000	0	0	0	15,000
	Dissemination of the QIF		No. of copies disseminated	0	120,000	0	0	0	120,000
Planning for QI	Development of QI annual workplan	All levels	Annual workplans	0	0	0	0	0	0
Development of national QI manuals, tools and standards	Conduct consultative meetings	MoH / QAD	No. of meetings	0	20,000	0	0	0	20,000
	Print and disseminate the manuals, tools and standards	MoH / QAD	No. and types of guidelines, tools and standards developed	0	40,000	0	0	0	40,000
	Develop a QI Communication strategy	QAD	Communication Strategy developed	0	0	30,000	0	0	30,000
Develop a national in-service QI training manual	Develop TORs for Consultancy	QAD	Terms of Reference developed	0	0	0	0	0	0

Interventions	Actions	Responsibility	Output Indicators	Amount Ug. Shs '000					Total
				2010/11	2011/12	2012/13	2013/14	2014/15	
	Conduct Training Needs Assessment for QI	QAD	TNA carried out	0	55,000	0	0	0	55,000
	Procure Consultancy services for development of training manual	QAD / DP	Consultant procured	0	3,000	0	0	0	3,000
	Consultative meetings for consensus building	QAD	No. of Meetings	0	16,000	0	0	0	16,000
	Printing and binding of National In-service QI training manual	QAD	National in-service QI training manual	0	46,000	0	0	0	46,000
Liaise with academic institutions for review and update of the pre-service QI training curriculum	Make recommendations for review and update of the pre-service QI training curriculum	MoH / HRD / MoES	No. of Training Institutions with modules incorporating QI	0	0	0	0	0	0
Infrastructure development and reorganization for Health Systems Strengthening	Clarify and document implementation structures, roles and responsibilities for all stakeholders	MoH / QAD	Documentation of mandate and roles of various stakeholders	0	0	0	0	0	0

Interventions	Actions	Responsibility	Output Indicators	Amount Ug. Shs '000					Total
				2010/11	2011/12	2012/13	2013/14	2014/15	
	Facilitation and coordination of QI activities at the national, regional, district and health facility levels	MoH / DPs / Regional Committees / District Committees	No. of functional regional and district coordination structures	2,400	2,800	3,000	3,200	3,400	14,800
Support the development of a QI Research Agenda	Conduct intervention and operational QI research	DPs / Research Institutions	No. and types of QI Researches carried out		75,000	80,00	85,000	90,000	250,000
	Gather, develop and disseminate the continuum of medical care to promote effective models of care that are responsive to the needs of patients	Researchers / Managers	No. of publications	80,000	80,000	85,000	90,000	95,000	430,000
	Use of researched data/evidence base for planning QI interventions	Policy Makers	No. of QI policy statements / policies made	0	0	0	0	0	0
Strengthening coordination initiatives among different institutions to improve quality and	Review and establish QI coordination committees and teams at all levels	QAD / Managers	% of institutions with functional QI Committees / teams	0	0	0	0	0	0

Interventions	Actions	Responsibility	Output Indicators	Amount Ug. Shs '000					Total
				2010/11	2011/12	2012/13	2013/14	2014/15	
responsiveness of health services	Conduct coordination meetings	Chairpersons	% of planned meetings conducted	1,200	4,000	4,800	5,000	5,200	20,200
Strategic Objective 2: To improve quality of health care and patient safety at all levels including the private sector while ensuring efficient utilization of available resources.									
Build capacity for QI at all levels of the health service that include planning and self assessment with participation of both internal and external clients.	Conduct QI Training Needs Assessment	QAD	Training Needs Assessment conducted	0	60,000	0	0	0	60,000
	Training of National and Regional QI Facilitators	QAD / DPs / Programs	No. of QI facilitators trained	50,000	60,000	75,000	75,000	75,000	335,000
	Training of health workers at all levels	MoH / DPs	No. and cadre of health workers trained by level and district	160,000	170,000	180,000	190,000	200,000	900,000
	Establish a database for QI trainees and Trainers (Facilitators)	QAD	No. of QI trainers and trainees registered in data base	0	0	0	0	0	0
	Establish a Quality Facilitator Certification program	QAD / DPs	No. of facilitators certified	0	0	25,000	15,000	0	40,000
	Mentoring and coaching for QI at all levels of health care system	MoH / DPs	No. of mentoring / coaching activities	120,000	120,00	140,000	150,000	160,000	570,000

Interventions	Actions	Responsibility	Output Indicators	Amount Ug. Shs '000					Total
				2010/11	2011/12	2012/13	2013/14	2014/15	
	On/off site technical assistance opportunities by a pool of QI experts as well as experienced program staff	MoH / DPs	No. of health providers participating in QI activities	24,000	24,000	28,000	30,000	32,000	138,000
Strengthening data recording and reporting system	Revise HMIS guidelines to include QI indicators and their use	MoH – Resource Centre	QI indicators incorporated in the HMIS	0	0	0	0	0	0
	Develop standardized data formats for data collection and reporting with the HMIS and M&E plan to avoid duplication of efforts	MoH – Resource Centre	Standardized formats for data collection	0	0	0	0	0	0
	Provide technical assistance for QI data collection process and utilization at the facility level through district and regional	MoH – Resource Centre	No. of supervision / mentoring visits	30,000	34,000	34,000	36,000	38,000	172,000
	Timely share individual and comparative performance data and reports with internal and external stakeholders	Managers	No. of reports submitted timely	6,000	8,000	8,000	9,000	10,000	41,000

Interventions	Actions	Responsibility	Output Indicators	Amount Ug. Shs '000					Total
				2010/11	2011/12	2012/13	2013/14	2014/15	
	Provide routine feedback using findings to improve activities	Health Facility Managers	No. of feedback reports	4,000	4,000	5,000	6,000	7,000	26,000
	Analyze data on the national, regional, district and facility level to identify opportunities, gaps, priorities and programmatic decision making	Managers at all levels	Performance report with analytical data	0	0	0	0	0	0
Improve availability and access of health inputs	Establish a Supply Chain Management System	Pharmacy Division	% of health facilities without stock out of EMHS	0	200,000	300,000	300,000	400,000	1,200,000
Strengthening leadership and management	Training in leadership and management skills	HRD	% of Health managers trained in leadership and management	120,000	140,000	160,000	180,000	180,000	780,000
Improving the work environment	Implementation of 5S-CQI-TQM	QAD	% of facilities implementing 5S-CQI-TQM % of health workers satisfied with work	75,000	80,000	80,000	90,000	90,000	415,000

Interventions	Actions	Responsibility	Output Indicators	Amount Ug. Shs '000					Total
				2010/11	2011/12	2012/13	2013/14	2014/15	
Establish standards for medical equipment and their maintenance	User training	Infrastructure Division	% of functional medical equipment	50,000	50,000	55,000	55,000	60,000	270,000
Improve health facility infrastructure	Review and implement health facility structure standards	Infrastructure Division / LGs	No. of health facilities constructed according to standards	0	0	0	0	0	0
Improving health worker productivity and quality of care	Conduct regular supervision, monitoring and mentoring	QAD / Program / Project Managers	% of planned supervision, monitoring and mentoring visits conducted	46,000	40,000	45,000	50,000	55,000	236,000
	Routinely evaluate QI interventions based on standardized tools to reflect progress towards stated goals		No. of evaluation studies	50,000	50,000	55,000	60,000	65,000	280,000
	Create a system of recognition and awards for achievements in QI and performance measurement through involvement of providers and consumers	Managers	No. of providers recognized and rewarded	0	4,000	5,000	5,000	5,000	19,000

Interventions	Actions	Responsibility	Output Indicators	Amount Ug. Shs '000					Total
				2010/11	2011/12	2012/13	2013/14	2014/15	
Implement evidence based quality improvement initiatives	Scale up QI initiatives for clinical care and non-clinical services at all levels	Managers	No. of facilities by level implementing QI interventions						
	Integrate QI activities at Service Delivery Points	Managers / DPs	No. of facilities implementing an integrated QI approach	0	0	0	0	0	0
Establish patient safety practices	Identify and adopt patient safety goals	QI Committees	Patient safety goals identified annually	0	0	0	0	0	0
	Train staff on patient safety practices	CHS CS	No. of staff trained	0	0	60,000	65,000	68,000	193,000
	Establish an adverse events and near–miss reporting system	CHS CS	Reporting system established	0	0	25,000	30,000	35,000	90,000
	Develop active networks of patients and providers	Health Consumer Organizations	No. of networks developed	36,000	25,000	27,000	30,000	32,000	150,000
	Empowering and educating patients and the public, as partners in the process of care	CSOs	No. of sessions and people educated	26,000	38,000	40,000	40,000	45,000	189,000
Risk management system	Establish a risk management system in all health facilities	Managers	No. of facilities undertaking annual risk appraisal	0	0	25,000	26,000	30,000	81,000

Interventions	Actions	Responsibility	Output Indicators	Amount Ug. Shs '000					Total
				2010/11	2011/12	2012/13	2013/14	2014/15	
Establish safe surgery checklists	Print and introduce the WHO's safe surgery checklist in all NRH, RRH and General hospitals	Clinical Services	No. of hospitals using the checklist	0	0	17,000	0	0	17,000
Revitalize clinical audit and peer reviews	Develop and disseminate guidelines for clinical audits	Clinical Services	No. of hospitals with Clinical Audit guidelines	20,000	0	10,000	10,000	0	40,000
	Establish Clinical Audit Committees in all hospitals	Clinical Services	% of hospitals with Clinical Audit Committees	0	0	0	0	0	0
	Carry out clinical audits and peer reviews	Hospital Managers	No. of hospitals carrying out clinical audits and peer reviews	0	0	0	0	0	0
Strengthen infection prevention and control mechanisms	Integrate the National Infection Prevention and Control Guidelines	QAD	IPC guidelines integrated	30,000	12,000	0	0	0	42,000
	Printing and binding of IPC Guidelines	QAD	Guidelines printed	0	35,000	0	0	0	35,000
	Disseminate IPC guidelines to all health facilities	QAD	Availability of IPC guidelines at all facilities	0	0	55,000	0	0	55,000

Interventions	Actions	Responsibility	Output Indicators	Amount Ug. Shs '000					Total
				2010/11	2011/12	2012/13	2013/14	2014/15	
	Provision of adequate amounts of IPC supplies	NMS / Managers	Quantity of IPC supplies procured and distributed	0	0	0	0	0	0
	Improve hospital waste handling and management	CHS CS	% of health facilities with proper waste handling and management systems (Pits & incinerators)	0	40,000	100,00	150,000	200,000	390,000
Strengthen referral system	Functionalise HC IVs	Clinical Services / LGs	% functional HC IVs	0	0	0	0	0	0
Improve case management	Develop and distribute Clinical guidelines and Standard Operating Procedures at facilities	Program Managers	% of HUs using guidelines and SOPs	60,000	60,000	150,000	30,000	30,000	330,000
Improve pharmaceuticals safety	Develop system for identifying and controlling high hazard medication (e.g. narcotics and anticoagulants).	Pharmacy Division	Narcotics and anticoagulant controlled	0	0	30,000	0	0	30,000
Establish accreditation systems	Define service standards, criteria, implementation arrangements and tools	QAD	Accreditation system developed	0	120,000	0	0		0

Interventions	Actions	Responsibility	Output Indicators	Amount Ug. Shs '000					Total
				2010/11	2011/12	2012/13	2013/14	2014/15	
	Orientation of hospitals on the accreditation system	QAD	No. of hospital staff oriented	0	120,000	120,000	0	0	240,000
	Accreditation of public and private hospitals	Accreditation Body	No. of hospital accredited	0	0	200,000	250,000	250,000	700,000
	Accreditation of laboratories	CPHL	No. of laboratories accredited	40,000	50,000	50,000	55,000	60,000	255,000
Documentation and dissemination of best practices	Print and disseminate newsletters and journal articles	Implementers	No. of QI implementers with up to date journals	500	1,000	1,500	2,000	2,500	7,500
	Provide opportunities for peer learning through learning networks	Managers	No. of learning sessions, mentoring sessions held	30,000	35,000	50,000	60,000	70,000	245,000
Strategic Objective 3: To provide client-centered health care services.									
Conduct surveys	Conduct client satisfaction surveys	QAD / DPs / Managers	No. of surveys conducted periodically	50,000	80,000	50,000	60,000	80,000	320,000

Interventions	Actions	Responsibility	Output Indicators	Amount Ug. Shs '000					Total
				2010/11	2011/12	2012/13	2013/14	2014/15	
Development and implementation of a feedback / complaint management system at MoH, LG Offices, and Health facilities	Identification and establishment of appropriate methods for obtaining client feedback / complaints (Complaint management system)	All Managers	% of institutions with functional complaint management system	0	0	60,000	50,000	0	110,000
Develop and implement Performance Improvement Plans	Conduct performance assessment	All Managers	No. of staff meeting performance targets	0	0	0	0	0	0
Create awareness on roles and responsibilities for providers	Customize and roll out client charters in the health sector	All Managers	No. of service delivery level charters developed	0	5,000	40,000	40,000	40,000	125,000
Create awareness on rights, roles and responsibilities	Translate and disseminate patient's charter	QAD	No. of Patient charter translated and disseminated	50,000	35,000	38,000	0	0	123,000
Strengthen the Health Unit Management Committees	Review, print and disseminate HUMC guidelines	Clinical Services	Revised HUMC guidelines	15,000	30,000	0	0	0	45,000
	Induction of HUMCs	Clinical Services LGs / Partners	% of facilities with functional committees	0	75,000	75,000	60,000	50,000	260,000
Involvement of CBOs / Village Health Teams / Communities in QI	Develop Partnership Defined Quality manual for QI interventions	Partners / MoH	PDQ manual developed	0	0	25,000	0	0	25,000

Interventions	Actions	Responsibility	Output Indicators	Amount Ug. Shs '000					Total
				2010/11	2011/12	2012/13	2013/14	2014/15	
	Training & follow up of VHTs/Peers on QI principles and community responsiveness	HPE / CSOs / CBOs	% trained	0	40,000	35,000	35,000	35,000	145,000
	Conduct Community dialogue	QI Implementers	No. of community dialogues	0	26,000	30,000	35,000	40,000	131,000
Monitoring and Evaluation									
Strengthen M&E activities	Compile and submit QI performance reports	Managers / Implementers	% of QI reports submitted timely	1,000	1,500	2,000	2,500	3,000	10,000
	Review and identify QI indicators	QAD / Managers	Indicator booklet	0	0	0	0	0	0
	Conduct QI stakeholder meetings at different levels	QAD / Managers	% of planned meetings conducted	40,000	200,000	120,000	150,000	150,000	660,000
	QOC Program Assessment	Consultants	% assessments conducted timely	15,000	20,000	20,000	25,000	25,000	105,000
	Mid-term and End Evaluation of the QIF & SP	Consultants	Evaluations carried out	0	0	30,000	0	40,000	70,000
				1,262,100	**2,464,300**	**2,703,300**	**2,639,700**	**2,856,100**	**11,805,500**

9 References

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