Republic of Uganda
Ministry of Health

National Quality Improvement Framework & Strategic Plan

(2021-2025)

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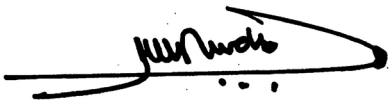
Foreword

The Government of Uganda (GoU) is committed to improving the quality of health services delivered to the population. This derives from the enshrined Ministry of Health (MoH) mandate and commitment to accelerate attainment of universal health coverage (UHC) with a focus on primary healthcare (PHC) by the year 2030. The key result areas of the National Development Plan (NDP) III, Human Capital Development Program, include reducing neonatal, infant, under-five and maternal mortality, and fertility rates, among others. The health sector has a revised and updated the National Quality Improvement framework to facilitate effective implementation of healthcare interventions and address current health service challenges.

The National Quality Improvement Framework and Strategic Plan (NQIP & SP) 2020/21 – 2024/25, like previous editions, serves primarily to facilitate well-coordinated and streamlined implementation of the different quality of healthcare interventions in the country. The MoH has embraced the 5S (Sort-Set-Shine-Standardize-Sustain) philosophy in regional referral hospitals and now must be considered for scaling-up to district health facilities as the method of choice for improving the working environment. Leadership involvement is greatly needed to support and operationalise the introduced quality improvement (QI) organisational structures. The next five years shall lay additional emphasis on capacity building in monitoring, supervision, and mentorship for improved health outcomes in the national health system.

The country recognizes the need to pay more attention to implementation of health service standards as a key step towards meeting the expectations of health service users. This requires the ministry to identify and acknowledge outstanding performance gaps and to address them for improved quality of health services across all levels of care. The national financing strategy has endorsed the Result Based Financing (RBF) framework to incentivise service delivery in the country. Therefore, the framework emphasizes harmonised and well-coordinated implementation of Health Facility Quality-of-care Assessment Programme (HFQAP) and data use in the advancement of improved health care services. All actors in healthcare services in Uganda are expected to prioritise and facilitate quality-of-care assessments and operations towards QI.

The MoH would like to appreciate all those who participated in the development of the National QIF & SP 2020/2021 – 2024/2025. Your effort is highly appreciated, and I have confidence that the ideas in this new framework shall be put to the best use by both private and public health service providers.



Dr. Henry G. Mwebesa
Director General Health Services

Acknowledgments

The Ministry of Health (MoH) National Quality Improvement Framework and Strategic Plan 2021-2025 has been developed due to the concerted effort of the different stakeholders to whom we are all very grateful. Special thanks to the Health Development and Implementation Partners notably the United States Agency for International Development (USAID); USAID funded institutions of University Research Co. (URC)/RHITES-North, Acholi Activity; Clinton Health Access Initiative (CHAI); the WHO Uganda country office; UNFPA; METS; Makerere University School of Public Health; the Civil Society Organisation, the health service providers, and all other key actors that have continued to support implementation of quality of care (QoC) interventions in Uganda.

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The MoH shall always be indebted to you for the support, time and effort provided to have the National Quality Improvement Framework and Strategic Plan 2021-2025 finalised and made ready for use for the next five years.

Dr. Martin Ssendyona
Acting Commissioner, SCAPP-D
Ministry of Health, August 2021

Operational Definitions

Accreditation: Recognition of an institution or entity that meets the required standards or competence to carry out specific tasks.

Certification: A formal statement recognizing the fulfilment of relevant official requirements to provide a service.

Standard: Desired or accepted level of performance in a system.

Clinical mentorship: Guidance provided by a high-ranking and/or experienced health professional to a health worker mentee to improve his/her knowledge, skills, practice and confidence to provide quality client-centred healthcare. It promotes correct documentation and use of data to inform clinical and operational decision making, using and ensuring availability of critical supplies and equipment, and creation of an enabling environment for service delivery.

Mentors: Experienced clinicians who support the professional development of health worker mentees by providing support, guidance, and collaborative problem solving to identify systems barriers to quality service delivery. Mentors help mentees address system challenges over time, while integrating best practices into health worker workflow.

Support supervision: Process of supporting health workers to meet performance expectations for their job functions by reinforcing accountability for care and quality standards. Support supervision enables conditions required for proper functioning of facilities and clinical teams.

Quality Improvement (QI): Quality improvement (QI) can be defined as the process and sub-processes of reducing poor operational practices or variation from quality standards to achieve better health outcomes for clients. QI of service systems and processes can be achieved through the routine use of health and program data to evaluate challenges and identify practicable solutions that meet client and program needs.

5S-QI Philosophy: Quality-of-care approach for improving the working environment. The 5S (Sort-Set-Shine-Standardize-Sustain) approach can improve the arrangement of items in the workplace so that items are well organized. The implementation steps include: S1: Sorting (remove unwanted items); S2: Setting (arrange/label items etc); S3: Shine (clean the environment); S4: Standardise (repeat S1-S3 for all work-place units), and S5: Sustain (continuous: supervision/monitoring; coaching/mentoring, etc.)

Continuous Quality Improvement (CQI): A scientific approach of improving organizational processes through iterative tests of work systems and flows OR Processes of continuous measurement and rapid tests of change to implementation processes from their current state towards the desired standard or quality.

Total Quality Management (TQM): Approach by which all members of an organization, including management and employees, are involved in continuously improving the delivery of health services. TQM embeds awareness of quality improvement goals into all organizational processes.

Work Improvement Team (WIT): Smallest operational unit (can be a department or unit within a department) where members work together to address issues related to quality care of services in a health facility.

Client-centred care: Provision of services in a way that address individual needs while considering and respecting and their social circumstances.

Charter: Written instrument/contract or commitment between parties for a defined purpose.

Quality-of-care: The degree to which health services for individuals and populations increase the likelihood of desired health outcomes. It is based on evidence-based professional knowledge and is critical for achieving universal health coverage.

Acronyms

ADHO-MCH	Assistant District Health Officer Maternal Child Health
AHSPR	
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal care
ART	Antiretroviral Therapy
ARV	Antiretroviral
BOGs/HUMCs	Board Of Governors/Health unit Management Committees
CAO	Chief Administrative Officer
CBO	Community Based Organisation
CHAI	Clinton Health Access Initiative
CHEWs	Community Health Workers
CPHIL	Central Public Health Laboratory
CQI	Continuous Quality Improvement
CSO	Civil Society Organisation
DG	Director General
DGHS	Director-General Health Services
DHIS	District Health Information System
DHMT	District Health Management Team
DHO	District Health Officer
DHT	District Health Team
DICO	District Quality Improvement Committee
DLG	District Local Government
DPs	Development Partners
DQIC	District Quality Improvement Committee
GoU	Government of Uganda
HSDP II	Health Sector Development Plan
HCII	Health Centre II
HCIII	Health Centre III
HCIV	Health Centre IV
HFS	Health Financing Strategy
HMIS	Health Management Information System
HR	Human Resource
HSC	Health Service Commission
QIF & SP	Health Sector Quality Improvement Framework and Strategic Plan
HFQAP	Health Facility Quality of Care Assessment Program
iHRIS	Integrated Human Resource Information system
IPC	Infection Prevention and Control Committee
IPs	Implementing Partners
JRM	Joint Review Mission
HIV	Human Immunodeficiency Virus
KIIs	Key Informant Interviews
LQAS	Lot Quality Assurance Sampling
MCH	Maternal and Child Health
MoH	Ministry of Health
M&E	Monitoring and Evaluation
MPDSR	Maternal and Perinatal Death Surveillance and Review
NASCO	National QI Steering Committee
NCD	Non-Communicable Diseases
NGOs	Non-Governmental Organizations
PDSA	Plan, Do, Study, Act
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PFP	Private for Profit
PNFP	Private Not for Profit
QAD	Quality Assurance Department
QAP	Quality Assurance Program
QI	Quality Improvement
QIF	Quality Improvement Framework
RBF	Results Based Financing
RECO	Regional QI Committee
RMNCH	Reproductive, Maternal, Newborn, and Child Health
RRH	Regional Referral hospital
SARA	Service Availability and Readiness Assessment
SCAPPD	Standards Compliance Accreditation and Patient Protection Department
SDG	Sustainable Development Goal
SOP	Standard Operating Procedure
SWOT	Strengths, Weaknesses, Opportunities and Threats
SP	Strategic Plan
TQM	Total Quality Management
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic Health Survey
UHC	Universal Health Coverage
UNACO	Uganda National Association of Consumers' Organization
VHTs	Village Health Teams
WHO	World Health Organization
WIT	Work Improvement Teams

Executive Summary

The health sector aims to provide quality services so that clients can maximize the health benefits from available care. However, according to the Service Availability and Readiness Assessment (SARA) Report 2019, there are critical gaps in the availability of priority services and inadequate capacity of facilities to provide them. Health facilities have a 52% capacity to provide general services according to the report (MoH SARA Index, 2019). In addition, the 2019 MoH Client Satisfaction Survey revealed a 25% satisfaction rate among clients, indicating a need to focus the QIF & SP (2020/21-2024/25) to tackle enduring systems issues that continue to impact availability and quality of care. For this reason, the goal of NQIF & SP is to achieve effective implementation of QoC interventions that meet the expected health services standards in Uganda.

The first QIF & SP (2010-15) largely focused on setting up QI structures across the entire health system in Uganda, while the second edition (2015-2020) focused more on operationalizing QI structures. The third edition (QIF & SP 2020/21-2024/25) goes further to suggest how QI and clinical mentorship structures must work in tandem to improve health worker competence and build an enabling environment for quality-of-care.

The target audience for the QIF & SP includes policy makers, partners, program managers, program, and project implementers, development partners, public and private health service providers, and civil society. It is the intent that the 2020/21-2024/25 QIF & SP is used to promote continuous QI in the priority areas of reproductive, maternal, new-born and child health (RMNCH), tuberculosis (TB), HIV, laboratory, and diagnostic services, in line with Uganda's commitment to achieving the Sustainable Development Goals (SDGs).

To accomplish this larger goal, the QIF & SP 2020/21-2024/25 includes the following strategic objectives:

1. To strengthen organisational structures, leadership, and accountability for quality improvement at all levels.
2. To improve compliance to the health sector standards at all levels of care.
3. To improve client-centred care at all levels.
4. To improve patients and health workers' safety in all healthcare practices.
5. To strengthen data management and monitoring systems for quality improvement initiatives across all levels.
6. To promote research and implementation of innovative evidence-based care models in Uganda.

The QI framework is aligned to the 5S-QI philosophy and should be implemented in the following phases:

Phase I: Protect patients and health workers from harmful care and prevent waste of resources. This will be proven by showing the value of QI through the quantification of cost-savings, which will be shared with Work Improvement Teams (WIT).

Phase II: Improve the use of effective and proven practices, treatments, service delivery models and health protection approaches using QI testing and research adopted for Uganda from different organizations.

Phase III: Implement Total Quality Management (TQM) where quality improvement is institutionalized. Employ the MOH QI manual for health workers in Uganda which provides health workers with detailed information on QI concepts, approaches, and QI tools for implementation.

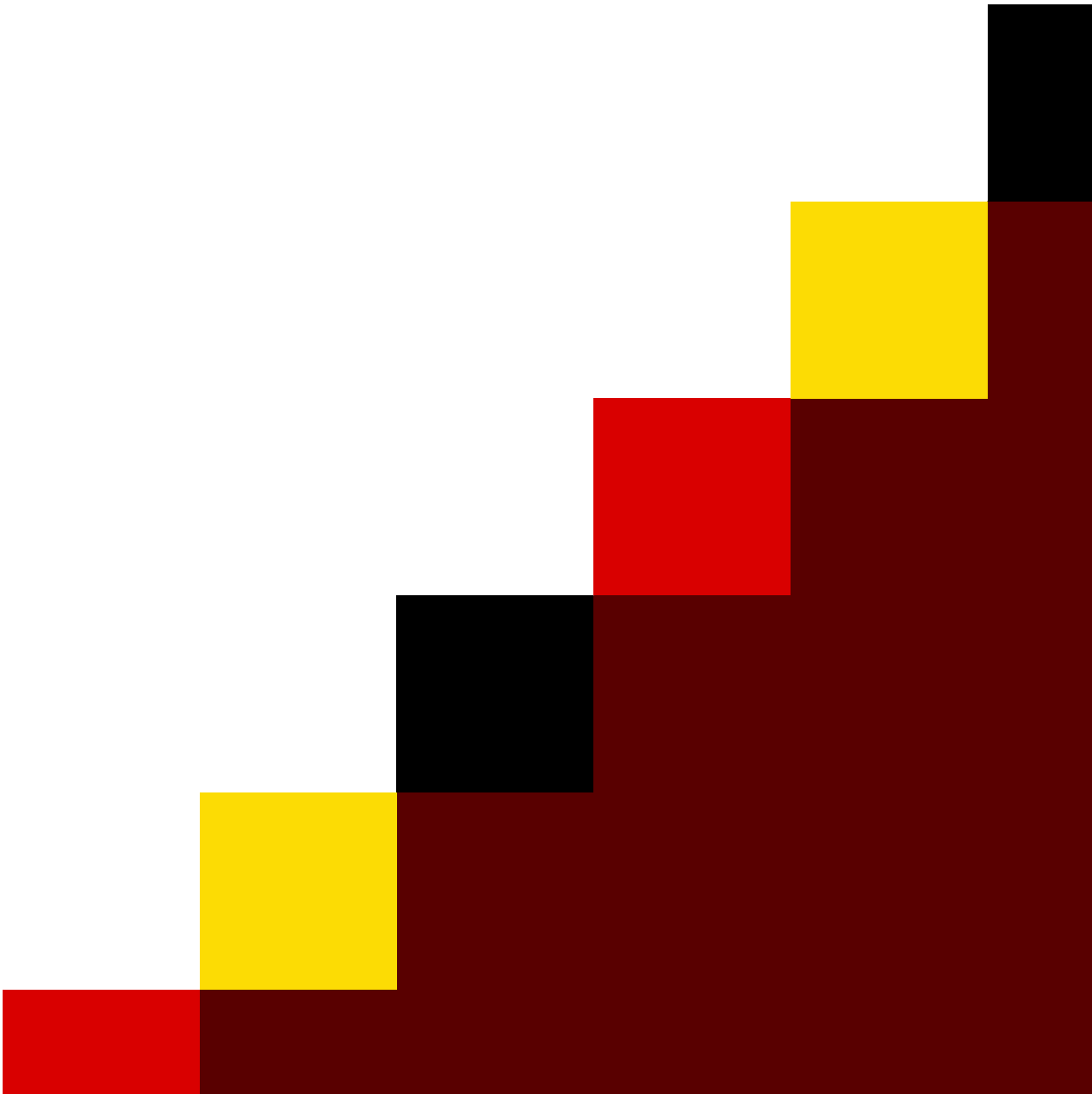
Operationalizing the framework will require an integrated approach to systems-based clinical mentoring that involves the activation of clinical mentorship structures, QI coaching, implementation and monitoring and evaluation of standards of care. Districts and partners implementing QI initiatives shall implement evidence-based, targeted QI models, and interventions which apply the principle of collaborative cycles of improvement such as the plan, do, study and act or PDSA Cycle. QI efforts will be geared towards health systems strengthening, enabling staff to be more dynamic and effective with emphasis on efficiency, safety, and return on investment.

It is imperative that the implementation of QI programs and interventions utilizes existing structures and systems of government, as well as interventions designed to strengthen service delivery at all levels. Integration of QI activities, mentorship plans, and budgets into the district, health facility and community work plans with government funding is essential for sustaining quality service delivery and achieving total quality management. This will enable optimal use of resources, avoid replication, and ensure that QI matters are mainstreamed and integrated into the health system. Health managers at all levels have a duty to defend the public from harmful practices which the public may not know about, reduce waste from ineffective organization and care, and inefficient/inappropriate deployment of resources. Health managers should therefore take the lead in managing healthcare quality and be held accountable for service delivery outcomes. The community and individuals are beneficiaries of health service delivery and have a critical role to play in ensuring quality services as well. The roles and responsibilities are expounded in the MoH patient charter.

Lastly, monitoring and evaluation are an integral part of QI implementation at all levels of the health system. The M&E of the QIF & SP implementation process will measure the degree to which the set goal and strategic objectives have been attained and guide changes in the proposed strategies or application methods.

CHAPTER 1:

Introduction



1.1 Background

The population of Uganda is approximately 41.6 million people (UBOS, 2021) and the annual population growth rate is 3.3%. Nearly half of the population (49%) is under the age of 15 years, and 75% of the population is 25 years or younger (UBOS, 2020). The country has a high fertility rate of 5.4% and consequently continues to experience a high child and adolescent dependency ratio. The current per capita allocation for health is 62,031 UGX /- (17USD) per the 2019/20 fiscal year (MoH-AHSPR 2020), falling short of the WHO recommendation of a per capita allocation to health of 46USD to achieve Universal Health Coverage (UHC) by 2030. This translates to a high out-of-pocket expenditure for patients. Meanwhile, the health sector continues to face challenges providing quality and accessible healthcare services.

Uganda has recently made some improvements in national key performance indicators. For example, the infant mortality rate (IMR) declined from 54 in 2011 to 43 deaths per 1000 live births in 2016 (UDHS 2016); the under-five mortality rate decreased from 38 in 2011 to 22 deaths per 1000 live births, and the maternal mortality ratio (MMR) decreased from 438 in 2011 to the current 336 deaths per 100,000 live births. Though most maternal deaths are preventable, the mortality rate for women is still high. The three leading causes of maternal deaths are haemorrhage, obstructed labour, and complications from abortion. Almost 28% of maternal deaths in Uganda occur in young women aged 15 – 24 years. In addition, Uganda faces a high-burden of infectious diseases as indicated by the MoH-AHSPR 2020 report with malaria (18%) being the highest cause of mortality among under-five admissions. In addition, non-communicable diseases, violence, and injuries contribute 33% to hospital admissions. Current morbidity trends demand a more concerted effort to strengthen the quality-of-care across the entire health system in Uganda.

Since 1991 the Ugandan MoH has embraced the use of QI methodologies to improve QoC in the health sector. To date, national QI interventions have included the Yellow Star Program (2001), the Quality Assurance Programs (QAP) (2004), the Service Availability and Readiness Assessments (SARA), the Lot Quality Assurance Sampling (LQAS) (2011), the 5S-QI-CQI-TQM (2010) programme, and Health Facility Quality of Care Assessment Programme to assess the quality of health service delivery in the country (2015). These interventions were largely program based and aligned with larger funding mechanisms.

To harmonize, institutionalize, and coordinate QI implementation in all service delivery areas, the MoH developed the first Health Sector Quality Improvement Framework and Strategic Plan (QIF & SP 2010-15). The first edition of QIF & SP focused predominantly on setting up QI structures across the entire health system. With this initiative in place, the second edition of the QIF & SP 2015-2020 focused more on operationalizing QI structures. Recently the MoH launched a new strategy for support supervision (MoH Comprehensive Support Supervision Strategy 2020) during the Joint Review Mission (JRM) in November 2020. The strategy focuses on the use of sub-national structures at Regional Referral Hospitals (RRHs) to improve the quality of support supervision to districts in their respective regions. There is now an opportunity and need to ensure an up-to-date QIF & SP is in place to guide institutionalization of the Health Facility Quality of Care Assessment Programme and the Comprehensive Support Supervision Strategy.

The MoH Health Financing Strategy (HFS) provides a framework for the health sector to protect the population from financial hardship. The goal of the National Results Based Financing (RBF) Program is to contribute to the reduction of morbidity and mortality trends by improving access to an affordable package of essential healthcare services. RBF is currently implemented in all 135 districts in the country (MoH RBF Report 2020-April) and the revised QIF & SP will be used to standardize quality assessment methodology used as part of the RBF Program.

The United Nations (UN) third Sustainable Development Goal (SDG) emphasizes the improvement of quality of health services for RMNCH and the communicable diseases of HIV, TB, and malaria. The QIF & SP (2020/21-2024/25) will inform ongoing QI efforts in these areas as well as national clinical standards and guidelines for laboratory and diagnostic services.

Lastly, as Uganda works to accelerate progress towards Universal Health Coverage per the Health Sector Development Plan (2020/21-2024/25), it also seeks to increase access to and quality of Primary Health Care (PHC) to improve population health and safety. The QIF & SP will, therefore, inform ongoing efforts to address persistent issues in quality-of-care across all areas of PHC.

1.2 Goal of QIF & SP 2020/21-2024/25

Improvements in access to healthcare without appropriate attention to quality of healthcare will not lead to the desired population health outcomes. Therefore, explicit focus on QI in health service delivery and systems at all levels is critical. According to the 2019 Service Availability and Readiness Assessment (SARA) report, Uganda continues to see significant gaps in availability of and inadequate capacity of facilities to provide quality services; only 52% of facilities have capacity to provide general services while only 25% of clients are satisfied with services (MoH Client Satisfaction Survey, 2019). This suggests an urgent need to address persistent QoC issues.

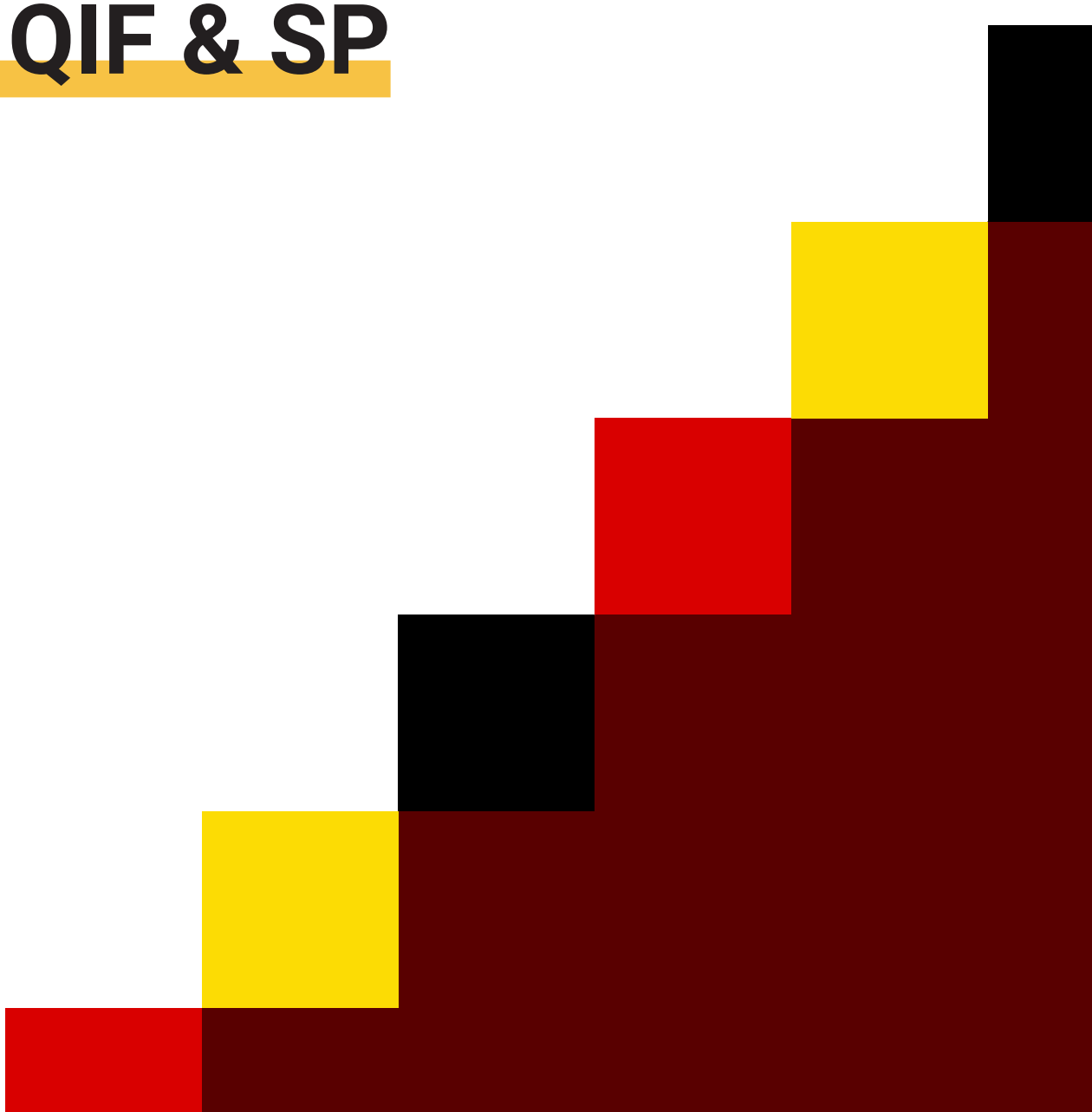
In line with the goal of the NDP III (2020/21-2024/25) to improve the quality of life of Ugandans, the goal of The National QIF & SP 2020/21-2024/25 is **"to have effective implementation of QoC interventions that meet expected health service standards in Uganda."** The National QIF & SP contributes to accelerating movement towards Universal Health Coverage by harmonizing and standardizing health system interventions for improved health outcomes, safety, and health service management.

The QIF & SP 2020/21-2024/25, therefore, focuses on the institutionalisation of a culture of QI through coordinated identification of gaps and concerted efforts for improvement using national QI structures. In keeping with the 5S-QI Philosophy, the framework focuses on building a conducive working environment using the principles of sorting, setting, shining, standardising, and sustainability. This iteration of the QIF & SP goes further; it aims to promote harmonisation of different processes to improve QoC, including the implementation of Clinical Mentorship, as well as processes of documentation, reporting, monitoring, and supervision related to QI.

The QIF & SP 2020/21– 2024/25 also aims to improve leadership and management accountability at district and facility levels for the operationalisation of QI by establishing functional QoC Committees. QoC Committees must work with Clinical Mentorship teams to accelerate the implementation of health service standards and to improve quality-of-care. The QIF & SP emphasizes regular assessments and identification of gaps to improve client-centred care, regular review of health service provider safety, data management, innovation, monitoring and evaluation, as well as increased use of data for evidence-based decision-making.

CHAPTER 2:

Process of developing the QIF & SP



The development of the QIF & SP 2020-2025 was preceded by the evaluation of the previous QIF & SP 2015-2020. The evaluation included: desk review and secondary analysis of District Health Information System (DHIS2) data, key informant interviews, and development of comprehensive evaluation tools. For key informant interviews, the evaluation team used open-ended and semi-structured questions to guide discussions on QoC issues. The key informants were selected from implementers of healthcare at all levels. The interviews provided an opportunity to validate information obtained from the desk review. There were field visits to facilities at the national, regional, district, and facility level where exit interviews were conducted, and observation checklists were completed. Review workshops were conducted after the evaluation to validate the findings, solicit input from stakeholders, and gain consensus over the strategic objectives and interventions for the period 2020/21 – 2024/25. The drafting team constituted of QI experts including policy makers, CSOs and health partners. The team then undertook development of the first draft of QIF & SP 2020/21-2024/25.

2.1 Results from evaluation of the NQIF & SP 2015-2020

The QIF & SP, since its inception in 2010, has been instrumental in creating a more conducive environment for the implementation of QI interventions in the country. The QIF & SP for 2015-20 guided the setting-up of QI structures and streamlined implementation of QI in both private and public health facilities.

Leadership and management: Implementation of the 5S-QI philosophy has been remarkably successful in all 14 RRHs including the newly accredited Entebbe RRH. Significant change in implementing 5S-QI was also registered in Tororo General Hospitals, the National Referral Hospitals of: Mulago, Kawempe, Kiruddu, and Uganda China Friendship Hospital. From 2014, the Japan International Cooperation Agency (JICA) has been supporting the MoH to implement the 5S-QI CQI TQM approach and most of the RRHs are currently at the implementation stage of the Kaizen (CQI) process. The 5S-QI CQI TQM 2019 guidelines were developed and continue to be a useful addition in strengthening the implementation of the 5S-QI framework. The guidelines have been used in consolidating the organisational structures for QI in the health sector and have been a useful tool for RRHs to conduct quarterly 5S-QI M&E and facilitate capacity building for 5S-QI monitoring at subnational level.

Human resource management: Only 74% of health workforce posts are currently filled (MoH AHSPR 2020); while this is a positive change upwards from 2010/2011 staffing levels at 58%, there is need to improve availability of human resources, and this is a responsibility of leadership and management. Spark Africa have demonstrated how focusing on behavioural change leads to improved quality of health services delivery in the seven districts where the project was implemented. Perform to Scale (Makerere University School of Public Health) has showcased the use of QI methodologies to improve staff scheduling, staff appraisal, and coordination of supervision and Clinical Mentorship for improved QoC. The QIF & SP should be used to inform QI for better Human Resource Management.

Functionality of QI structures: Regional and district-level support for the implementation of QI must be strengthened. The management at the RRHs and the District Health Teams (DHTs) have to some extent embraced 5S-QI and participation and support of these activities grew during this period of implementation of the QIF &SP. There was, however, still additional need for leadership support for planning, budgeting, supervision and monitoring of 5S-QI activities. More effort is required to build capacity for leadership engagement in implementing 5S-QI in new administrative units/districts. Regional and district leadership is required to improve coordination between DHTs, RRHs, and QI implementing partners and to mobilize resources for regular onsite QI coaching and Clinical Mentorship to improve QoC.

The evaluation observed that RRHs have established QI structures in the form of Work Improvement Teams (WITs) in every functional unit. This has been progressively emulated in lower-level HFs in their respective districts. However, functionality of QI structures varies considerably from one administrative unit to another: At some facilities visited, QI committees were not meeting regularly, nor documenting QI interventions or submitting reports with standard tools. Leadership and management support for operationalising QI structures was inadequate. Just as RRHs face a critical challenge of organising and coordinating the large number of WITs in each hospital department, the same problem extends to GHs and HCIVs. It was further observed that there is a growing number of committees performing QoC related functions in several health facilities. Examples include, Infection Prevention and Control Committee (IPC), Maternal and Perinatal Death Surveillance and Review (MPDSR),

Medicines, and Therapeutic Committee, among others. The increase of parallel QoC structures appears to cause conflict with QI organisational structures and is creating avoidable additional work for health service providers.

Implementation of 5S-QI Philosophy: The rate of implementing the 5S-QI approach in districts has been relatively slow with many IPs disregarding 5S-QI philosophy in their QI projects. The health sector, therefore, must consolidate learning from 5S-QI implementation in the RRHs and take steps to cascade implementation of the 5S-QI philosophy to lower-level health facilities. Implementing partners in the country should embrace this approach. National level leadership support for QI interventions has grown over the years. At national level the minister for health has consistently attended all national QI conferences. The Director General Health Services (DGHS) and other top leaders at MoH equally support and participate in most of the major QI related activities.

Implementation of the Health Service Standards: There was encouraging effort towards the implementation of service standards in HIV/AIDS care, MCNH and laboratory service delivery areas. By December 2020, 33 laboratories are internationally accredited to ISO 15189 Standards and 62 laboratories are certified by WHO-AFRO through the African Society for Laboratory Medicine (ASLMMoH Lab) according to the QoC Report 2020.

Currently, there is a gap in the national strategy and plans articulating how Clinical Mentorship should drive QI throughout the health system. Clinical Mentoring approaches are not standardized, and implementing partners often use their own curricula, Standard Operating Procedures, and tools to implement clinical mentorship, working outside of MoH systems and processes. There is also a gap in national strategy and plans describing the linkage between support supervision processes and Clinical Mentorship.

The Clinton Health Access Initiative (CHAI) since 2018) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) funded implementing partners have worked to support implementation of Clinical Mentorship and QI coaching to improve quality of service standards for RMNCH and HIV/AIDS. CHAI's partnership with the MoH and Association of Obstetricians and Gynaecologists of Uganda (AOGU) to strengthen RMNCH Clinical Mentorship capacity in greater Mubende and Kibaale has resulted in the Standard Operating Procedures and tools adopted at national level. These tools will be cascaded nationally to standardize RMNCH Clinical Mentorship across the country..

HFQAP has been undertaken in 91 out of the 135 districts (65%) (MoH Performance Review Report 2020/21 FY) and the coverage is expected to be improved further from 2020/21 FY. West Nile has had three HFQAP assessments, while Karamoja has had only one assessment completed. The 18 districts in the Southwestern part of Uganda were yet to be assessed and hence lagged in the implementation of HFQAP. The HFQAP tool has been refined and digitized which is expected to improve the rate and quality of HFQAP assessments. There was noticeable increase in stakeholder appreciation for regular HFQAP assessments, identification of gaps and generation of solutions with the available resources.

Client-centred care: While the MoH Client Charter (reviewed in 2019) is currently available for use and accessible on the MoH website, all RRHs client charters have expired. Client Charters inform client engagement and provide a feedback mechanism to improve quality of health services. Some health facilities introduced linkages and peer client experts who help to track individuals who have missed antiretroviral treatment (ART) appointments. Generally, there was slow progress in operationalising feedback in most health institutions. The delay to have updated Client Charters for RRHs and key messages for districts, reduced the expected community participation and contribution to improved health management in the health sector. Community dialogue meetings, radio talk shows, and social media networks have not yet been fully embraced by the health sector and are not well articulated in the current QIF &SP. The Patient/Health-worker Rights and Responsibility Charters developed in 2019 have not yet been circulated widely and translated into the vernacular for improved access and use in health facilities across the country. r.

Patient and health worker safety: Following the development of the MoH infection prevention and control (IPC) guidelines, QI committees were constituted and trainings conducted to handle patient safety intervention measures in a number of health facilities. The outbreak of COVID-19 has created pressure on the national health system to support IPC functions, and review of the QIF & SP provides an opportunity to focus on IPC adherence within the national QI strategy.

The MoH Patient Safety Practice Survey 2019 revealed that 50% of leadership in health facilities demonstrated low levels of knowledge of the national health worker protection policies and guidelines. Therefore, few leaders have developed policies on health worker protection within their health units (Patient Safety Practice in Uganda -2019). Continuous

Quality Improvement (CQI) support systems such as clinical audits and MPDSR have been rolled out in most of the health facilities but are not fully functional. In addition, action points coming out of these processes are not consistently implemented. The health system lacks an established system for reporting medical errors.

Documentation, use of data and reporting of QI processes: There were areas of improved documentation, reporting, and sharing of QI processes and activities in health facilities largely due to partner support. WITs were provided with counter books to document weekly meetings; these were used to record QI activities in several health facilities visited. Some units were using the reporting format and QI software tool developed by Mildmay to ease reporting of QI processes. The use of some of these tools, however, requires more concerted support and coordination from X. The health sector has a gap in QI data generation, analysis and use at all levels of service delivery. The use of standard QI tools for data collection, analyses and reporting to the next level of care up to the MoH must be prioritised. A lack of a QI data base and a well-coordinated QI M&E system for the health sector was observed as a critical gap. Lessons can be drawn from the USAID-funded QI database used by over 1470 ART sites to monitor national level improvement initiatives for the TB and HIV programmes The wider use of the database is attributed to its simplicity and flexibility for different user skill sets, and automated layered analytics that enables different stakeholders to keep track of progress of QI indicators. For sustainability, MoH is coordinating key stakeholders to develop a QI database in DHIS2 with lessons learned from the national level HIV improvement collaboratives. It is worth exploring whether such a database could be expanded or replicated to include QI data for additional service areas.

Where regional learning sessions took place, there was an opportunity for sharing knowledge and experience in implementing QI but this was yet to be institutionalised and the documentation was insufficient. At the national level, the MoH has consistently organised and hosted the annual National QI Conference since 2013. This continues to be a great opportunity for sharing both local and international experience in the implementation of 5S-QI and other QoC interventions. A national knowledge management portal exists on the MoH website but is not regularly updated with QI information.

Innovation and research: Innovation and research continue to improve, and the quality of abstracts submitted to the QI conference continue to improve each year. Across the country, capacity in operational research was built where Regional Learning Sessions were supported by partners. The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and Clinton Health Access Initiative (CHAI) have implemented innovative mentorship programs in the areas of HIV/AIDS and SRMNH that have strengthened health service provider skills in data recording and documentation. , and in data analysis to determine root causes of QoC issues, and these learnings have been shared through regional learning sessions and harvest meetings. The role of academia in working closely with the MoH to promote research and to improve QI was not well appreciated. Although, MOH has promoted research and learning through participation in PEPFAR summits where different stakeholders share scientific research learnings, that support public health interventions.

The UN SDG 3 highlights the importance of addressing communicable diseases which include tuberculosis (TB), HIV/AIDS, and Malaria, as well as improving access and quality of reproductive health services. The QI interventions in these critical areas of service delivery have continued to increase in the last 5 years and hence should be a key priority of focus for the revised QIF & SP.

2.2 Recommendations for the NQIF &SP 2020/21-2024/25

Leadership and Management: Leadership and management must drive implementation of the 5S-QI-CQI-TQM methodology in the health sector. Managers at all levels of service delivery must be actively involved in planning, coordinating, and monitoring of QI and in the overall operationalisation of the QIF & SP. Capacity building at the RRH Community Health Departments (CHDs), DHTs (especially for the new districts) and Health Unit Management Teams must be prioritised to have more staff available and participate in QoC activities. Recognition of performance through rewards and sanctions ought to be given consideration.

Human Resources Management: Increased focus on QI and HRM performance management is important to increase participation and improving health outcomes in the health sector. Clear roles, job schedules and appraisals are required to allow each staff to take part in QI and enable them to appreciate their input. QI related interventions for HRH, including support to HRH reporting on provider attendance and other work supported by the relevant TWG must be prioritized and budgeted for.

Functionality of QI Structures: QI structures have been established at all levels of health service delivery in the health sector. Full functionality of the QI structures is yet to be realised and this must be addressed and harmonised especially where standalone committees have been created to provide parallel QI functions. There is also need for QI structures at the community level. Improved coordination of QI committees (Work Improvement Teams-WITs) more especially in the big health service institutions such as RRHs, General Hospitals up-to HC IVs should be harmonised for regular and internal monitoring and support supervision. All QI related functions should be handled by the proposed QI structures in the QIF & SP. Efforts should be made to minimise creating additional committees with interrelated roles and functions. Regional and district leadership must improve coordination between DHTs, RRHs, implementing partners, and Clinical Mentorship structures.

Implementation of 5S-QI Philosophy: The progress made in establishing structures and implementing 5S-QI in the RRHs must be sustained and planned for, cascading all the way down to districts, for both private and public health facilities. M&E for 5S-QI must be strengthened and institutionalised at all levels of implementation of the QI interventions. All stakeholders should embrace the 5S-QI philosophy.

Implementation of Health Service Standards: Implementation of service standards and assessments to identify gaps in QoC is still an outstanding and critical strategic intervention. Development of a comprehensive manual is required to harmonise and improve implementation of service standards. The different tools used for assessment must be streamlined and where possible digitalised and linked to the MoH ICT server. All assessments made in the implementation of service standards should be analysed and areas of intervention addressed using the established QoC structures in the health sector.

Uganda has seen an increase in QI interventions targeting RMNCH QoC as well as communicable diseases like HIV/AIDS, Malaria, TB, (and in 2020, COVID-19). This necessitates harmonisation and proper coordination for improved QoC services in the health sector. To achieve harmonization, quarterly support supervision must be prioritized across the health sector. The MoH Comprehensive Support Supervision Strategy should be operationalised and linked to the QoC at all levels of health service delivery. Capacity must be provided for RRHs to plan, mobilise resources, monitor and coordinate support supervision in their respective districts in the region. Following a support visit, QI processes such as documentation, reporting, and follow-up on critical issues using proper QI channels should be followed. Support supervision should be conducted regularly each quarter as intended.

Similarly, Clinical Mentorship to support adoption of and adherence to service standards and QoC best practice should be standardized and coordinated with support supervision and QI coaching. While quarterly supportive supervision and QI coaching often focuses on skills building, entrenched systems barriers (i.e., stock-outs, lack of data systems, poorly organized clinical workspaces) can make integration of new skills and skills application difficult and often lead to skills attrition over time. Whereas supportive supervision reinforces accountability for QoC, Clinical Mentorship supports health workers with the technical skills, knowledge, and tools they need to improve service delivery practice and systems. Thus, Clinical Mentorship guidelines should be developed, costed, and resourced for the coordinated implementation of service delivery mentorship across geographies. National, regional and district mentorship teams should be activated and should work in close coordination with activated QI structures to build health worker skills, which will add value to facility-led QI processes.

Client-Centred Care: The MoH Client Charter was revised in 2020, whereas the Client Charters for the RRHs expired in 2016. The districts on the other hand lack key client charter messages. Up-to-date Client Charters and key messages should be made available and used for improved community engagement. The increased use of ICT services including social media should be considered to encourage clients to give feedback on the quality of health services provided in the country.

Patient safety in the health sector: The awareness on patient safety is still low and must be addressed. The provision of relevant tools, as well as a i mechanism for reporting errors in health service delivery at all levels of care is important in handling patient safety related issues. Supportive Supervision and Clinical Mentorship can be used to identify and resolve issues affecting patient safety.

Documentation, use of data and reporting of QI processes: There is need to strengthen the QI M&E system for improved QI documentation and reporting at all levels of health service delivery. The MoH harmonised QI data base must be developed and capacity established for improved use of data at all levels of service delivery. QI committees at all levels should place more emphasis on generation, analysis and use of QI data alongside improved mentorship, coaching and support supervision.

Innovation and Research: Health facility-based QI committee meetings, regional learning sessions and the national level QI conferences/meeting opportunities should be strengthened to encourage knowledge sharing at different levels of health service delivery. The QI knowledge management portal should be updated regularly.

Figure 1: SWOT analysis for the health sector

Strengths

Strengths of the health system include supportive leaderships right from the MoH Senior Top Management to the Health Facility Ward In-charges as well as community-based leaders. QI structures have been established across the health system for both public and some private health facilities. The Patient Safety practice survey was conducted in 2018 to inform policy changes. Capacity in patient safety practice continues to be built for service providers and consumers, especially following the COVID-19 outbreak. The use and assessment of service standards has been undertaken and forms a foundation for increased focus in this direction. The digitalisation of tools to assess compliance to health standards/ HFQAP and the linkage of tools to the MoH DHIS2 server is an opportunity for improved quality and management of QI data. The initiative for knowledge sharing at health facilities, regional learning sessions, and QI conferences and the MoH knowledge management portal shall continue to be appropriate for capacity building for QI.

Weaknesses

GoU funding continues to be inadequate for effective implementation of 5S-QI interventions. Most critical activities including programme-based QI interventions, HFQAP and other are funded by 5S-QI/QI partners. There is need for more active leadership involvement in the different QI processes, especially in districts and health facilities. Managers should play an increased role in guiding planning, coordination, monitoring and supervision of QI interventions on a regular basis. Patient safety, use and assessment of service standards, documentation, and reporting of QI related activities are still weak. 5S-QI is yet to be rolled out to districts to improve the working environment. In addition, QI structure meetings are held irregularly, and there is poor documentation, and reporting of QI activities. There is inadequate MoH-led support supervision, coaching, mentorship as well as monitoring for the ongoing QI processes. The lack of QI M&E system with a robust data base is key weakness in the QI system.

Opportunities

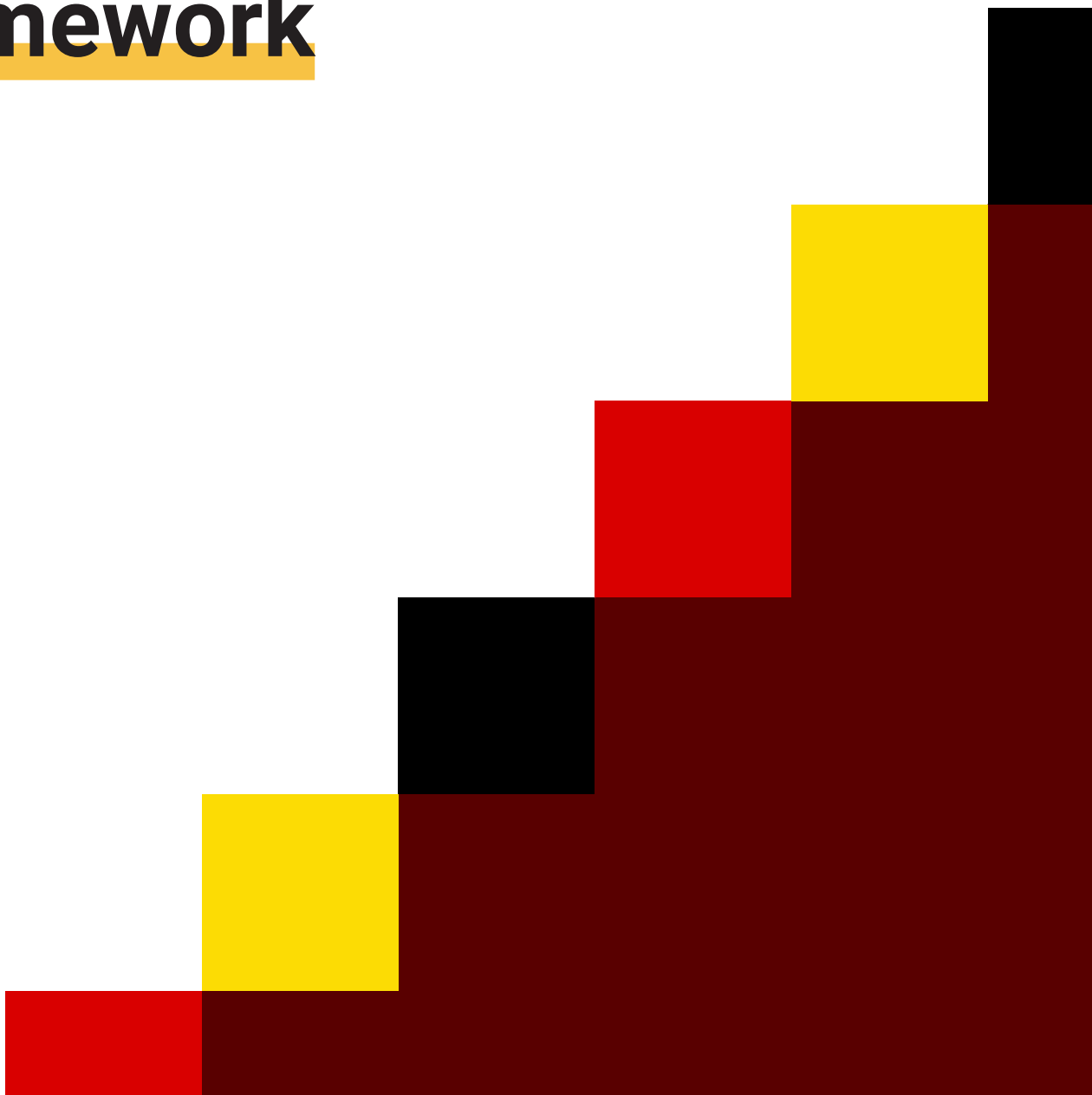
QI partner support has provided a vital incentive for 5S-QI operations to take place. More involvement of the RRHs CHDs at sub-national level to support QoC operations should improve coordination of QI coaching and Clinical Mentorship. The new financing strategy based on performance (RBF) should foster focus on QI to provide improved quality of health services in the country. The planned infrastructure development to improve health service delivery at sub-counties (HC III) and the general planned restructuring at RRHs and Local Government shall provide an opportunity to improved access to quality health services to the community. The increased and deliberate focus of the 3rd SDG should he used to address QoC in RMNCH, HIV/AIDS, Malaria, TB, diagnostics and laboratory services.

Threats

The COVID-19 outbreak remains a big challenge towards implementing QI in the country. The pandemic has claimed lives of some critical health service providers. It has also pulled funding away from other essential health services in the health sector. Other infectious diseases particularly the Ebola haemorrhagic fevers and the continued critical need for care and support for communicable diseases such as Malaria, HIV/AIDs and TB shall require a well-coordinated QoC service delivery system to meet the expectations of health services consumers. Donor funding is always time bound and hence the health system must be prepared for integration and sustainability at the end of the projects. The poor coordination of donor support at all levels of service delivery continues to cause ineffective use of the available resources. All QI interventions would require to be aligned to the health sector QIF & SP.

CHAPTER 3:

Quality improvement framework



3.1 Dimensions of Quality Improvement

Quality-of-care can be defined as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (6). WHO Handbook for National Policy and Strategy adds that quality health care includes the following three dimensions:

1. **Effective:** providing evidence-based health care services to those who need them
2. **Safe:** avoiding harm to people for whom the care is intended
3. **People-centered:** providing care that responds to individual preferences, needs, and values

The Uganda health system identifies the following to be the dimensions of Quality Improvement:

- **Safety**: Harm-free healthcare and the degree to which patients and healthcare workers are protected from risks of harm which could be produced by clinical practice or other aspects of healthcare, and the activities carried out to prevent and reduce risks.
- **Effectiveness**: Achieving timely desired outcome of care (QI manual).
- **Efficiency**: Maximises resources to achieve the desired outputs and avoid wastage.
- **Access**: Available healthcare service that is within reach for clients where skills and resources are appropriate to the needs of the consumer as well.
- **Equity**: Healthcare service that does not discriminate humanity and addresses personal characteristics such as gender, race, age, ethnicity, physical disability, geographical location, or socioeconomic status.
- **Technical competence**: Health service providers that have knowledge, competence, right attitude, and behaviour to meet the expectations of the client.
- **Patient and family centred care**: Involvement of clients in health service management and decision-making and beyond the individual's healthcare aspirations.
- **Continuity**: The ability of the health service to initiate and sustain a program of care for individuals and communities.
- **Interpersonal relationships**: The working relations between healthcare providers, managers, patients, and the community are cordial and respectful.
- **Choice**: Opportunity and autonomy to choose from the various available options, unconstrained by external parties. .

The Ugandan MoH has adopted **5S-QI, Continuous Quality Improvement (CQI) and Total Quality Management (TQM)** as well as **Clinical Mentorship Principles** as QI methodologies for improving Quality-of-care in the health sector. Implementation of the 5S-QI Philosophy and framework helps to create a conducive working environment. CQI is the day-to-day monitoring process to identify gaps in service delivery and implement possible solutions for better health outcomes. CQI involves applying appropriate methods to close the gap between current and the expected levels of service delivery. This entails the following:

- Identifying what one wants to improve
- Analysing the system capacity of care/problem
- Developing a hypothesis on which changes (solutions) might improve quality
- Testing/implementing the changes to see if they yield improvement
- Based on the results of testing, deciding whether to abandon, modify, or implement the solutions

Total Quality Management stresses having the culture of QI by engaging key stakeholders. This approach focuses on involving clients and communities to understand how they want services to be provided and strives to meet their expectations.

3.2 Phases of Quality Improvement Methodology

With respect to the phases of QI, various QI methodologies differ, but the content and basic principles are very similar. In Uganda, we shall continue to apply evidence-based targeted QI models and interventions which use the principle of an iterative cycle of improvement (Plan, Do, Study, Act or PDSA Cycle). Since the first strategy through the second, the MoH recommends that QI interventions in health facilities to start with 5S-QI as a fundamental background to QI, CQI and finally TQM, (5S-QI-CQI-TQM).

Phase 1: 5S-QI: Aims at a suitable working environment which provides protection from harm and optimises waste reduction. The process is used by a health facility to implement CQI to achieve tangible health outcomes for the services provided. The 5S-QI philosophy is applied within PDSA cycles so that improvement teams rapidly test changes to care processes and examine whether they are closing gaps and achieving the desired outcomes for an enabling environment for service delivery.

Phase 2: Continuous Quality Improvement (CQI): is focused on application of effective and proven interventions adapted for Uganda to make change in the different processes required to improve quality of healthcare. PDSA cycles are used continuously to quickly test changes and foster ongoing improvement in QoC over time.

The 5S-QI Philosophy

A Quality-of-care approach for improving the working environment.

The 5S (Sort-Set-Shine-Standardize-Sustain) approach can improve the arrangement of items in the workplace so that items are organized. The implementation steps include:

S1: Sorting (remove unwanted items)
S2: Setting (arrange/label items, etc.)
S3: Shine (clean the environment)
S4: Standardise (repeat S1-S3 for all work-place units)
S5: Sustain (continuous: supervision/monitoring; coaching/mentoring, etc.)

Phase 3: Total Quality Management (TQM): The management and employees become involved in the continuous improvement of the services as a routine practice. There is comprehensive and fundamental rules or beliefs for continuously improving performance over the long-term by focusing on clients while addressing the needs of all stakeholders.

All QI interventions include the identification of issues, the analyses of problems, and the development of changes or solutions, explored during PDSA cycles, as visualized in the process flow below.

Figure 2: Quality improvement model

1. Setting Aims
Improvement requires setting goals. The goals should be time-specific and measurable; it should also define the specific population of patients that will be affected.

2. Establishing Measures
Teams use quantitative measures (indicators) to determine if a specific change measurably leads to an improvement. QI tools like the fish bone analysis, histograms, pareto charts, etc., are used.

3. Selecting Changes
All improvement requires making changes but not all changes result in improvement. Organization therefore must identify the changes that are most likely to result in improvement.

4. Testing Changes
The PDSA cycle is shorthand for testing a change in the real work setting - by planning it, trying it, observing the results, and acting on what is learned.

Figure 3: Schematic of GoU's Clinical Mentorship model

Science	Management		
1. Skills, knowledge, and patient-centered care	**2. Documentation and data use**	**3. Supplies and equipment**	**4. Enabling environment**
• Confidence to provide a service; ability to do so to a high standard of independency • Provide individualized guidance/counseling • Provide accurate and engaging health talks • Confidentiality, audio-visual privacy, and respectful care	• Complete, accurate and timely documentation of work done • Facility registers and logbooks accurately and fully filled out • Frequent review of data and use to inform decision making	• Availability of all necessary supplies and equipment • Functionality of necessary equipment • Review of medicines expiration dates	• 5S implementation and organization of space; efficiency of client-flow • Cleanliness and infection prevention measures

Uganda has adopted the following Clinical Mentorship Principles to standardize how mentorship is conducted across different levels of care. Standardising Clinical Mentorship is a systems-strengthening approach that recognizes that technical competence is a key dimension of Quality Improvement necessary for improving quality of care in the health sector.

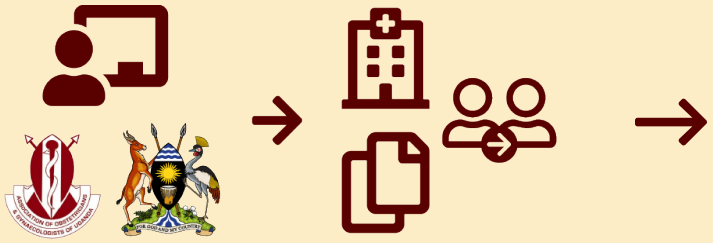
1. **Principle One**: The government of Uganda's training and Clinical Mentorship model is composed of three operational stages: i) intensive didactic training for health workers ii) high-volume clinical attachment for health workers and iii) on-site Clinical Mentorship to enable health workers to perfect skills, including identification and addressing of systems gaps at the frontline. The combination of these three stages results in a more competent and skilled workforce than conventional approaches that lack one or more of these components.
2. **Principle Two:** The government of Uganda's mentorship approach conceptualizes that there are four main pillars of mentorship that address both individual and facility systems-based gaps. These are the pillars of:
    - Skills, knowledge, and patient-centred care
    - Documentation and data use
    - Supplies and equipment
    - Enabling environment

The rationale underlying these principles is that systems-based mentorship helps health workers integrate skills and knowledge into daily workflow. It strengthens their ability to identify and address barriers, improves clinical judgment, and integrate information to build their professional expertise with support from their mentors. It provides health workers with the confidence to address or appropriately escalate systems gaps. In addition, it empowers health workers to create a supportive and enabling environment for quality service delivery that includes timely onward referrals, compliance with safety protocols and infection prevention practices, and streamlined workflows to provide efficient and respectful care.

To note, Clinical Mentorship is a different and distinct process from supportive supervision and QI implementation; when implemented in tandem with coaching and QI supportive supervision, it is possible to rapidly increase health worker effectiveness at identifying systems issues that inhibit provision of high-quality services. This leads to greater efficiency in designing and demonstrating highest-impact solutions to systemic barriers to Quality-of-Care. Figure 4 illustrates the relationship with Clinical Mentorship and QI processes.

Figure 4: The relationship between Clinical Mentorship and QI processes

Clinical Mentorship



Trained mentors from professional associations/ MoH conduct integrated QI coaching and clinical mentorship visits at the facility to address skills gaps and health systems barriers and improve overall competence of HCWs and strengthen health systems to provide high quality service of care.

Quality Improvement

Phase 1: 5S
- Team formation
- Working environment
- Staff motivation

Phase 2: CQI
- Process and systems improvement
- Skills and knowledge staff

Phase 3: TQM
- Productivity and safety
- Quality of care

HCWs utilize strengthened knowledge, skills, critical thinking, and problem solving capabilities to address the health systems barriers to quality through implemention of rapid interactive cycles of improvement.

Districts and partners continue to implement evidence-based targeted QI models and interventions, through the PDSA cycle, 5S-CQI and TQM.

What is clinical mentorship?

Clinical mentorship is a process which promotes quality outcomes by increasing competence and confidence of health workers for effective service delivery. It involves training health workers on skills, knowledge, and systems patient-centred care; correct documentation and use of data to inform clinical and operational decision making; using and ensuring availability of critical supplies and equipment; and creating an enabling environment for service delivery. Mentors are experienced clinicians who support the professional development of health worker mentees, providing support, guidance, and collaborative problem solving to identify systems barriers to quality service delivery and address this over time, while integrating best practices into their workflow.

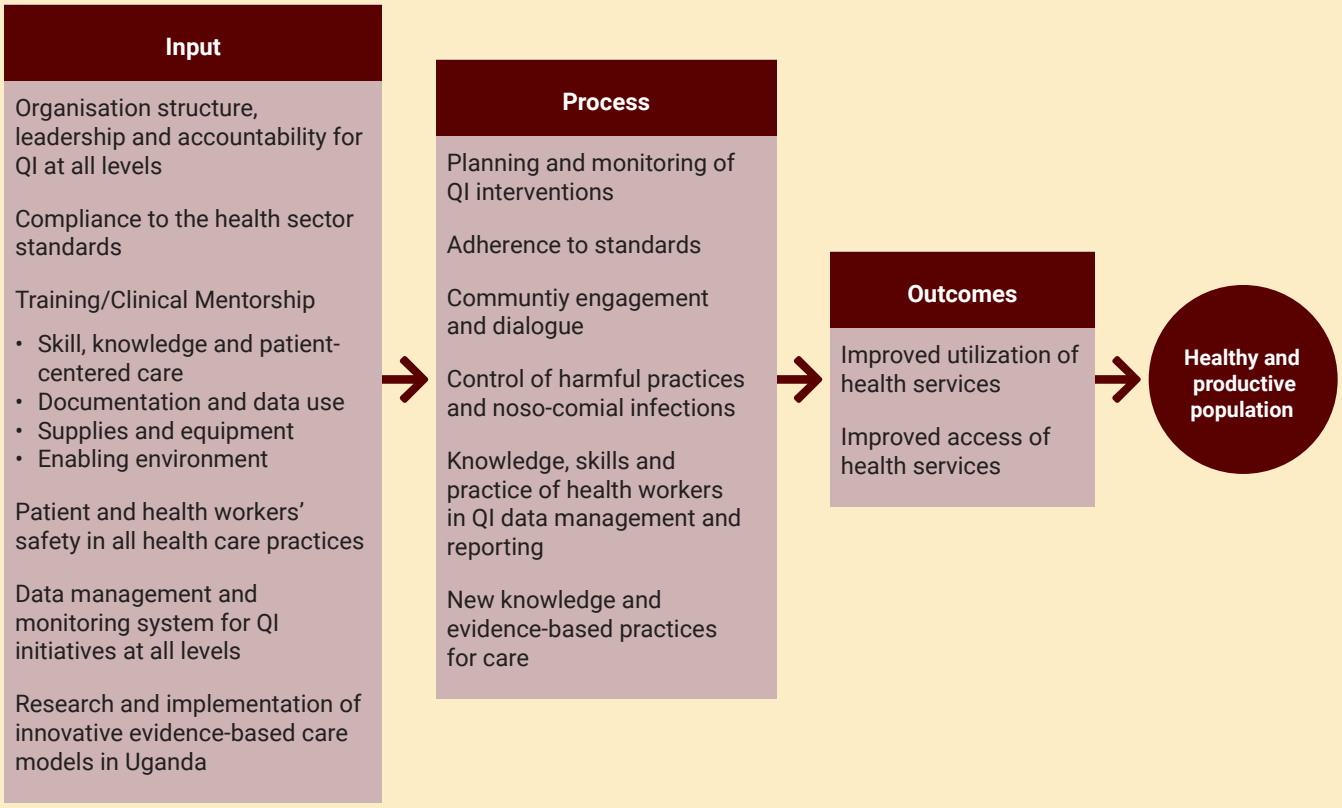
Why clinical mentorship?

Pre-service education often does not offer sufficient opportunities for health workers to develop competence and confidence in complex clinical skills and judgement. The landscape of care is ever-changing requiring health workers to constantly adapt to new skills, science, technology, and products, necessitating continuous medical education. Health workers must learn to apply new information through the development of appropriate clinical judgment and integration of new techniques and skills into their already busy workflow. Additionally, workspace organization and documentation are a health worker's responsibility and requires practical training. Continuing medical education, through in-service training and mentoring can meet this need for supported clinical learning. Whereas QI provides a process to identify issues, design interventions, test hypothesis and scale solutions, mentorship supports development of key technical skills which are foundational to Quality of Care and which health workers must demonstrate to achieve successful QI outcomes.

3.3 Theory of Change for Health Sector Quality Improvement – 2020-2025

The theory of change is derived from the Donabedian Model for QoC where the health system shall organise the key inputs as guided by the proposed strategic objectives of the National QIF & SP 2020/25. The harmonisation and improved mobilisation and coordination of sourcing for QoC at all levels shall facilitate processes to achieve the desirable key health outcomes. The implementation of 5S-QI/CQI model using a collaborative approach with the embedded PDSA cycle shall require health service standards to be appreciated and assessed regularly. In addition, it shall require recognition and reward where expectations of the consumers are realised and sanctioning where there is a shortfall in performance. The effort to achieve the desirable outcomes shall be accompanied with effective monitoring, evaluation, supervision, coaching and mentorship at the different service delivery points.

Figure 5: Conceptual framework for quality improvement approaches in Uganda



3.4 Resources for QIF & SP 2020-2025

The major sources of funding for the health sector are the Government of Uganda, out-of-pocket payments, and health development partners. Other funds come from social health insurance schemes. The appreciation of quality of services delivered is fundamental to client willingness to pay for or take up services. As the quality of the health services increase, the user willingness to pay for and or use a service will also increase.

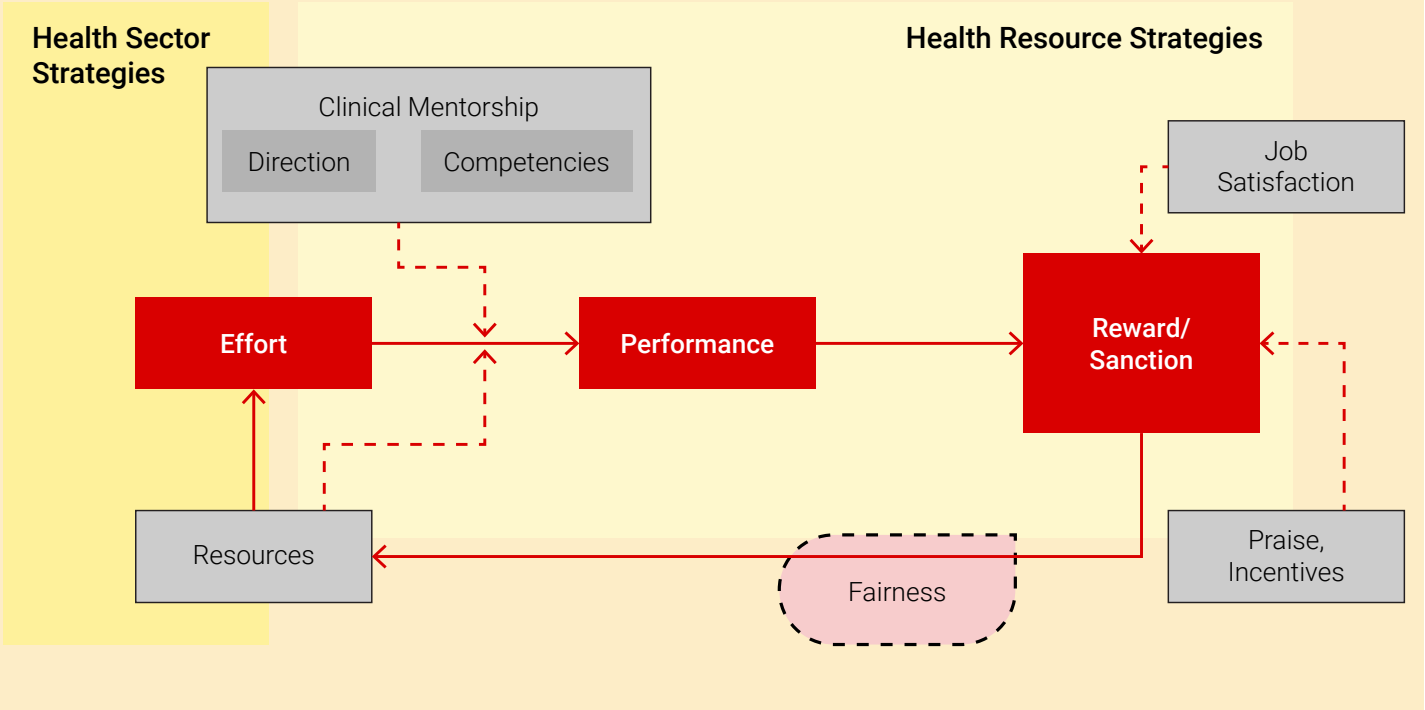
The government of Uganda shall continue to provide minimum medical care package to all its citizens with the goal of reaching Universal Health Coverage (UHC) by 2030. Generally, adequate financing towards the health sector influences the availability of inputs like medicines, supplies, equipment, and transportation to bigger health facilities which directly impacts quality of care. The total government expenditure on health as a percentage of GDP is 7.2% for FY 2019/20 (AHSPR-2019/20FY), which is below the Abuja

declaration target of 15%. As such, the health sector is underfunded, and the balance of the expenditure is heavily financed by development partners who contribute about 43% (AHSPR-2019/20FY) in addition to the out-of-pocket expenditure of 38.4%.

The availability of appropriate inputs and their efficient and effective use translates to improved utilisation of services and overall client satisfaction. According to the FY 2020/21 National Annual Needs Analysis for essential medicines, health, and laboratory supplies for public health facilities in Uganda, the government funding for medicines and supplies has been consistently increasing over the financial years, which is commendable. Conversely, there is still a funding gap for laboratory reagents, parenteral medicines, and medical supplies for the increasing number of cases of non-communicable diseases. The availability of 41 tracer medicines was at 79% in 2020 (AHSPR 2019/20). The availability of appropriate resources and inputs (Health Sector Strategies) ensures motivation of healthcare providers/workers. For instance, healthcare providers/workers need to have a sense of direction to take the right actions. This can be operationalised through ensuring that health workers have clear job schedules as well as performance plans with clear performance targets, upon which they can be appraised at the end of the year. They also need continuous clinical mentorship and quarterly support supervision to increase their skills and knowledge, strengthen their clinical judgment, and ability to identify and solve systems gaps. Finally, health workers also need rewards and sanctions to influence their behaviour and performance in service delivery. Figure 6 summarises the factors that influence individual health worker performance.

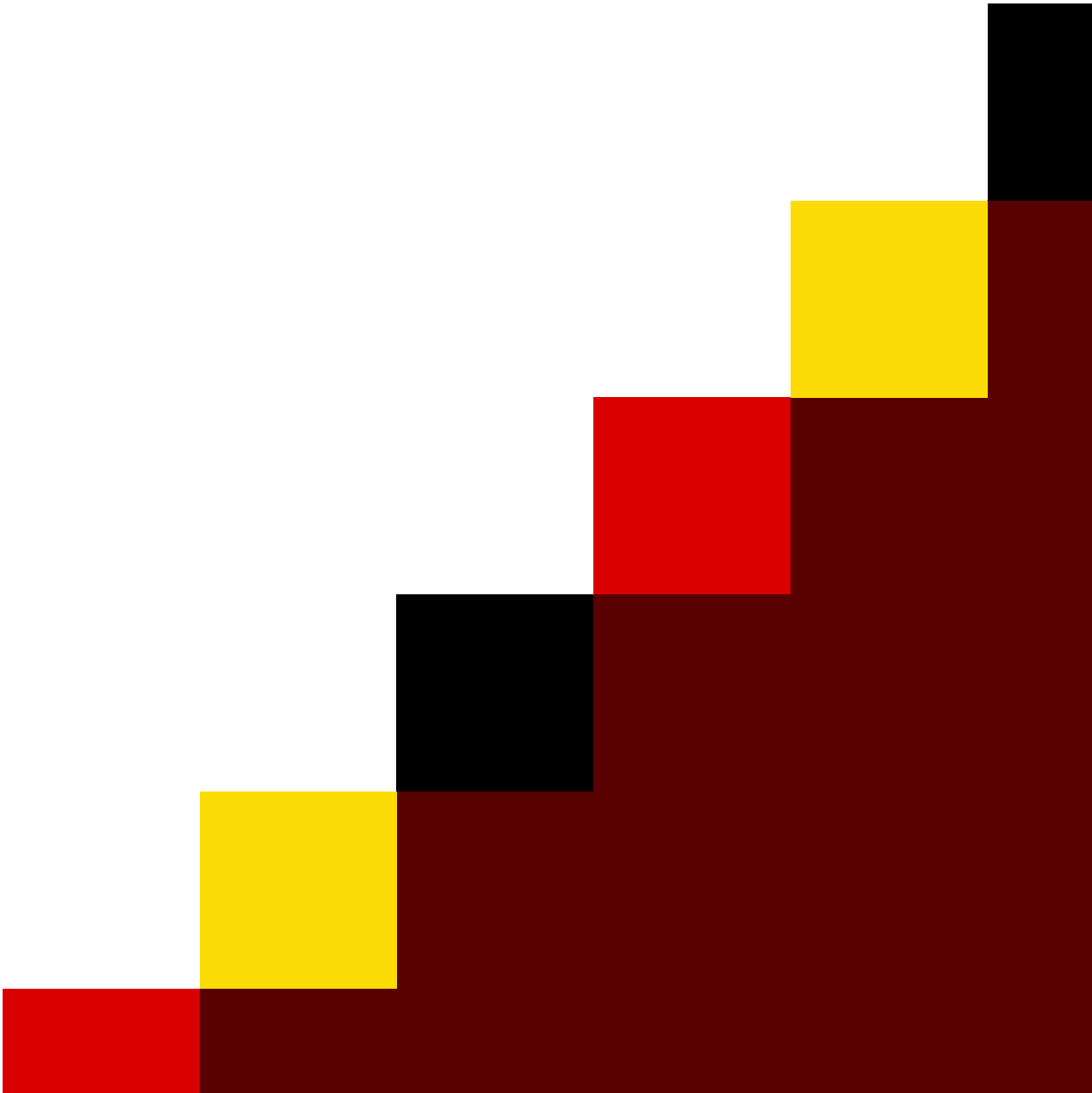
Quality of health services is also an important determinant of health service provider attitude and willingness to work. One of the reasons why there is a negative attitude and low morale of health workers is because of the poor work environment. A conducive work environment is fundamental to health worker willingness to work. Health workers should feel supported at work through the cultivation of an environment where there is a cordial employer-employee relationship. Such an environment can be developed by setting to targets for appraisal at the beginning of financial years with workers, supportive supervision, and clinical mentorship to promote positive physical, mental and emotional health of health providers.

Figure 6: Factors influencing health worker performance. Adapted from Open University, 1997



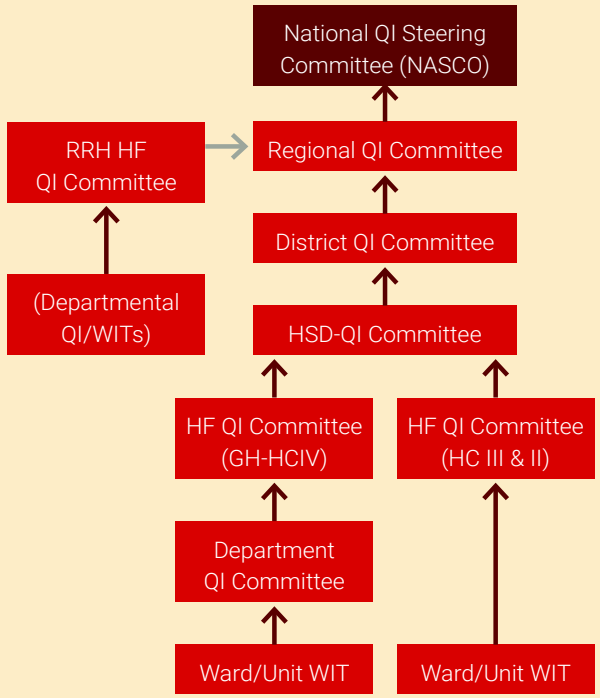
CHAPTER 4:

Structures to be used in implementing QIF & SP



QI organisational structures form a critical component for effective implementation of QoC in the health sector. Since the inception of QIF & SP in 2015, the QI structures were the first to be considered as priority areas of focus and have been established from the lowest health facility (HC II) up-to the national level (National QI Steering Committee). See illustration below:

Figure 7: Organisation of the QI Committees



The QI structures serve as mechanisms for coordinating 5S-QI/QI related activities at each level of health service delivery. Every task related to 5S-QI/QI is expected to be handled by the QI committee established in that health service delivery unit. Creating new parallel or programme/activity based QoC committees within the national health system is not proper and has to be discouraged.

For each development where QoC must be addressed, the established QI structures as guided by the QIF & SP should be used. Health service delivery units should avoid duplication of roles and fatigue due to too many committees/ meetings often involving the same service providers in the health facility.

Health workers that receive systems-based Clinical Mentorship from a qualified mentor in priority service areas are strongly positioned to implement successful QI processes at the facility level. The structures responsible for implementing QI should therefore work closely with national, regional and district structures responsible for training and mentorship to identify needs for clinical mentorship. Clinical Mentorship should be deployed to address significant skills gaps impacting QoC; it should be deployed to help health workers internalize and operationalize latest changes made to national service standards and guidelines, as well as to support the introduction or scale up of new or underutilized services, commodities, and equipment.

Clear roles and responsibilities for each level of **QI Committees** should be established to ensure their functionality. QI Committees shall guide the implementation of 5S-QI, the identification of QoC performance gaps and initiate new QI projects as well as properly document and regularly report QI activities for action. QI Committees particularly, at health facilities are expected to hold regular meetings to discuss progress made in implementation of 5S-QI and QI projects. The time for the meetings should be short (lasting about 20 minutes or less) to enable members to dedicate the available time to routine work in the health facility.

WITs are the forefront functional units in a health facility and are supposed to meet weekly. All members of the functional unit (ward or clinic, store, laboratory, etc.) are supposed to be members of the WITs including support staff and the community. They should produce monthly reports, which are then discussed during the Department or HF QI committee meetings in case of HC III and HC IIs.

Department QI committees should be considered for high-volume health facilities: **RRH, GH, and HC IV**. There should be monthly department QI committee meetings that are used to receive, review reports and review functions of the WITs. Department QI committees are to prepare quarterly reports, which are to be discussed during the monthly **Health Facility QI meetings**. In addition, Departmental QI committees should organise a few WITs meetings at time until all WITs in the department have been covered at the end of each quarter.

Monthly health facility QI committee meetings should be organized for the Heads of Departments to meet and deliberate on the performance of WITs in their respective departments. Similarly, HF departments should schedule spread review meetings throughout the quarter until all departments have had a meeting. HC IIIs and HC IIs are low-volume units, and therefore, WITs can meet monthly during the HF QI Committee meetings. Where need may arise, the HF WITs meeting can be scheduled in a quarter, especially in HC IIIs.

Figure 8: Meeting schedule for the QI structures

Unit		Meeting frequency	Chair	Reports to
WITs	RRH, DHT, GH, HC IV	Weekly	Ward In-charge	Department QI Committee
	HC III, II	Weekly	Ward In-charge	HF (HC III, II)
Department QI Committee		Monthly	Head of Department	HF QI Committee
HF QI Committee		Monthly	HF in-charge	HSD/District QI Committee

The National QI Steering Committee (NASCO) coordinates implementation of 5S-QI and QI at national level. The committee is responsible for ensuring that there is streamlining of all QI processes, resource mobilisation, monitoring, supervision, and general capacity building in the health sector. NASCO meetings take place quarterly for stakeholders to get updates from the Regional QI Committees and plan for implementation 5S-QI/QI in the health sector.

Regional QI Committee (RECO) meets quarterly and coordinates QoC operations for all districts in the region. The RECO shall get regular reports from the District QI Committees and generally guide implementation of 5S-QI/QI andcoordinate partner support for improved health service delivery. The Regional QI Committee must be represented at the RRH Community Health Department. Regional QI Committees should coordinate with Regional Clinical Mentorship teams to ensure implementation of QI activities and clinical mentorship.

District QI Committee meetings are conducted quarterly and should be used to receive reports from health facilities. Reports can be summarised by HSD or sub-county, but the 5S-QI/QI performance of each health facility should be appreciated for the different activities being implemented. Regional QI Committees should work closely with District and Facility Clinical Mentorship teams to ensure coordination of QI activities and clinical mentorship.

Community QI Committee shall be established basing on the approved MoH Community organisational structure (VHTs or Community Health-workers-CHEWs). They are expected to be supported and hence report to the nearest health facility. They shall be involved in QI support to the community and appropriate tools shall be developed to serve that purpose. Other peer support groups shall also be encouraged to participate in QI related community-based service delivery areas such as malaria, HIV/AIDS, TB and RMNCH.

Each one of the QI committees mentioned above should have access to a **QI data base** to report progress of the processes that are aligned to priority health outcomes. The use of proper documentation for QI projects, and M&E tools for 5S-QI including regular reporting should be promoted. Documentation tools in the form of counter books (especially for WITs) and QI record files should be made available and used at all levels of QI implementation. Effort should be made to digitalise, harmonise the process and facilitate access of QI data on the official MoH server. QI data should be analysed to identify strengths and weaknesses of all levels of care in the health sector. Rankings based on performance should be undertaken to recognise and reward performance and to identify those that require support for improvement.

> ***All institutions and units should plan and budget for clinical mentorship, QI monitoring and evaluation, support supervision, and coaching. There must be documentation and reporting, feedback should be regularly given, and all processes must be linked with QI.***

Linkage of QI to QoC: All QI interventions should be linked to the established 5S-QI/QI structures to make it easy to identify gaps and areas for improvement. QI Committees should receive QoC reports and guide how critical QI issues should be handled in the health system. To optimize QI structures and functionality, HFQAP, RBF, Client Satisfaction Surveys, SARA result and others should be disseminated.

Similarly, QoC interventions for **maternal and perinatal audit, medicines management and use, infection prevention and control** should all be aligned to the relevant 5S-QI/QI structures for effective implementation.

4.1 The National QI Coordination Structure

The composition, roles, and responsibilities for the QI Committees are summarised below:

The National QI Steering Committee (NASCO)

The NASCO brings together major stakeholders such as priority programs, DPs/IPs, PNFPs, CSOs, and health consumers. The key responsibility of the NQIC is to plan, coordinate and support QI interventions in Uganda. The NASCO will report to the Directorate of Governance and Regulation (G/R) for planning efforts geared towards improving QoC in the health sector.

The NASCO shall be composed of the following:

Unit Representative	Comment
Director Health Services, Governance and Regulation Chairperson	Head of Directorate for Governance and Regulation
Commissioner Health Services: SCAPP-D	Secretariat for the Committee
Selected MoH Departments/ Programmes	Clinical Services, Health Infrastructure, Nursing, Human Resource for Health
Regional QI Committees	3 Regional QI Committees as guided by the NASCO
Uganda Health Federation (UHF)	To represent the Private Health Facilities (PHF)
Medical Bureaus (Catholic, Protestant, Orthodox, Pentecostal, and Muslim faith)	To represent the Private Not for Profit (PNFPs) health facilities
HDPs and IPs	All major QI supporting Partners
Civil Society Organisation	To be determined by the Committee
Academia	To be determined by the Committee

Responsibilities of the NASCO:

- To give advice on the coordination, planning, and implementation of 5S-QI/QI in the health sector.
- Participate in the development of policies and strategies for improving health outcomes.
- Support and participate in the formulation of national QI guidelines and standards.
- Advocacy and resource mobilization for QI.
- Participate in building the capacity of health workers in the implementation of QI interventions.
- Participate in M&E performance reviews and implementation of QI interventions in the health sector including developing a 5S-QI/QI data base and receiving reports from Regional QI Committees.
- Conduct quarterly National Steering Committee meetings.

4.2 Regional QI Committee (RECO)

The RECO reports to the NQIC quarterly and is composed of the following members:

Unit Representative	Comment
The Hospital Director of the Regional Referral Hospital	Chairperson of the committee
Head of CHD	Represents districts in the region
Head of Nursing in the RRH	Represents nurses and midwives in the region
Regional representatives for key programmes (TB, Laboratory, HIV/AIDs, etc)	To be determined by the Regional QI Team
Lead Regional Clinical Mentors	To be determined by Regional Mentorship Teams
DHOs in the region	Hosting the quarterly meetings can be rotated in the different districts
Diocesan Health Coordinator	Represents the medical bureaus. Consider rotation of membership each year.
Regional Hospital QI Focal Person	The RQIC shall select a Regional QI focal person among the Committee members. Shall be head of the Secretariat for the Regional QI Committee
Representatives from Implementing Partners (IPs)	To be determined by the Regional QI Team
Community representative	Preferably a member of the BoGs who sits on the Committee for Quality Assurance in the Region

Responsibilities for the RECO:

- Supports planning, coordination and implementation of QI interventions in the region.
- Advocate and coordinate resource mobilisation for QI interventions.
- Develop the Regional QI work-plan.
- Supervise, coach, and provide mentorship to support QI in the region.
- Identify training needs and coordinate QI capacity building of health workers in the region.
- Conduct monitoring and evaluation of implementation of QI interventions in the region (Develop 5S-QI/QI database which includes receiving reports from District QI Committees and IPs in the region).
- Recognize, reward, and sanction implementation of5S-QI/QI interventions in the region.
- Hold quarterly RECO meetings.

The role of lead regional Clinical Mentors includes:

- Guiding the integration of Clinical Mentorship into existing QI activities, advising on how to sequence Clinical Mentorship, providing QI coaching, support supervision, and contributing to regional and district review meetings, etc.
- Working with the district biostatisticians to keep mentorship databases and iHRIS up-to-date.
- Sharing periodic mentorship reports for inclusion within district and regional reports.
- Sharing updates related to content of care, e.g., updated clinical protocols and guidelines, information on new innovations and products.
- Supporting the incorporation of new products and updates to the Uganda's clinical guideline and the Essential Medicines and Health Supplies List of Uganda; incorporating product introduction and scale up into district and regional workplans.

4.3 District QI Committee (DICO)

The DICO reports to the RECO and is composed of:

Unit Representative	Comment
The DHO	Chairperson of the committee
DHT members	DHT members: Biostatistician, DHO, ADHO-MCH, ADH-Environment, Health Inspector
Head of Nursing in the General Hospital or HSD	Represents the nurses and midwives in the district
HSD QI Focal Persons	To be determined by the District QI Committee. Person shall serve as the Secretary of the DQIC and carry out the QI coordination functions.
Lead District Clinical Mentors	To be determined by District Mentorship Teams
Representatives from IPs	All IPs in the district should be invited
Representatives from the Medical Bureaus	Represents the bureaus. Consider rotation of membership each year.
Community representatives	One should be male and the second one female

Responsibilities for the DICO:

- Conduct planning and resource mobilisation for QI in the district.
- Develop the district QI work plan.
- Supervise, coach and mentor for QI in health facilities.
- Participate in building the capacity of health workers in QI.
- Conduct M&E for 5S-QI/QI activities including developing a 5S-QI/QI data base.
- Conduct QoC assessment at all levels to identify QI gaps and priorities for follow-up.
- Compile and submit quarterly district 5S-QI/QI reports to the RQIC and MoH (to include reports from HFs and IPs in the district).
- Recognize, reward, and sanction performance of 5S-QI/QI interventions in the district.
- Hold quarterly District QI Committee meetings.

The role of lead district Clinical Mentors includes:

- Guiding the integration of Clinical Mentorships into existing QI activities; advising on how to sequence Clinical Mentorship, providing QI coaching, support supervision, and contributing to district review meetings etc.
- Working with the district biostatisticians to keep mentorship databases and iHRIS up-to-date.
- Sharing periodic mentorship reports for inclusion within district reports.
- Sharing updates related to content of care, e.g., updated clinical protocols and guidelines, information on new innovations and products.
- Supporting the incorporation of new products in line with updates to Uganda's clinical guideline and the Essential Medicines and Health Supplies List of Uganda; incorporating product introduction and scale up into district workplans.

4.4 Health Sub-District (HSD) QIC

The HSD QIC reports to the DQIC and is composed of the following:

Unit Representative	Comment
HSD-charge	Chairperson of the committee
HSD Management Team	Incudes: NO, Public Health Nurse, Health Inspector, Laboratory Technician, Clinical Officer
Head of Nursing in the General Hospital or HSD	Represents the nurses and midwives in the district
HSD QI Focal Persons	To be determined by the HSD QI Committee. Person shall serve as the Secretary of the HSD QI Committee and carry out the QI coordination functions as guided by the HDS in-charge
Representatives from IPs	All IPs in the HSD should be invited
Representatives from the Community/ Patient	Consider gender (Male and female representative)

Responsibilities for the HSD QIC:

- Plan and advocate for resource mobilization for 5S-QI/QI.
- Receive 5S-QI/QI reports from all HSD health facilities and advise on methods of improvement.
- Develop HSD 5S-QI/QI work-plan.
- Supervise (Integrated), coach and mentor lower-level facilities and report findings.
- Participate in building the capacity of health workers in QI.
- Convene HSD stakeholders' meetings for performance review.
- Develop and maintain a 5S-QI/QI data base; compile and submit HSD QI reports to the DQIC.
- Recognize and reward good performance.
- Hold quarterly HSD QIC meetings.
- .

4.5 Health Facility QI Committee

The Health Facility QIC reports to the facility manager (Hospital Director or Medical Superintendent or Assistant Medical Superintendent (HC IVs) or In-charge).

The Health Facility QIT is composed of:

Unit Representative	Comment
Health Facility In-charge	Chairperson of the committee
Health Facility Administrator	Applies in case of larger facilities (hospitals)
Heads of Departments	Represents all the sub-units in the department
Ward managers (HC IVs and Hospitals)	*More applicable for the low-volume health facilities (HC III and HC II)*
Medical Records Officer / Health Information Assistant	Expected to provide up to date 5S-QI/QI data
Representatives of the Local IPs	All IPs available should be invited (develop a schedule if they are many)
Representatives from the Community/ Patient	Consider gender (Male and female representative). Preferably a member of the Community QI Committee

Responsibilities for the Health Facility QIT:

- Plan and coordinate 5S-QI/QI activities in the health facility.
- Develop the health facility 5S-QI/QI work-plan.
- Advocate for resource mobilization for 5S-QI/QI.
- Receive reports from QI Departments/WITs and advise on methods of 5S-QI/QI improvement.
- Develop a 5S-QI/QI data base; compile and submit facility quarterly QI reports to the HSD/DICO.
- Supervise, coach and mentor 5S-QI/QI activities in the health facility.
- Support Department/WITs in developing action plans, implementing QI initiatives, and documentation of progress.
- Recognize and reward good performance.
- Hold monthly health facility 5S-QI/QI meetings.

4.6 Department QI Committee

The Department QIC reports to the Health QI Committee described above. This applies to the high-volume health facilities of RRHs, General Hospitals and HC IVs (cluster management). The committee is responsible for guiding and coordinating 5S-QI/QI interventions taking place in the respective Department WITs (Units). Due to the big number of WITs in these health facilities (RRHs, GH, HC IV) it is necessary to organise 5S-QI/QI Committee meetings in Departments. All WITs should have had at least one meeting byhe end of each quarter.

The Department QIC is composed of:

Unit Representative	Comment
Department In-charge	Chairperson of the committee
Ward/Unit In-charges	*All wards/units in the Department are represented*
Representatives of the Local IPs	*All IPs available should be invited (develop a schedule if they are many)*

Responsibilities for the Department QI Committee:

- Receive reports from Units/Wards and advise on methods of 5S-QI/QI improvement.
- Develop a 5S-QI/QI data base; compile and submit facility quarterly QI reports to the Health Facility QI Committee.
- Supervise, coach and mentor QI activities in the wards/units.
- Support Units/WITs in developing action plans, implementing QI initiatives, and documentation of progress.
- Recognize and reward good performance.
- Hold monthly Department 5S-QI/QI meetings.

4.7 Work Improvement Team (WIT) – (Functional Unit QIC)

The WIT is the main functional unit for implementing 5S-QI/QI activities in a health facility or institution. The aim of WITS is to provide a platform for health service providers to identify gaps, analyse data, and contribute to solving 5S-QI/QI problems. All functional units in a health facility should have a WITs in place; where units are too small with few staff, the possibility of mergers should be considered.

WITs meet weekly and are expected to focus on reviews of data for 5S-QI/QI. The meetings should be short (not exceeding 20 minutes) and properly documented in a counter book. Monthly reports should be prepared and submitted for discussion in the Department/Health Facility QI Committees.

The composition of WIT should include staff working in the unit *(including the support staff)*:

Unit Representative	Comment
Ward in-charge	Chairperson of the WIT
Ward staff	Includes the clinical staff
Support staff	Should be represented especially in implementation of 5S-QI
Representatives of the Local IPs	*More especially where there key projects are being implemented*

WIT is responsible for the following activities:

- Problem identification and analyses focused on 5S-QI/QI; coming up with a relevant solution-based project.
- Development of an action plan for the ward/unit.
- Implementation of 5S-QI/CQI interventions in the wards/units.
- Development of a 5S-QI/QI data base; documentation of processes and progress of 5S-QI + CQI activities.
- Development of weekly 5S-QI/QI progress reports for the WITs and monthly Departments/Health Facility QI Committee meetings.
- Development of a checklist to suit their work environment.
- Conducting weekly WIT 5S-QI/QI meetings.

CHAPTER 5:

Strategic objectives and interventions for the QIF & SP

The current NQIF & SP for the implementation of QI in the health sector builds on where previous plans from 2014/15 to 2019/20 left off. The NQIF &SP 2020/21-2024/25 places emphasis on the responsibility of leadership and management to operationalize QI while also emphasizing the role of QI committees in driving QI processes. The QIF & SP 2020/21-2024/25 includes the following strategic objectives:

1. To strengthen organisational structures, leadership, and accountability for quality improvement at all levels.
2. To improve compliance to the health sector standards.
3. To improve client-centred care at all levels.
4. To improve patients and health workers' safety in all health care practices.
5. To strengthen data management and monitoring systems for quality improvement initiatives at all levels.
6. To promote research and implementation of innovative evidence-based care models in Uganda.

The QI strategic objectives and interventions for the NQIF &SP 2021/25 are outlined below:

Objective 1: To strengthen leadership, accountability, and functionality of the organisational structures for QoC at all levels

Leadership drives the implementation of QI in the health sector. This objective aims to get leadership and management to provide oversight and embrace implementation of QI in the health sector. Leadership at all levels of health service delivery should catalyse the active involvement of all stakeholders, including clinicians and IPs in the implementation of QI in the national health system. There should be participatory planning, supervision, monitoring, documentation, and reporting.

There shall be capacity strengthening of human resources to drive performance of QoC activities at all levels of care. This shall be extended to address areas of attitude and behaviour change for health service providers. Performance plans and job descriptions should include roles and responsibility related to QI. In addition, pre-service curricula for tertiary institutions should be revised to include QI components.

QI structures have been reorganised to improve coordination and monitoring in high-volume health facilities. All tasks to do with QI should be aligned to fit within established QI structures as described in the previous chapter. There should be regular meetings, documentation of 5S-QI and other QI activities and reporting. Effective monitoring, support supervision, and QI coaching needs to be given priority as this will enable QI Committees to become fully functional.

Interventions and actions:

1.1 To operationalise the MoH Comprehensive Support Supervision strategy

- Build capacity of RRHs to conduct regular technical support supervision to districts.
- Provide tools for support supervision at all levels of health service delivery.

1.2 Strengthen leadership involvement in the implementation of QI at all levels of health service delivery

Health Facility and institutional managers should be involved in coordinating 5S-QI/QI activities in the health sector. This includes the following engagements:

- Chairing QI meetings and guiding/coordinating the implementation processes in the health unit/institution.
- Conducting monitoring and supervision of QI interventions taking place.
- Mobilising resources for QI interventions in health facilities/institutions.
- Appraising staff in-line with implementation of 5S-QI/QI activities.

1.3 Continuous capacity building of leadership, and management in behavioural change for QI

- • Facilitate capacity building of leadership at all levels on QI interventions through formal trainings, onsite QI coaching, workshops and Continuous Medical Education (CME). Key focus shall be attitude and behavioural change training at RRHs who will cascade to districts.
- Strengthen human performance management to include QI in staff job schedules and plans for which they can be held accountable during performance appraisals.
- Implement recognition, reward, and sanctions for 5S-QI/QI.
- Introduce pre-service QI training curriculum in universities and other tertiary training institutions.

1.4 Strengthen mobilisation and efficient utilisation of resources for implementation of QI

- Develop, use and implement QI work plans and budgets at all levels.
- Build capacity for planning and monitoring resource utilisation for QI in the health sector.

1.5 Improve the functionality of QI structures at all levels

QI committees should be supported so that they are functional by conducting the following:

- Identify established QI structures (QI Committees and WITs) at each level of health delivery and support the committees to hold regular QI meetings.
- Build capacity of QI committees to **identify and address gaps, document and report** implementation of QI interventions taking place in health facilities/ institutions. Efforts should be made to use CMEs and locally available resources for QI coaching.
- Conduct regular QI coaching, **monitoring and supervision** of the implementation of 5S-QI/QI activities at all levels of health service delivery in the national health system.

Objective 2: To improve implementation of health service standards in the health sector

This objective shall promote the recognition and implementation of health service standards at all levels as a means of improving QoC in the national health system in Uganda.

Support shall be provided for the development, awareness creation and monitoring of implementation of service standards by the different stakeholders in both private and public health facilities.

The health sector shall undertake to implement and coordinate QoC assessments of service standards in health facilities. The process shall enable the recognition of outstanding performance as well as identification of gaps for improvement in the national health system. QoC assessments shall be harmonised, regular, and focused on effective use of research findings to address identified gaps.

Clinical Mentorship will be used to support adoption and implementation of service standards. Clinical Mentorship content of care should be standardized and combined with support supervision and QI coaching.

The linkage between QoC assessment findings and 5S-QI/QI in the health sector shall have to be strengthened through data use and general improvement of QoC in health facilities. The established 5S-QI/QI structures should be involved in the assessment processes including sharing of feedback to address issues required for improved QoC in the health sector.

Effort should be made to institutionalise QoC assessments and monitoring of QoC implementation using the DHIS2 platform and performance review meetings using properly defined indicators. The digitalisation of the QoC assessment process including timely sharing of feedback for action shall be prioritized. There shall be use of standard MoH QoC assessment tools which should be digitised and accessible for more accurate and real time 5S-QI/QI data management.

Interventions and actions:

2.1 Establish a national accreditation system

- Develop relevant structures, tools, and a mechanism for accreditation of health facilities in Uganda for both public and private health facilities.

2.2 Standardize Clinical Mentorship curricula, SOPs, and tools

- Develop implementation guidelines and plans for Clinical Mentorship and mobilize domestic and partner resources for coordinated implementation across geographies.

2.3 Activate national, regional and district Clinical Mentorship teams

- Clinical mentorship teams should work in close coordination with activated QI structures to build HCW skills, which will add value to facility led QI processes.

2.4 Plan and budget for QI monitoring and evaluation, support supervision, Clinical Mentorship and QI coaching.

- Emphasize documentation and reporting to ensure all processes speak to each other

2.5 Strengthen QoC assessments in the health sector

- Coordinate and harmonise regular health facility QoC assessments.
  - The health sector should use harmonised QoC assessment tools to minimise duplication.
  - The QoC assessment tools should be standard to facilitate accurate 5S-QI/QI data collection, timely reporting, and monitoring of progress/ following-up on gaps identified after the QoC assessments are conducted.

  - Programme specific QoC assessments (Nutrition, RBF, MNCH, etc) can be conducted bi-annually to allow follow-up on issues identified.
  - To conduct annual Health Facility Assessment Programme (HFQAP) assessments for the health sector preferably in the 3rd quarter of the FY. This would allow the required information for the upcoming FY to be available during the planning period.
  - QoC assessments should be linked to 5S-QI/QI processes to address areas for improving health sector challenges.
- Conduct annual *Service Availability and Readiness Assessment* (SARA) assessments for the health sector in Uganda.
- Continuous capacity building in the implementation of service standards in the health sector.

Objective 3: To strengthen client-centred care in the health sector.

This objective aims at strengthening involvement of clients in health sector performance. There must be a clear mechanism for clients to share their views (feedback) regarding the quality of health services in the country. Client-centred care should be prioritised for both internal and external clients.

Interventions and actions:

3.1 Increase awareness on the rights, roles, and responsibilities of patients/clients and health workers through patient charters

- Translate Patient and Client Charters into local languages and disseminate widely to ensure effective use by all stakeholders.
  - **Key messages** should he displayed at strategic locations in both English and local dialect.
- Establish and implement effective feedback management plans in the health sector at all levels of health service delivery.
- Develop health worker rights and responsibility charter 2021-25.
- Sensitize clients including opinion leaders and health service providers on their rights, roles, and responsibilities in health care.

3.2 Strengthen governance and client engagement in the functionality of health facility management structures in the health sector

- Coordinate availability of health facility governance structure (BOGs/HUMCs) guidelines in all health facilities.
- Print, disseminate and ensure effective utilisation of the governance structure (BOGs/HUMCs) guidelines at all levels of health service delivery.
- Strengthen implementation of the governance structure guidelines in all health facilities.
  - Coordinate the induction and orientation of members of governance structures.
  - Conduct regular monitoring of functionality of the BOGs/HUMCs at all levels. There should be regular tracking of functionality of the governance structures in the heath sector.
  - Conduct regular support supervision of health facilities of BOGs/HUMCs.

3.3 Assess level of client satisfaction in the health sector

- Coordinate regular client satisfaction assessments (exist interviews) at all levels of health service delivery.
- Conduct the annual client satisfaction survey for the health sector.
- Disseminate client satisfaction survey reports and link the findings to 5S-QI/QI.

Objective 4: To improve patients and health worker safety in all health care practices

This objective seeks to promote both patient and health worker safety through improving the working environment. MoH shall focus on promoting implementation of occupational safety practices by availing the necessary policy regulations and guidelines, and upholding the health worker protection charter.

Interventions and actions:

4.1 Improve infection prevention and control (IPC) mechanisms in the health sector

- Coordinate review, dissemination and effective use of the IPC **strategy** at all levels of health service delivery.
- Coordinate review, dissemination and effective use of the IPC **guidelines** at all levels of health service delivery.

4.2 Strengthen and promote patient safety practices

- Coordinate the development, dissemination and effective use of Patients and Health-workers safety guidelines and SOPs.

- Strengthen capacity building in the implementation of Patients and Health-workers safety guidelines.

Objective 5: To strengthen QI Monitoring and Evaluation in the health sector

This objective aims to strengthen QI data use including documentation, analysis, and reporting of 5S-QI/QI interventions at all levels of health service delivery. The 5S-QI/QI structures at each level of health service delivery are expected to generate a QI data base that should be used routinely for evidence-based decision making to improve QoC in the health sector.

The QI structures should be used to share data and knowledge through proven means such as regular meetings, QI learning sessions, peer-to-peer exchange visits, and knowledge management portal.

Interventions and action:

5.1 Develop QI database at each level of health service delivery

- Strengthen capacity building for the development of a **QI data base** which would involve data documentation and proper record keeping at all levels of health service delivery.
- Strengthen **use of QI data** and best practices at each level of health service delivery.
- Strengthen regular compiling and submission of QI implementation reports at all levels of service delivery in the health sector.
- Conduct regular supervision, mentorship, and coaching on data management at the facility level.

5.2 Strengthen capacity for monitoring and evaluation mechanism for implementation QI intervention in the health sector

- Coordinate the development and dissemination of QI M&E tools which would include:
  - M&E tools for documentation, data analysis, and reporting
  - QI M&E dashboards at all levels of service delivery
- Strengthen regular QI performance review meetings at all levels of health service delivery in the country. These shall include the **National QI Conferences, Learning Sessions,** and **harvest meetings**.
- Conduct mid and end-of-term review of implementation of the QIF & SP 2020/21 to 2024/25.

Objective 6: To promote research and innovations and use of evidence-based care models in the health sector

This objective will promote QI research and the use of proven innovative models to inform policy in the health sector.

6.1 Promote QI research

- Develop a QI research agenda for the health sector.
- Promote implementation of operational QI research.
- Document and publish QI research findings.
- Build capacity of operational QI research at all levels of service delivery.
- Mobilise resources for QI research.

CHAPTER 6:

Monitoring and evaluation of the implementation of QIF & SP

Monitoring and evaluation of the implementation of the QIF & SP 2020/21-25 shall involve all the key stakeholders in the national health system. There shall be emphasis on implementation processes and outcomes for the various QI interventions. The culture of documentation, data collection, analysis, and dissemination for informed decision making shall be promoted at all levels of health service delivery. The development of a robust QI database by care level shall be undertaken to facilitate the use of QoC data in the health sector. Indicators collected in HMIS primary registers and reporting forms, and those reported in DHIS2 shall continue to be used in assessing progress.

The QI committees should hold regular meetings, review and ensure proper documentation of all processes included in the activity reports regarding QI implementation. An elaborate reporting system is required from the lowest functional unit for QI intervention to the national level including the National Steering Committee at the MoH.

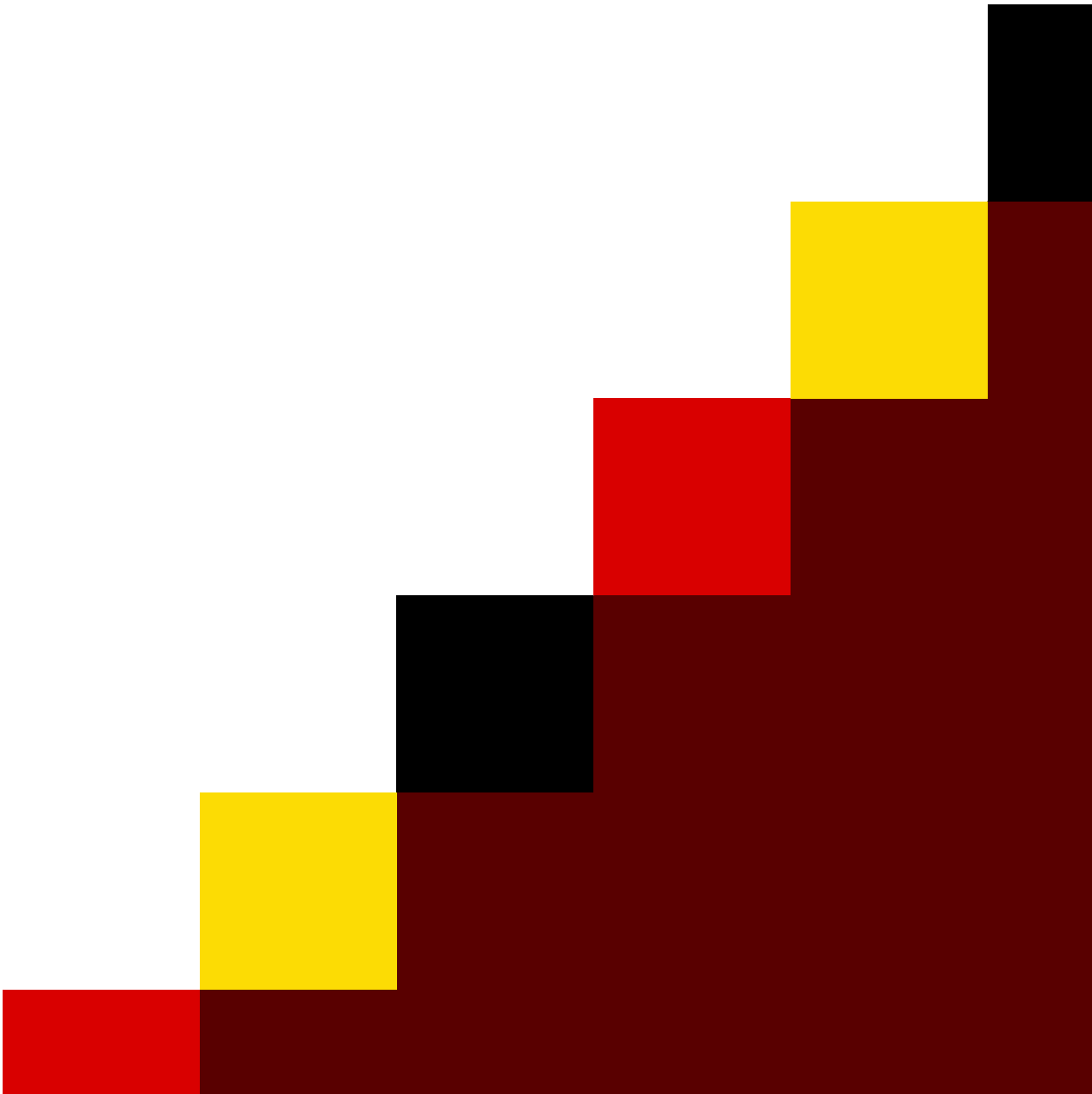
Other key sources of QI M&E data shall include: monitoring, supervision/coaching, learning sessions, and performance review meeting reports, as well as-health facility QoC assessments such as HFQAP, RBF, SARA, skills development, exit interviews, and other forms of research in the national health system.

MoH shall promote digitalisation of QI data and subsequent linkage to DHIS2. The QI tools shall be up-to-date and made available throughout the national health system. The Key Performance Indicators selected to monitor progress in implementation of QIF & SP are attached in table 2 appendices.

The mid-term 2022/23 and end-of-term 2024/25 evaluation of implementation of HS QIF & SP shall take place to assess the extent of implementation of the strategy and to evaluate performance against targets.

CHAPTER 7:

Recognition, reward and sanctions



Supervision strategy, the public service rewards and sanctions framework shall provide appropriate criteria for recognition and rewards by level of implementation of 5S-QI/QI interventions in the health sector. Good performance by institutions or individuals should be recognised while unsatisfactory performance is identified and supported to ensure improvement. Both non-monetary and monetary incentives (in cases where RBF is being implemented) shall be considered to reward good performance for individuals and institutions. Sanctioning for disciplinary action should be considered in extreme circumstances of failure to comply to the expected key deliverables in health service delivery. To note, increased attention on incentivized services could result in decreased performance in non-incentivized services. RBF should be closely monitored to mitigate against these and other unintended consequences.

Institutions are expected to plan and allocate a budget/resources for incentives for professional performance recognition and reward. Agreed on criteria shall be developed based on existing Public Service provisions.

Key QI Performance Monitoring Indicators:

1. **To strengthen leadership, accountability, and functionality of the organisational structures for QoC at all levels**
    - Number of MoH/RRH/District quarterly support supervision visits conducted
    - Percentage of RRHs management teams with training in leadership, management, and behavioral change
    - Percentage of RRHs functional QI Committees
    - Percentage of Districts functional QI Committees
2. **To improve implementation of health service standards in the health sector**
    - Percentage of RRHs with HFQAP score assessment of Star 3
    - Health Facility Assessment Programme (HFQAP) survey index
    - Percentage 5S M&E score assessment for the RRHs
    - Service Availability and Readiness Assessment (SARA) survey index
3. **To strengthen client-centred care in the health sector.**
    - Percentage of RRHs with effective feedback mechanism
    - Annual client satisfaction survey index
4. **To improve patients and health worker safety in all health care practices**
    - Patient Safety guidelines developed
5. **To strengthen QI Monitoring and Evaluation in the health sector**
    - Percentage of RRHs with a QI data base
    - Annual National QI Conference conducted
    - Ongoing and completed national QI collaboratives
6. **To promote research and innovations and use of evidence-based care models in the health sector**
    - Research agenda developed

Budget estimate:

Strategic Objective and Interventions	Costs in 5 years (in million UG. SHS)					
	2021	2022	2023	2024	2025	Total
Objective 1: To strengthen leadership, accountability and functionality of the organisational structures for QoC at all levels	1,830	1,830	1,830	1,830	1,830	**9,150**
Objective 2: To improve implementation of health service standards in the health sector	5,650	5,650	5,650	5,650	5,650	**28,250**
Objective 3: To strengthen client-centred care in the health sector.	382	382	382	382	382	**1,910**
Objective 4: To improve patients and health worker safety in all health care practices.			250	100	100	**450**
Objective 5: To strengthen QI Monitoring and Evaluation in the health sector	2,160	2,160	2,160	2,160	2,160	**10,800**
Objective 6: To promote research and innovations and use of evidence-based care models in the health sector	45	45	30	30	30	**180**
Grand Total						**50,740**

CHAPTER 8:

Appendices

Table 1: Cost of Implementing the QIF &SP

Summary of the cost estimates for interventions and actions of Quality Improvement Framework & Strategic Plan 2020 – 2024. To note, the below excludes costs of Clinical Mentorship; implementation guidelines for Clinical Mentorship should be developed and costed separately.

Strategic Objective and Interventions	Costs in 5 years (in million UG. SHS)					
	2021	2022	2023	2024	2025	Total
Objective 1: To strengthen leadership, accountability and functionality of the organisational structures for QoC at all levels						
1.1 To operationalise the MoH Comprehensive support supervision strategy	1,200	1,200	1,200	1,200	1,200	6,000
1.2 Continuous capacity building in leadership, management and behavioural change for QI intervention (RHHs to districts)	400	400	200	200	200	1,400
1.3 Monitoring and supervision/coaching for implementation of QI	350	350	350	350	350	1,750
Objective 2: To improve implementation of health service standards in the health sector						
2.1 Conduct annual National Health Facility Assessment Programme-HFQAP	450	450	450	450	450	2,250
2.2 Conduct bi-annual HFQAP (by each district)	4,050	4,050	4,050	4,050	4,050	20,250
2.3 Conduct annual Service Availability and Readiness Assessment (SARA)	400	400	400	400	400	2,000
2.4 Print and binding MoH Health Service Standards and QI guidelines	450	450	450	450	450	2,250
2.5 Regional dissemination of the MoH Health Service Standards and guidelines	300	300	300	300	300	1,500
Objective 3: To strengthen client-centred care in the health sector.						
3.1 Review, translate, print, and disseminate Client Charters for the Regional Referral Hospitals	45	45	30	30	30	180
3.2 Develop, print, and disseminate health service-provider (health-worker) rights and responsibility charter	150	45	45	45	45	330
3.3 To print, disseminate, and ensure effective utilisation of the governance structure (BOGs/ HUMCs) guidelines at all levels of health service delivery	200	200	200	200	200	1,000
3.4 Establish National Accreditation System			400			400
Objective 4: To improve patients and health worker safety in all health care practices.						
4.1 Patient Safety guidelines developed and disseminated at all levels of health service delivery			250	100	100	450

Strategic Objective and Interventions	Costs in 5 years (in million UG. SHS)					
	2021	2022	2023	2024	2025	Total
Objective 5: To strengthen QI Monitoring and Evaluation in the health sector						
5.1 Develop QI data base at each level of health service delivery	250	250	250	250	250	1,250
5.2 Improve capacity for monitoring and evaluation mechanism for implementation QI intervention in the health sector	200	200	200	200	200	1,000
5.3 Conduct mid and end of term review of implementation of the N-QIF & SP 2020/21 to 2024/25			150		150	300
5.4 Print and disseminate QI M&E tools	150	150	150	150	150	750
5.5 Coordinate performance review meetings (Learning sessions; QI performance reviews; National QI Conference.)	1,500	1,500	1,500	1,500	1,500	7,500
Objective 6: To promote research and innovations and use of evidence-based care models in the health sector						
6.1 Develop research agenda	45	45	30	30	30	180
Grand Total						**50,740**

Table 2: QI Key Performance indicators for monitoring progress in implementation of QIF& SP

Strategic Objective and Key Performance Indicators (KPIs)	Period/ by who	Data Source	Baseline	Targets for 2021-2025				
			2020	2021	2022	2023	2024	2025
1. To strengthen leadership, accountability, and functionality of the organisational structures for QoC at all levels								
Number of MoH/RRH/District quarterly support supervision visits conducted	Quarterly/ M&E Unit	DHIS-2	4	4	4	4	4	4
Percentage of districts receiving quarterly technical support supervision	Quarterly/ M&E Unit	DHIS-2	75%	80%	90%	100%	100%	100%
Percentage of RRHs submitting quarterly support supervision reports to MoH	Quarterly/ M&E Unit	DHIS-2	N/A	100%	100%	100%	100%	100%
Percentage of RRHs Management Teams with training in leadership, management, and behavioral change	Quarterly/ M&E Unit	QI database	0	25%	75%	100%	100%	100%
Percentage of functional Regional QI Committees (Functional: meeting quarterly/submitting reports to MoH)	Quarterly/ M&E Unit	DHIS-2	TBD	25%	50%	75%	100%	100%
Percentage of functional Districts QI Committees (Functional: meeting quarterly/submitting reports to the RRH)	Quarterly/ M&E Unit	DHIS-2	TBD	20%	40%	60%	75%	80%
2. To improve implementation of health service standards in the health sector								
Percentage of RRHs scoring Star 3 and above in the Health Facility quality of care assessment (HFQAP)	Quarterly/ M&E Unit	DHIS-2	TBD	30%	40%	50%	60%	70%
Percentage of RRHs undertaking annual HFQAP	M&E Unit SCAPP	TBD	50%	75%	100%	100%	100%	100%
Percentage of HFs with score Star 3 and above in HFQAP	Quarterly/ M&E Unit	DHIS-2	TBD	20%	30%	40%	50%	60%
Percentage of districts undertaking at least HFQAP annually	M&E Unit SCAPP	TBD	30%	40%	50%	60%	70%	75%
Annual Health Facility Assessment Programme (HFQAP) conducted	Annual/ M&E Unit	Annual Survey	1	1	1	1	1	1
Health Facility Assessment Programme (HFQAP) survey index	Annual/ M&E Unit	DHIS-2	TBD	35%	40%	45%	50%	55%
Percentage 5S score for the RRHs	Quarterly/ M&E Unit	DHIS-2	60%	65%	70%	75%	80%	85%
Annual Service Availability and Readiness Assessment (SARA) conducted	Annual/ M&E Unit	Annual Survey	1	1	1	1	1	1
Service Availability and Readiness Assessment (SARA) survey index	Annual/ M&E Unit	Annual Survey	52	53	56	58	60	62
Establishment of a national accreditation system	Calendar Year / M&E Unit	Supervision reports				X		

Strategic Objective and Key Performance Indicators (KPIs)	Period/ by who	Data Source	Baseline	Targets for 2021-2025				
			2020	2021	2022	2023	2024	2025
3. To strengthen client-centered care in the health sector.								
Number of RRHs with Client Charter with key messages translated into local language	Quarterly/ M&E Unit	Supervision reports	TBD	4	7	14	16	16
Percentage of RRHs Boards that fully constituted and inducted	Quarterly/ M&E Unit	Supervision reports	N/A	30%	50%	75%	100%	100%
Percentage of RRHs Boards are functional (Functional: meeting quarterly; with minutes; brief to the Hon. MOH)	Quarterly/ M&E Unit	Supervision reports	N/A	0%	40%	60%	80%	90%
Percentage of National Referral Hospital Boards that fully constituted and inducted	Quarterly/ M&E Unit	Supervision reports	N/A	30%	50%	75%	100%	100%
Percentage of National Referral Hospital Boards that are functional (Functional: meeting quarterly; with minutes; brief to the Hon. MOH)	Quarterly/ M&E Unit	Supervision reports	N/A	25%	80%	100%	100%	100%
Percentage of National Level Specialised Institution (UHI, UCI, UVRI, NMS, HSC; Entebbe Children Surgical Hospital) Boards that fully constituted and inducted	Quarterly/ M&E Unit	Supervision reports	N/A	50%	80%	100%	100%	100%
Percentage of National Level Specialised Institution (UHI, UCI, UVRI, NMS, HSC; Entebbe Children Surgical Paediatric) Boards that are functional (Functional: meeting quarterly; with minutes; brief to the Hon. MOH)	Quarterly/ M&E Unit	Supervision reports	N/A	0%	40%	60%	80%	90%
Percentage of RRHs conducting client satisfaction exist interviews	Quarterly/ M&E Unit	Supervision reports	N/A	25%	50%	80%	100%	100%
Health service provider guidelines developed	Calendar Year / M&E Unit	Supervision reports			X			
Annual Client Satisfaction survey index	Annual/ M&E Unit	Annual Survey	25.6	30	40	50	55	60
4. To improve patients and health worker safety in all health care service delivery units								
Patient Safety guidelines developed	Calendar Year / M&E Unit	Supervision reports			X			

Strategic Objective and Key Performance Indicators (KPIs)	Period/ by who	Data Source	Baseline	Targets for 2021-2025				
			2020	2021	2022	2023	2024	2025
5. To strengthen QI Monitoring and Evaluation in the health sector								
Percentage of RRHs with a QI data base	Calendar Year / M&E Unit	Supervision reports	N/A	50%	100%	100%	100%	100%
Annual National QI Conference conducted	Calendar Year / M&E Unit	Activity report	1	1	1	1	1	1
Mid of Term evaluation of N QIF conducted	Calendar Year / M&E Unit	Activity report				X		
End of Term evaluation of N QIF conducted	Calendar Year / M&E Unit	Activity report						X
6. To promote research and innovations and use of evidence-based care models in the health sector								
Research agenda for the MoH developed	Calendar Year / M&E Unit	Activity report	N/A		X			

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