



THE REPUBLIC OF UGANDA

**HEALTH SECTOR
QUALITY IMPROVEMENT
FRAMEWORK AND STRATEGIC PLAN
2015/16 – 2019/20**

*Improving the value of healthcare in Uganda
with proven interventions, implemented with quality methods.
“Our care saves” and “Spend to save”*

June 2016

TABLE OF CONTENTS

TABLE OF CONTENTS.....	ii
FIGURES.....	iv
TABLES.....	iv
FOREWORD.....	v
ACKNOWLEDGEMENTS.....	vi
EXECUTIVE SUMMARY.....	vii
ACRONYMS.....	Error! Bookmark not defined.
OPERATIONAL DEFINITIONS.....	Error! Bookmark not defined.
1 Introduction.....	1
1.1 Background.....	1
1.2 Review and Development Process.....	3
1.3 Situation Analysis.....	3
2 The Health Sector QIF and Strategic Plan (QIF&SP).....	9
2.1 Target Audience.....	9
2.2 Goal and Objectives.....	9
3 Methodologies and Steps for QI Implementation in Uganda.....	13
3.1 Methodologies for QI in Uganda.....	13
3.2 Steps for Introduction of QI in a facility.....	13
3.3 Steps for QI Project implementation.....	14
4 Organizational Structure.....	15
4.1 Governance, Partnership and Management for QI.....	15
4.2 QI Roles and Responsibilities.....	16
4.3 The National QI Coordination Structure.....	19
5 Monitoring and Evaluation of QI.....	25
5.1 Importance of M&E.....	25
5.2 QI Assessment Methods and Tools.....	25
5.3 Sources of Data.....	26

5.4	Quality Assessment Indicators	26
5.5	Data Management for QI.....	28
5.6	Performance Incentives, Recognition and Reward	29
5.7	M&E Activities	30
5.8	Evaluation	31
6	Evidence Generation	32
7	Sustainability of the QI Program in Uganda.....	32
8	Five Year QI Strategic Plan 2015/16 – 2019/20 Operational Matrix	34
9	Costing of the Strategic Plan.....	41
10	References	45
11	Annex	i
11.1	QI Indicators.....	i



FIGURES

<i>Figure 1: How QI integrates Content of Care and the Process of Providing Care.....</i>	<i>2</i>
<i>Figure 2: Trends in Health Systems Performance Indicators</i>	<i>4</i>
<i>Figure 3: Households' rating of public health facilities</i>	<i>4</i>
<i>Figure 4: Stakeholder Roles in QI.....</i>	<i>16</i>
<i>Figure 5: National QI Coordination Structure</i>	<i>19</i>

TABLES

<i>Table 1: SWOT Analysis of the Implementation of the QIF & SP 2010/11 – 14/15.....</i>	<i>5</i>
<i>Table 2: Budget Summary.....</i>	<i>41</i>
<i>Table 3: Annualized costing of the QI Strategic Plan</i>	<i>41</i>


FOREWORD

The Health Sector Development Plan 2015/16 - 2019/20 aims at accelerating movement towards Universal Health Coverage with essential health and related services needed for promotion of a healthy and productive life'. To ensure provision of high quality health services and contribute to the attainment of good quality of life and well-being at all levels of health care in Uganda, during the next five years, the Ministry of Health has revised the Health Sector Quality Improvement Framework and Strategic Plan (QIF & SP) 2010/11 - 2014/15. This is to provide a common framework for all public and private health institutions including the policy makers, managers, health service providers, partners, health consumers and other stakeholders to coordinate, plan, mobilize resources, implement, monitor and evaluate quality improvement initiatives in Uganda.

The Health Sector QIF & SP 2015/16 - 2019/20 has been largely informed by lessons learnt during the implementation of the previous plan and recommendations from an Evaluation of the Uganda Health Sector QIF & SP 2010/11 - 2014/15. This time round the framework emphasizes the responsibilities of line management at all levels of healthcare, supported by quality specialist staff, to protect the public from harmful care, and to reduce waste from ineffectual care and inefficient organization and inappropriate deployment of resources. Financial arrangements need to ensure those who achieve savings share in the gains. All stakeholders are encouraged to make use of it to ensure responsiveness, transparency and accountability for service delivery.

I wish to express my appreciation to all who participated in the development of the QIF & SP 2015/16 - 2019/20 with special appreciation to the Ministry of Health Quality Assurance Department for taking the lead and the USAID ASSIST Project who supported the evaluation and review process. I look forward to successful implementation the National QIF & SP 2015/16 - 2019/20 towards attainment of our national and international health goals.

For God and My Country



Hon. Dr. Jane Ruth Aceng
Minister of Health

ACKNOWLEDGEMENTS

The Health Sector QIF&SP 2016-2020 is a follow on guiding document from the National QIF&SP 2005-2010 document to policy makers, planners, program managers, programs and projects implementers, Development Partners (DPs), health service providers, partners in public and private sectors, CSOs, and Health Consumers with a goal of ensuring that all people in Uganda have access to quality healthcare services by 2020 which involves the provision of accessible and equitable services with optimal professional performance, taking into account the available resources and achieving consumer acceptability and satisfaction. The process of developing this framework was highly participatory involving key stakeholders and interest groups in a consultative manner covering a wide range of stakeholders at national and sub-national levels including consumers and providers in private and public sectors. This product was made possible through the invaluable discussions and contributions of resource persons with diverse expertise and experience in service provision, policy formulation and technical experience in provision of quality improvement services. To the individuals who contributed, a million thanks for your selflessness and dedication in the development of this framework. We would also like to thank all the health workers and other services providers who participated in the evaluation of the previous framework. Your contribution was instrumental in making this new framework what it is now. The contributions of everybody right from the inception meeting, consensus building meeting, and retreat workshop of stakeholders to review the draft framework is highly appreciated.

We extend our deep gratitude to USAID ASSIST for funding the entire work through the MoH QAD from evaluation of the ending framework by hiring a consultant and supporting the development of the new framework. Special appreciation is also extended to various Institutions/Organizations whose representatives provided technical expertise, guidance, and general contributions that have resulted in successful production of this framework. Specifically we wish to thank the following people who contributed tirelessly and sacrificially in the process of developing this framework.



Prof. Anthony Mbonye
Ag. Director General Health Services

EXECUTIVE SUMMARY

The health sector aims to provide services of an acceptable level of quality, to ensure the clients are able to maximize the health benefits from available care. Good quality of care will enhance clients' satisfaction and their use of services. It will also increase job satisfaction and motivation among service providers, leading to effective and efficient utilization of resources.

Evaluation of the Health Sector QIF & SP 2010/11 - 14/15 showed progress in QI implementation compared to the findings in the HIV/AIDS Quality of Care Program evaluation conducted in 2010. The main recommendations for this strategy were that the strategy emphasizes line manager's accountability for quality and how they can start and manage quality projects to help achieve their objectives, with examples of practical safety improvement and waste reduction; and prioritizes safety improvement priorities.

The target audience for the QIF&SP include: policy makers, planners, program managers, programs and projects implementers, Development Partners (DPs), health service providers, partners in public and private sectors, CSOs, and Health Consumers.

The goal of this plan is to ensure that all people in Uganda have access to quality healthcare services by 2020. This involves the provision of accessible and equitable services with optimal professional performance, taking into account the available resources and achieving consumer acceptability and satisfaction. The strategic objectives are;

1. To strengthen leadership capacity and support for QI throughout the health sector.
2. To strengthen the framework for documentation, reporting and sharing of QI processes and activities at all levels.
3. To strengthen patient / client centered care (patient and population involvement) in health care at all levels.
4. To improve compliance of all health facilities to the health sector service delivery standards.
5. To strengthen organizational capacity for QI implementation in the health sector.
6. To promote implementation of innovative and evidence based models of care in Uganda.

Operationalisation of the QIF&SP will be through implementation of selected priority interventions under the 6 strategic objectives.

In Uganda, districts and partners involved in QI shall implement evidence based targeted QI models and interventions which apply the principle of an interative cycle of improvement (Plan, DO, Study, Act (PDSA) Cycle). The MoH recommends initiation of QI interventions in health facilities to start with 5S as a fundamental background to CQI and then introduce appropriate QI interventions. QI efforts should be towards enabling the staff to be more active and effective, and an emphasis on safety, waste-reduction, and return on investment. Thus, 5S should be taken as Phase 1: protection from harmful care and releasing resources from easy waste-reduction which is quantified to show the value of QI, and where savings can be shared with those who made them. CQI is Phase 2: aiming at more use of effective and proven practices, treatments, service delivery models and health promotion strategies, adapted for

Uganda using QI testing and suitable research from different organizations. Phase 3 is Total Quality Management where the culture of quality is institutionalized. The MoH developed the QI Methods: A Manual for Health Workers in Uganda and this will provide health workers with detailed information on QI concepts and methods, and define the QI tools for implementation of QI in Uganda.

It is important that the implementation of QI programs and interventions utilizes the existing structures and systems of government. This will minimize utilization of resources and ensure that QI issues are mainstreamed and integrated within the health system. Health managers at all levels have the duty to protect the public from harmful practices that the public may not know about, and to reduce waste from ineffective care and inefficient organization and inappropriate deployment of resources. Health managers should therefore take leadership in managing quality and be held accountable for the care outcomes. The community / households & individuals are beneficiaries of health service delivery but also have a critical role to play in ensuring quality of services. Their roles and responsibilities are elaborated in the MoH Patient Charter, 2010.

Monitoring and Evaluation (M&E) is an integral component of QI in health services. The methods of data collection will be a combination of quantitative and qualitative methods. As far as possible, standardized data collection tools and techniques will be used. Data for monitoring quality may be from the routine or periodic data that we collect in the facilities and in the communities. The data needs for QI intervention assessment shall be based on agreed performance indicators (QI framework and program specific) to facilitate M&E, reporting and decision-making for specific interventions. Client satisfaction surveys will be carried out at all levels of service delivery to determine the quality of services offered in the client perspective. The MoH will also roll out the Health Facility Quality of Care Assessment Program whereby all health facilities will be assessed annually. This will provide information on the quality of care and the general functionality of both the public and private health facilities in Uganda and use it for CQI.

The M&E of the QIF&SP implementation process will measure the extent to which the set goal and strategic objectives have been attained and guide adjustments in the proposed strategies or implementation modalities.

Integration of the QI activities and budgets into the district and facility workplans with government funding is necessary for sustaining the quality infrastructure and quality activities within government and other services after particular donor projects and programs have finished.

The total budget estimate for the 5years is UGX 24,152.5 million. Funding for the QI activities will be mainly from the respective programs, departments or institutions implementing QI and this should be integrated in their annual budgets.

1 Introduction

1.1 Background

The Health Sector Development Plan (HSDP) 2015/16 - 2019/20 is the second in a series of six 5-year Plans aimed at achieving Uganda Vision 2040 of a healthy and productive population that contributes to socioeconomic growth and national development. The goal of this Plan is to accelerate movement towards Universal Health Coverage (UHC) with essential health and related services needed for promotion of a healthy and productive life. UHC makes it possible to ensure that all people receive essential and good quality health services they need without suffering financial hardship (MoH, HSDP 2015). Globally, there is consensus on the need for UHC to be a flagship for health in the context of sustainable development in the post-2015 agenda.

The first strategic objective of the HSDP 2015/16-2019/20 is “contributing to the production of a healthy human capital for wealth creation through provision of equitable, safe and sustainable health services”. The fourth strategic objective is “enhancing health sector competitiveness in the region and globally”. The aforementioned objectives inherently stress the need for improvement of the quality of health services if the HSDP goal and objectives are to be realized.

The overall quality objectives of the health sector are to;

1. Improve the client/patient perception of the health services
2. Improve patient safety
3. Improve health worker occupational health and safety
4. Provide logical, effective and efficient documentation for the QMS processes and activities
5. Comply with the health sector service delivery standards
6. Reduce cost of health care through waste
7. Have services provided by qualified health workers

(The QI Methods: A Manual for Health Workers in Uganda, MoH 2015)

The health sector aims to provide services of an acceptable level of quality, to ensure the clients are able to maximize the health benefits from available care. Good quality of care will enhance clients' satisfaction and their use of services. It will also increase job satisfaction and motivation among service providers, leading to effective and efficient utilization of resources.

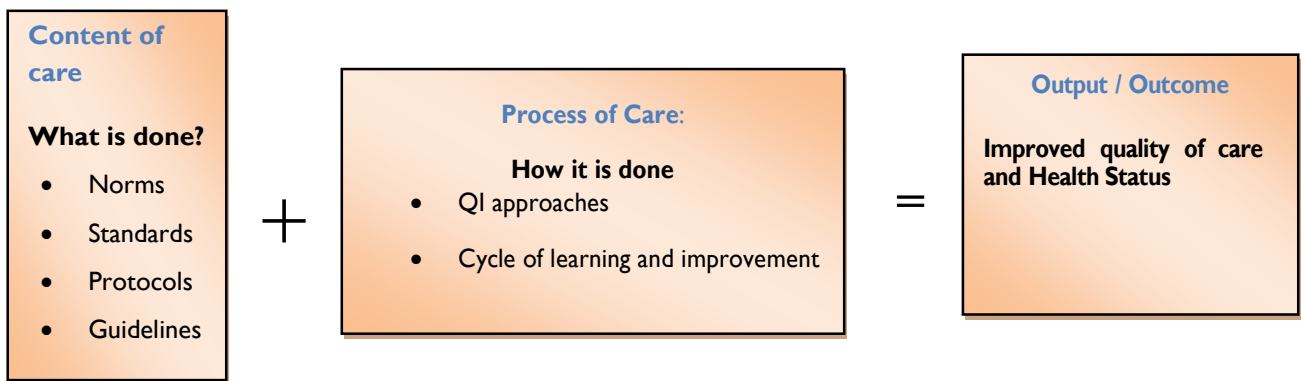
The health system should seek to make improvements in all dimensions of quality which include;

- i) **Safety:** harm-free healthcare and the degree to which patients are protected from risks of harm which may be produced by clinical practice or other aspects of healthcare, and the activities carried out to prevent and reduce risks.
- ii) **Effectiveness:** delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need;

- iii) **Efficiency:** delivering health care in a manner which maximizes resource use and avoids waste;
- iv) **Access:** delivering health care that is timely, geographically reasonable and provided in a setting where skills and resources are appropriate to need;
- v) **Equity:** delivering health care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status;
- vi) **Technical competence:** Health workers have the knowledge, skills, attitudes and behavior which a health worker needs to have in order to do a good job.
- vii) **Patient and family centered care:** delivering health care which ensures that decisions respect patients and families wants, needs, and preferences and patients have the education and support they require to make decisions and participate in their own care".
- viii) **Continuity:** the ability of the health service to initiate and complete a program of care to individuals and communities.
- ix) **Interpersonal relationships:** the working relations between health care workers, managers, patients and the community.
- x) **Choice:** an individual's opportunity and autonomy to perform an action selected from at least two available options, unconstrained by external parties.

The framework for improving quality of care in Uganda will be based on the framework for improving clinical quality adapted from (P.B Batalden and P.K Stolz, 1993), Figure 1. In this framework improvement looks at two major components: what is done (content) and how it is done (process of care). Either component could lead to improvement, but the most powerful impact occurs by addressing both simultaneously. This framework requires evidence-based norms, standards, protocols, and guidelines to be in place and these are used to identify gaps and measure performance improvement. The QI initiatives adopted by the MoH shall operate within this framework.

Figure 1: How QI integrates Content of Care and the Process of Providing Care



1.2 Review and Development Process

The development of this QIF & SP was highly participatory with involvement of various stakeholders and QI experts locally and internationally. A Taskforce was constituted to undertake the coordination and secretarial role of the entire process. These included: service providers, program managers, Development Partners (DPs), Civil Society Organization (CSO) representatives, academia, QI Implementing Partners (IPs) and Health Consumer representatives, among others.

The review process was initiated by the MoH Quality Assurance Department (QAD) with an independent evaluation of the implementation of the QIF & SP 2010/11 - 2014/15. The evaluation was supported by the USAID - ASSIST Project - Uganda, which engaged an International QI Expert. The evaluation drew on reports, documents and data, some collected in a field visit in August 2015. The recommendations of this evaluation were reviewed and guided the review and development process of this QIF & SP.

A series of meetings and workshops were held by the QIF Task Force and the drafts presented to the Supervision, Monitoring, Evaluation & Research Technical Working Group (SME&R TWG) and National QI Coordination Committee (NQICC) for input. A final stakeholders meeting was held to incorporate input and generate consensus on the framework and strategic plan. The final draft was presented to the MoH Senior Management Committee and finally to Health Policy Advisory Committee (HPAC) for endorsement.

1.3 Situation Analysis

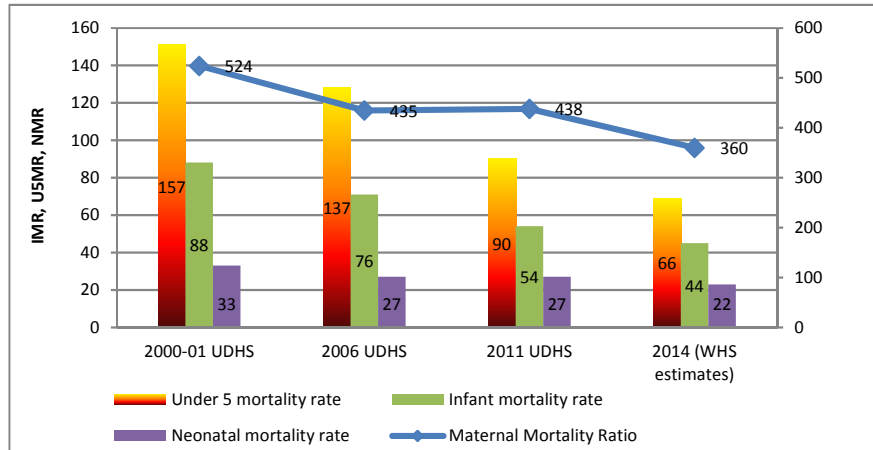
Since 2010, Uganda has made some progress towards the Millennium Development Goals (MDGs). There has been major progress in the delivery of health services, including dramatic improvements in medicines availability resulting from strengthened supply chain management by the National Medical Stores and Government's medicine grant to private not-for-profit (PNFP) providers. Access to affordable essential medicines through public health facilities and treatment for HIV/AIDS for those who need it has also improved significantly. The training and recruitment of additional health workers has facilitated the delivery of maternal health interventions, with skilled attendance at birth improving significantly over recent years.

Improvements in child health outcomes have recently registered a marked acceleration, with the under-five mortality rate falling by 34% between 2006 and 2011 (Figure 2). Despite significant improvements in skilled assistance at delivery, maternal mortality remains a big challenge with many deaths occurring more than a day after the birth. Improving health coverage without improve the overall quality will not led to UHC goals.

Past gains in the fight against HIV/AIDS have not been sustained, with a disturbing recent increase in new infections. This slow progress is primarily because health care interventions that are known to save lives

are not being implemented for every patient every time they are needed. A gap exists between what is known to work and improve health care quality and safety and what is being practiced routinely (MoH, 2011).

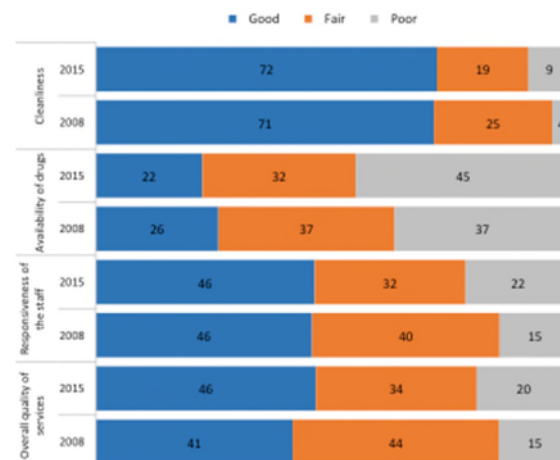
Figure 2: Trends in Health Systems Performance Indicators



Community surveys and media reports indicate that the quality of services in public sector in Uganda leaves a lot to be desired. (1) Ugandans do not receive the services they need in terms of missed opportunities, leading to waste and inefficiency; delayed care leading to dissatisfaction and ineffective services or systems; (2) Ugandans receiving services they do not need; (3) Ugandans are harmed by the services they receive e.g. medical errors generate additional costs and waste, leading to inefficiency and dissatisfaction; (4) There is a growing number of consumer bodies which campaign for rights of individuals or groups. Consequently this has increased public awareness of their rights to quality health care.

Figure 3: Households' rating of public health facilities

The Ministry of Public Service in collaboration with the Uganda Bureau of Statistics undertook a National Service Delivery Survey (NSDS) in 2015 to get feedback on government programs. The NSDS report indicated that there was an increase from 41% in 2008 to 46% in 2015 of households that rated the overall quality of services at Government health facilities as good.



In improvement activities focus should be first in “do no harm”, then on increasing effectiveness using proven treatments and service models. Some Ugandan clinical practice and healthcare is likely to be harming patients, often without staff not knowing as there is little training on patient safety. At the same

time, harmful and ineffective practices and other quality deficiencies could be wasting up to 40% of the health budget, although the cost of solving this needs to be considered.

One example is from the 2013 assessment of 400 HC IIIs and IIs (with no doctors, MoH 2013), which reported,

- 40% inaccurate diagnosis for tuberculosis; diabetes; malaria with anemia; acute diarrhea; pneumonia in children. For these, 50% of patients did not get guideline recommended care
- 80% maternal / neonatal complications not correctly managed
- 50% availability of medications

The challenges can be overcome through concerted action of key stakeholders and the application of scientifically grounded management methods to enable the reliable implementation of high-impact interventions for every patient every time needed. The clinical application of Continuous Quality Improvement (CQI) is needed so as to improve outcomes of care while reducing costs.

Evaluation of the Health Sector QIF & SP 2010/11 - 14/15 showed progress in QI implementation during its implementation period as highlighted Table 1. According to the QIF evaluation, the most important missing items were safety, waste reduction, attention to selecting and managing projects for return on investment, and initial recommendations. Missing also were plans for full integration into line management, with line managers accountable for quality, supported by quality specialists, in the same way that managers are accountable for budgets, supported by finance personnel.

The main recommendations for this strategy were that;

1. The strategy emphasizes line manager's accountability for quality and how they can start and manage quality projects to help achieve their objectives, with examples of practical safety improvement and waste reduction, implemented through short relevant training with manuals, materials.
2. The strategy prioritizes safety improvement priorities where we expect: a) likely widespread harm, b) simple cost effective solutions, c) solutions can be implemented at low cost in settings where they need to be implemented, d) low cost data to give good enough indications of progress.
Possible examples: i) wash hands to reduce infections in specific areas where infection rates are high, ii) using volunteers with small incentives to improve cleanliness and hygiene in these areas, iii) improving diagnosis and prescribing in specific subjects (e.g. malaria testing before prescribing, reducing overuse of antibiotics), iv) reducing waste in supplies and time in records/registers by simple QI (including 5S) by facility project teams and by supplies agencies, v) SBAR and read-back for safer communications, as a policy, with management leading by example (Haig et al 2006, NQF 2003).
3. Carry out both simple assessments as well as longer more systematic assessments of service harm done to patients and inappropriate medical care, to discover which issues and interventions most need prioritizing to stop harming patients and reduce waste.

Table 1: SWOT Analysis of the Implementation of the QIF & SP 2010/11 – 14/15

Strengths	Weaknesses (Challenges)
<ul style="list-style-type: none"> • There was a common framework, across government partners and programs in terms of training materials especially the 5-day course. • There was some consistency in the use of quality terms and methods. • In many cases where partners were involved, the strategy contributed to measurable improvements specific indicators of process and possibly outcome. • Additions to the human resource for QI with more staff in the QAD. • Further development was made of the regional, district and facility infrastructure for QI (at each level committees and QI focal persons were developed further). • Existence of greater general awareness about quality of service and QI • Excellent practical manuals (QI Methods: A QI Manual for Health Workers in Uganda, the Implementation Manual and tools for the Health Facility Quality of Care Assessment Program, Service Delivery Standards, Patient Centered Care Guidelines) were developed. • Functional HMIS system and Biostatisticians to provide data 	<ul style="list-style-type: none"> • Low awareness of safety problems and of waste, of how safety and waste are inherently connected, and the potential of quality methods to release time and resources. • Insufficient skills on the part of quality specialists and management to choose and implement cost-effective interventions to reduce harmful care and to know if a return on investment has been achieved. • Insufficient evidence of how widespread harmful care is, and which are the most harmful practices which can be reduced. • Political and communication challenges: in being open about likely harmful and wasteful care. • Resources from donors to date have been allocated to disease specific improvements. • Lack of a clear set of quality indicators for different levels of the health system. • Under utilization of data to define priorities, and track quality project progress.
Opportunities	Threats
<ul style="list-style-type: none"> • Wasted time and resources in many areas which could be reduced and redirected for more investment in QI. • To improve training content, and methods, and timely follow up with supervision assistance. • In-country experience applying the methods in some projects, with some evidence of results, which can be used for peer learning program, if staffs are suitably trained and supervised. • Enabling patients and citizens to take a greater role in helping QI. • Peer to peer training, if small amount of additional resources were provided. • Staff wishing to improve quality, and only needing a little support, which would return large improvements, if they can carry out projects effectively. • Young professionals interested in QI methods. 	<ul style="list-style-type: none"> • Most of the QI initiatives were disease specific mainly focusing on HIV/AIDS especially where partners were involved. • Most of the support for QI is donor support.

4. Make harmful and inappropriate practices visible through audits and patient safety studies.
5. All training to include examples of harm and of quality project interventions to increase the safety of care for those priority areas where resource-constraints still allow staff to make effective changes.
6. General management supervision by each level should be improved by assuming responsibility for checking that mechanisms are in place and functioning which provide specialist improvement supervision as well as clinical supervision, as this is necessary for the quality performance for which general management is accountable.
7. That the following three selected elements are part of future strategy to increase integration and sustainment of QI after donors projects finish, i) peer training, ii) training managers at all levels & iii) quality indicators.

8. Training is updated to be more relevant for each target group in content, learning methods, examples and tools and materials for learners to use.
9. Introduce QI methods by starting with simple methods chosen to yield fast and visible result before more complicated approaches.
10. Provide a problem-solution checklist for common problems to enable local improvers to choose the simplest tool for the problem.
11. Document regularly staff satisfaction with feedback and follow up regarding the reports they make in order to introduce more accountability for follow up.

It is against this background that the health sector needs to review and align the Health Sector Quality Improvement Framework and Strategic Plan (QIF & SP) to the HSDP and recommendations of the evaluation.



2 The Health Sector QIF and Strategic Plan (QIF&SP)

The Health sector QIF&SP has been revised in recognition that the health sector needs to put greater emphasis on safety, waste-reduction, return on investment and general line management actively leading and managing projects, training, materials, indicators and reporting adjusted to support this. The health sector aims to ensure a maximum possible level and distribution of health is achieved against the HSDP goal and targets. This will be measured using the key sector performance indicators at impact level like; maternal mortality ratio, neonatal mortality, infant mortality and under five mortality rates, in addition to other health and related services outcomes.

This section describes the QIF and strategies for improving quality of care by the health sector in Uganda. It has been developed to provide a common strategic framework for QI in Uganda during the five year period. The plan will guide all QI initiatives by all parties and at all levels in the health sector. As such, achievement of its objectives is a collective responsibility of all stakeholders and service providers.

2.1 Target Audience

The target audience for the QIF&SP include: policy makers, planners, program managers, programs and projects implementers, Development Partners (DPs), health service providers, partners in public and private sectors, CSOs, and Health Consumers.

2.2 Goal and Objectives

2.2.1 Goal

The goal of this plan is **to ensure that by 2020, all people accessing the healthcare services in Uganda attain the best possible health outcomes and improving consumer acceptability and satisfaction.** This is in line with the HSDP Goal, ***‘To accelerate movement towards Universal Health Coverage with essential health and related services needed for promotion of a healthy and productive life’.*** This involves the provision of safe, effective, efficient, accessible, equitable, and patient centered care services with optimal professional performance, taking into account the available resources and achieving consumer acceptability and satisfaction.

2.2.2 Strategic Objectives

The strategic objectives have been aligned to the six domains of QI interventions namely; leadership, information system, patient and population involvement, regulation and standards, organizational capacity, and implementing innovative and evidence based models of care.

The strategic objectives are;

- I. To strengthen leadership capacity and support for QI throughout the health sector.

2. To strengthen organizational capacity for QI implementation in the health sector.
3. To improve compliance to the health sector service delivery standards at all levels.
4. To strengthen patient / client centered care (patient and population involvement) in health care at all levels.
5. To improve patient safety practices in all health facilities.
6. To strengthen the framework for documentation, reporting and sharing of QI processes and activities at all levels.
7. To promote implementation of innovative and evidence based models of care in Uganda.

2.2.2.1 Strategic Interventions

Operationalisation of the QIF&SP will be through implementation of selected priority interventions under each of the 7 strategic objectives.

Strategic objective 1: To strengthen leadership capacity and support for QI throughout the health sector.

Interventions:

- Build commitment and leadership capacity in governance, leadership and management for QI at all levels.
- Harmonize and integrate QI approaches into all service delivery areas and at all levels.
- Strengthen planning and resource allocation for QI interventions.
- Review and roll out implementation of the Performance Management Plan.
- Increase awareness on time spent and saved from quality projects and how to prioritise for return on investment.

Strategic objective 2: To strengthen organizational capacity for QI implementation in the health sector.

Interventions:

- Strengthen the national, regional and district QI coordination structures.
- Development of health workers skills to deliver quality care.
- Strengthen the supply chain management system.
- Establishing financial arrangements (Results Based Financing) that ensure those who achieve savings share in the gains.

Strategic objective 3: To improve compliance to the health sector service delivery standards at all levels.

Interventions:

- Increase availability and use of the service delivery standards, evidence-based clinical standards, guidelines, Standard Operating Procedures and tools.

- Strengthen the regulatory bodies (UMDPC, AHPC and UNMC) capacity to regulate and over see quality of the private health providers and professional ethics and code of conduct of all health workers.
- Roll out health facility quality of care assessment initiatives.
- Strengthen supervision, mentorship and coaching with follow up and feedback on the supervision findings.
- Establish a national accreditation system.

Strategic objective 4: To improve patient safety practices in all health facilities.

Interventions:

- Improve Infection Prevention and Control (IPC) system
- Roll out systems to support CQI e.g. clinical audits, Maternal Perinatal Death Surveillance and Reviews (MDPSR), surgical checklists, medical error reporting, peer reviews, internal commitment.
- Strengthen and promote patient safety practices.
- Strengthen healthcare waste management system.

Strategic objective 5: To strengthen patient / client centered care in health care.

Interventions:

- Create awareness on roles and responsibilities of patients and health workers through patient charters.
- Institutional capacity building for in patient / client centered care.
- Strengthen involvement of clients and community in patient management and care.
- Promote transparency and accountability of health providers through the client charters.
- Strengthen the client feedback management system.

Strategic objective 6: To strengthen the framework for documentation, reporting and sharing of QI processes and activities at all levels.

Interventions:

- Strengthen monitoring and evaluation for QI interventions (process and outcomes).
- Strengthen QI knowledge management and information sharing.

Strategic objective 7: To promote implementation of innovative and evidence based models of care in Uganda.

Interventions

- Promote and conduct operational research for evidence based decision making.



3 Methodologies and Steps for QI Implementation in Uganda

3.1 Methodologies for QI in Uganda

Situation analysis and literature review of the various QI methodologies indicates that although the presentation of various QI methodologies seems different, the content and basic principles are very similar and in most cases complement each other. In Uganda, districts and partners involved in QI shall implement evidence-based targeted QI models and interventions, which apply the principle of an iterative cycle of improvement (Plan, DO, Study, Act (PDSA) Cycle).

The MoH recommends initiation of QI interventions in health facilities to start with 5S as a fundamental background to CQI and then introduce appropriate QI interventions, and then develop the culture of QI in all processes (5S-CQI-TQM). All QI interventions should;

- Apply the principle of an iterative cycle of improvements;
- Apply systematic assessment of service delivery processes;
- Use data in daily work;
- Recognize the organizational dimension of improvement; and
- Recognize the need for commitment from leadership as well as active engagement of Frontline clinical staff;
- Involve patients / clients.

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

QI efforts should be towards enabling the staff to be more active and effective, and an emphasis on safety, waste-reduction, and return on investment. Thus, 5S should be taken as Phase 1: protection from harmful care and releasing resources from easy waste-reduction which is quantified to show the value of QI, and where savings can be shared with those who made them. Then CQI is Phase 2: aiming at more use of effective and proven practices, treatments, service delivery models and health promotion strategies, adapted for Uganda using QI testing and suitable research from different organizations. Phase 3 (TQM): is a method by which management and employees become involved in the continuous improvement of the services. It is a comprehensive and fundamental rule or belief for leading & operating an organization aimed at continuously improving performance over a long term by focusing on clients while addressing the needs of all stakeholders.

3.2 Steps for Introduction of QI in a facility

To effectively cultivate a QI culture in a facility, there are certain key activities to be considered. Some of these activities can be carried out at the same time.

The QI Team needs to ensure that the following activities are undertaken with leadership involvement;

- i. Seek commitment of the management to ensure participation and support improvement
- ii. Create awareness among staff
- iii. Form a multidisciplinary Facility QI team and Work Improvement Teams (WITs)
- iv. Review present state of quality
- v. Develop an action plan
- vi. Develop/adapt written guidelines / protocols
- vii. Organize / carry out facility QI training
- viii. Apply skills to continuously improve your performance
- ix. Monitor implementation
- x. Share results periodically with other staff, clients and stakeholders

3.3 Steps for QI Project implementation

The following steps should be taken for CQI project implementation at facility level

- i. Selecting a CQI topic (where/what to improve).
- ii. Sharing views on the importance of the selected topic in the WIT.
- iii. Situation analysis and feasibility check-up (how is it at the moment and what are the root causes of the problem?).
- iv. Objective setting for improvement (how it should be).
- v. Objective analysis for identifying measures (how to improve).
- vi. Alternative analysis and selecting approach (what kind of method can be applied).
- vii. Formulating a plan of operation with 5W/H; Why, What, Who, Where, When and How (plan how to do it, by when, who will, etc.).
- viii. Installing monitoring mechanism with indicators (how is the plan going).
- ix. Building in measures for sustainability and preventing setback (how we can keep it).
- x. Building in measures for impact creation for other parts of the organization.
- xi. Summarizing experienced constraints during the activity and suggestions to top management.

CQI activities should be implemented with a designated time frame for maximizing teamwork and work efficiency. Possible examples: i) wash hands to reduce infections in specific areas where infection rates high, ii) using volunteers with small incentives to improve cleanliness and hygiene in these areas, iii) improving diagnosis and prescribing in specific subjects (e.g. malaria testing before prescribing, reducing overuse of antibiotics), iv) reducing waste in supplies and time in records/registers by simple QI (including 5S) by facility project teams and by supplies agencies, v) SBAR and read-back for safer communications, as a policy, with management leading by example (Haig et al 2006, NQF 2003).

The MoH developed the QI Methods: A Manual for Health Workers in Uganda and this will provide health workers with detailed information on QI concepts and methods, and define the QI tools for implementation of QI in Uganda. It aims at ensuring careful planning, development and implementation of evidence based QI interventions and initiatives using proper QI tools, continued appraisal, mentoring and taking corrective action as required.

4 Organizational Structure

This section presents the organizational structure for the QI activities in terms of governance, partnership and management of health services, QI roles and responsibilities at all levels, the National QI coordination structure and the contextual considerations for existing structures and systems. It is important that the implementation of QI programs and interventions utilizes the existing structures and systems of government. This will minimize utilization of resources and ensure that QI issues are mainstreamed and integrated within the health system.

4.1 Governance, Partnership and Management for QI

Quality improvement requires active and continuing support from top leadership. At the National level it means the Ministers, the Permanent Secretary, and the DGHS (Top Management) give their full support. At district level, the Local Council V Chairperson, the Chief Administrative Officer (CAO), the DHO and the Hospital Director / Medical Superintendent should take leadership roles and be involved in efforts to improve the quality of district health services by supporting application of QI initiatives. Equally at institutional or health facility level, the leaders and managers play an important role in establishing and sustaining the culture of quality.

4.1.1 Organization and Management of Health Services

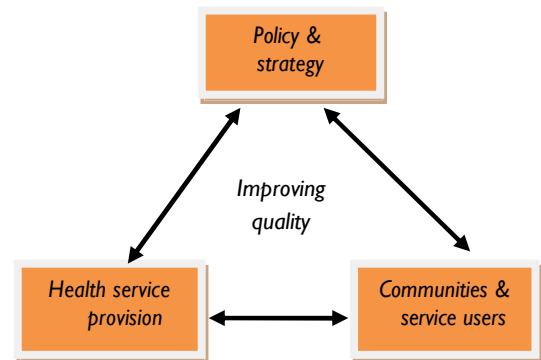
Poor quality of services and ineffective and harmful practices are the responsibility of service delivery managers at each level of healthcare. This is because their duty is to protect the public from harmful practices that the public may not know about, and because such practices and ineffective care wastes the scarce resources for which managers are responsible.

The Government possesses both service delivery, and stewardship functions in health. The stewardship function is exercised by the management, while the service delivery function is exercised by the facilities, and coordinated by the HSD's and districts. The organization is such that there is a clear communication linkage among the national, regional and district level for ease of planning, operations, monitoring and evaluation. At the district level the District Health Officer (DHO) is in charge of health services with his/her team, addressing both the management and governance issues at the district. In the absence of an institutionalized regional management team, the MoH with support from Global Fund to TB, HIV/AIDS and Malaria established the Regional Performance Monitoring Teams (RPMT) that support some of the supervision, M&E and capacity building activities focusing on performance monitoring. Other regional structures like the MoH Area Teams and EPI Regional Supervisors also play a key role in supporting QI implementation.

4.2 QI Roles and Responsibilities

Establishing and sustaining the culture of quality requires involvement and participation of a number of stakeholders responsible for; policy and strategy development; health service provision; communities and service users.

Figure 4: Stakeholder Roles in QI



4.2.1 MoH Top management

MoH Top management is comprised of the Ministers, Permanent Secretary, DGHS, Directors, Heads of Departments and other HPAC members. Responsibilities of Top Management are to;

- Take national leadership in policy and strategic direction and endorsement for QI institutionalization.
- Advocacy and resource mobilization for QI.
- Monitor implementation of the QIF&SP.

4.2.2 Quality Assurance Department

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

The specific responsibilities for QAD are to;

- Develop the national QI policy recommendations, strategy, standards and guidelines.
- Overall operational oversight and coordination of the planning, resource mobilization, implementation, supervision and M&E of QM/QI interventions within the sector.
- Provide technical support for QI at all levels.
- Compile and disseminating national QI workplans and reports.
- Ensure the dissemination of the guidelines to the regions, districts and stakeholders.
- Establish QI performance measures and data collection systems.
- Coordinate and supporting training at all levels (national, regional, district, health centers and community); including pre-service and in-service health training institutions in new technological and QI issues.

- Work with training institutions to develop and implement the national QI training curriculum and training manual.
- Provide overall guidance for QI in operational research.
- Document and disseminating quality of care best practices and share information with other interested stakeholders for adaptation.
- Convene national QI stakeholders meetings.
- Serve as Secretariat to the National QI Coordination Committee (NQICC).

4.2.3 Professional Councils

Responsibilities are to;

- Regulate of professional standards, ethics and code of conduct.
- Recognize and reward good performance and sanction or institute disciplinary measures for professional misconduct.

4.2.4 Development / Implementing Partners

Responsibilities are to;

- Offer technical and financial support for QI in consultation with the MoH Top Management, Departments, programs and health institutions guided by the QAD.
- Participate in QI supervision, mentoring and M&E activities.

4.2.5 Health Managers at all levels

Health managers at all levels have the duty to protect the public from harmful practices that the public may not know about, and to reduce waste from ineffective care and inefficient organization and inappropriate deployment of resources. A “quality saves” and “improving value” focus unites management and others to a common purpose: to use quality methods to reduce costs and suffering at the same time. Health managers should therefore take leadership in managing quality and be held accountable for the care outcomes.

Health managers responsibilities are to;

- Offer leadership and technical support in terms of identifying QI priorities in specific program areas.
- Develop facility / institutional QI workplans with specific budgets for QI activities.
- Establish financial arrangements that ensure those who achieve savings share in the gains.
- Identify QI Focal Persons / Officers who will coordinate planning, resource mobilization, implementation and M&E of QI activities in their programs or institutions.
- Ensure periodic Health Facility Quality of Care Assessments and implementation of QI interventions.
- Compile and submit QI performance reports.

- Document and disseminating QI best practices and share information with other interested stakeholders for adaptation.
- Set and monitor individual performance goals and targets.
- Recognize and reward good performance.

4.2.6 Health service providers at all levels

Providers may be seen as whole organizations, teams, or individual health workers including Community Health Workers like the Community Health Extension Workers (CHEWs) and Village Health Teams (VHTs). These may be from the private and public sectors and community based organizations. Service providers responsibilities are to;

- Provide the highest possible standards of care and meet the needs of individual service users, their families, and communities.
- Ensure proper understanding of the needs and expectations of those they serve so as to deliver the best results.
- Conduct regular self-assessments and identification of QI interventions.
- Use data for decision-making.
- Develop and implementation of facility QI action plans.
- Participate in QI trainings, mentorship and other Continuous Professional Development activities.
- Compile and submit performance reports.
- Document and share of best practices.
- Conduct operational research for QI.
- Involve community in QI.

4.2.7 Communities and Service users (Patients)

The community / households & individuals are beneficiaries of health service delivery but also have a critical role to play in ensuring quality of services. Their roles and responsibilities are elaborated in the MoH Patient Charter, 2010.

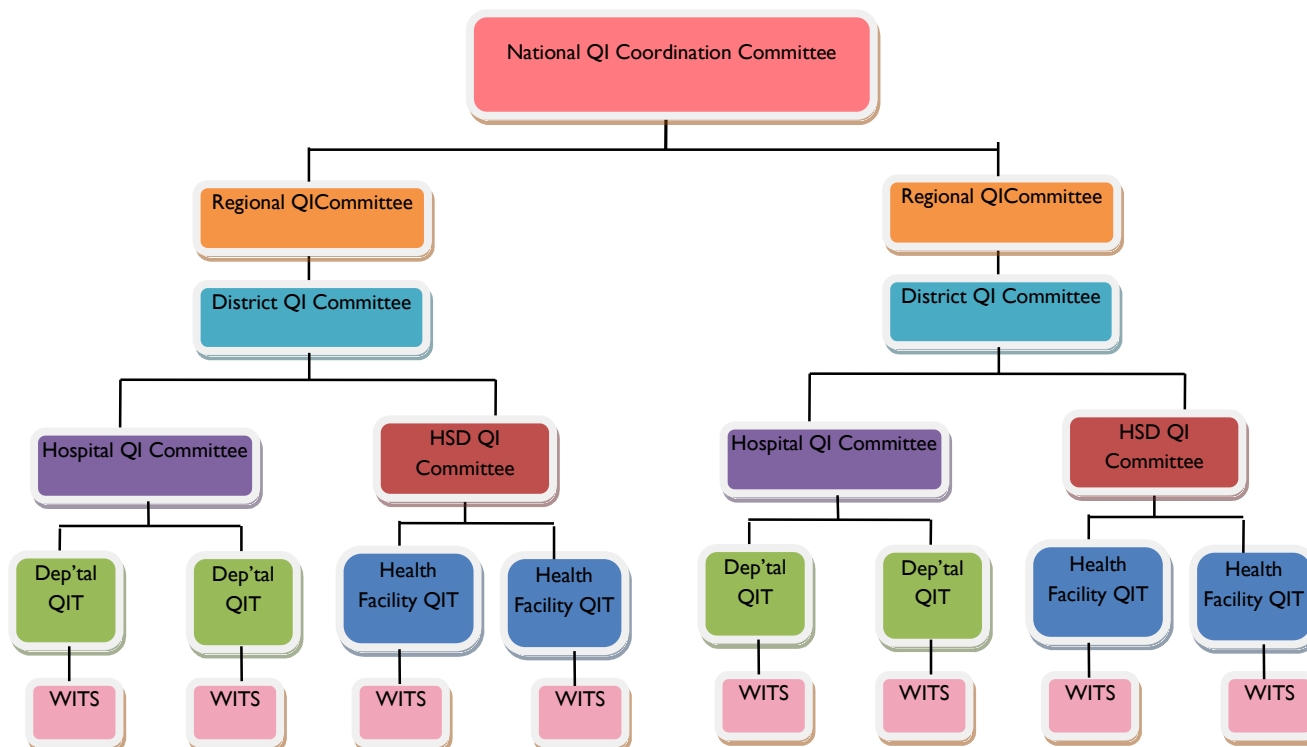
Communities and service users must be supported and encouraged to;

- Identify their own needs and preferences
- Manage their own health with appropriate support from health-service providers.
- Participate individually and collectively in the planning and implementation of their health care
- Community mobilization for utilization of the services
- Resource mobilization.
- Utilize the services provided.
- Provide feedback on service delivery through established mechanisms to address responsiveness like client satisfaction surveys, suggestion boxes, complaints desk, community meetings/dialogues, etc.

4.3 The National QI Coordination Structure

The QI coordination structure (Figure 5) has been created to enhance the QI policy, strategy development, communication and capacity building activities in a coordinated manner.

Figure 5: National QI Coordination Structure



4.3.1 The National QI Committee

The NQIC brings together major stakeholders such as the priority programs, DPs/IPs, PNFPs, CSOs and health consumers. The key responsibility of the NQIC is to identify opportunities and potential strategies to coordinate the QI initiatives in Uganda. The NQIC will report to the QAD any plans and decisions, to maintain and improve the quality of care within the sector.

Composition

The NQIC shall be composed;

- Director Health Services, Planning and Development as Chairperson
- Technical staff from the QAD
- Representatives from MoH departments and programs
- Representative from National Referral Hospital
- Representative from the Regional QI Committees
- Representatives from Public and Private Institutions

- Representatives from HDPs / IPs supporting implementation of QI
- Representatives from CSOs supporting implementation of QI activities
- Representatives from health consumers organizations
- Representatives from tertiary training institutions

Responsibilities for the NQIC

- Advocacy and resource mobilization for QI.
- Participate in developing policies and strategies for improving the health outcomes.
- Support and participate in the formulation of national QI guidelines and standards.
- Identify key priority areas for QI and make recommendations to the relevant stakeholders.
- Receive and review QI implementation reports.
- Discuss recommendations and lessons learnt during implementation of QI initiatives.
- Participate in building capacity of health workers in the implementation of QI activities.
- M&E of performance of the all the QI coordination structures.
- Attend quarterly NQIC meetings.

4.3.2 Regional QI Committee (RQIC)

The RQIC reports to the NQIC.

Composition

The RQIC is composed of;

- The Hospital Director of the Regional Referral Hospital as Chairperson.
- DHOs in the region
- Head of Nursing in the RRH
- Regional Laboratory QI Focal Person
- Ream Lead of the RPMTs
- Diocesan Health Coordinator (On rotational basis every 2 years)
- Regional Hospital QI Focal Person
- Representatives from HDPs / IPs supporting implementation of QI in the region
- Health Consumers (Community/Patient) Representatives (one male, one female) preferably from among the clients attending the chronic care clinics (Hypertension/DM, HIV, etc). The duration of community health consumer representatives on the committee is 2 years.

The RQIC shall select a Regional QI Focal Person from its members. The Regional QI Focal Person will serve as the Secretary of the RQIC and carry out the QI coordination functions under the guidance of the RQIC Chairperson.

Responsibilities for the RQIC

- Advocacy and resource mobilization for QI in the region.
- Develop the Regional QI Action plan.

- Supervise, coach and mentor for QI in the region.
- Identify training needs within the region.
- Participate in building capacity of health workers in QI.
- Monitoring and evaluating performance of District QI Committees.
- Hold quarterly RQIC meetings.
- Document and share best practices in the region.

4.3.3 District QI Committee (DQIC)

The DQIC reports to the RQIC.

Composition

The DQIC is composed of;

- The DHO as Chairperson
- DHT members
- In-Charges of HSDs
- Head of Nursing in the General Hospital or HSD where there is no General Hospital
- HSD QI Focal Persons if different from the HSD In-charge
- Representatives from IPs supporting implementation of QI in the district
- Representatives from the Medical Bureaus
- Community representatives, (one male, one female) e.g. Secretary for Health, Chairperson of a Health Unit Management Committee, Peers)

The DQIC shall select a District QI Focal Person from its members. The District QI Focal Person will serve as the Secretary of the DQIC and carry out the QI coordination functions under the guidance of the DQIC Chairperson.

Responsibilities for the DQIC

- Advocacy and resource mobilization for QI.
- Develop district QI Action plan.
- Supervise (Integrated), coach and mentor for QI in the general hospitals and HC IV and reporting findings
- Participate in building capacity of health workers in QI.
- Analyze district Quality of care assessment findings and performance data to determine district / health facility QI gaps and priorities.
- Compile and submit district QI reports to the RQIC and MoH.
- Recognize and reward good performance.
- Hold quarterly DQIC meetings.

4.3.4 HSD QIC

The HSD QIC reports to the DQIC.

Composition

The HSD QIC is composed of;

- The HSD In-charge as Chairperson
- HSD Management Team (NO, Public Health Nurse, Health Inspector, Laboratory Technician, Clinical Officer)
- In-Charges of HC Ills in the HSD
- Health Information Assistant
- Representatives from IPs supporting implementation of QI in the HSD
- Representatives from CSOs implementing QI in the HSD
- Health Consumers (Community/Patient) Representatives (one male, one female)

The HSD QIC shall select a HSD QI Focal Person from its members. The HSD QI Focal Person will serve as the Secretary of the HSD QIC and carry out the QI coordination functions under the guidance of the HSD QIC Chairperson.

Responsibilities for the HSD QIC

- Advocacy and resource mobilization for QI.
- Develop HSD QI Action plan.
- Supervise (Integrated), coach and mentor lower level facilities and reporting findings.
- Participate in building capacity of health workers in QI.
- Analyze HSD Quality of care assessment findings and performance data to determine HSD / health facility QI gaps and priorities.
- Convene HSD stakeholders meetings for performance review.
- Compile and submitting HSD QI reports to the DQIC.
- Recognize and reward good performance.
- Hold quarterly HSD QIC meetings.

4.3.5 Health Facility QI Team

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

Composition

The Health Facility QIT is composed of;

- The Health Facility Manager as Chairperson
- Representative of the Hospital Board or Health Unit Management Committee
- Administrator in case of larger facilities (hospitals)
- Heads of Departments

- Ward managers (HC IVs and Hospitals)
- Medical Records Officer / Health Information Assistant
- Representatives from DPs / IPs supporting implementation of QI
- Health Consumers (Community/Patient) Representatives (one male, one female)

Responsibilities for the Health Facility QIT

- Advocacy and resource mobilization for QI.
- Develop health facility QI Action plan.
- Supervise, coach and mentor QI activities in the health facility.
- Analyze the health facility Quality of care assessment findings and performance data to determine the QI gaps and priorities.
- Support health workers in developing action plans, implementing QI initiatives and documentation of progress.
- Compile and submit facility QI reports to the HSD and DQIC.
- Recognize and reward good performance.
- Hold monthly health facility QIT meetings.

4.3.6 Work Improvement Team (WIT) - (Departmental / Division / Unit QIT)

The WIT is the main actor of CQI activities. Their aim is to provide health workers with opportunities for meaningful involvement and contribution in identification, analysis and solving QI problems. They also implement improvement measures or recommend them to management. The bottom line outcome includes higher quality outputs, and improvement productivity in their unit. WITs are essential for implementation of departmental / section / unit / ward level QI activities. Examples of existing committees that are equivalent to WITs are; Infection Prevention and Control Committee, Medicines and Therapeutics Committee, Health Care Waste Management Committee, ART Clinic QI Committee, etc. A WIT reports to the immediate level manager.

Composition

The composition of WIT depends on the problem identified and the tasks agreed upon.

Responsibilities of the WIT

WIT responsibilities;

- Problem identification and analysis
- Development of action plan
- Conduct the day-to-day 5S practices and CQI activities that are suggested and executed within their workplace.
- Document the process and progress of 5S + CQI activities.
- Share QI results within the departments/sections/units/wards.
- Communicate the results to the health facility QIT.
- Develop checklist to suit their work environment.
- Hold WIT meetings at least monthly though can be more frequent depending on action areas.



5 Monitoring and Evaluation of QI

Monitoring and Evaluation (M&E) is an integral component of QI in health services. Health managers and other health workers need to understand M&E as a core process in QI. This chapter aims at highlighting M&E essentials for this plan.

5.1 Importance of M&E

M&E is crucial in QI programs/approaches. It is particularly so due to the fact that it;

- Assists Health Managers, health workers and other stakeholders in the health sector in performing the day-to-day management of health facilities and programs.
- Provides information for strategic planning and the design and implementation of health interventions and programs.
- Assists in making informed decisions on the prudent use of the meager resources available.
- Helps to improve performance by identifying those aspects that are working according to plan, and those aspects, which need a mid-course correction.
- Tracks changes in services provided and in the desired outcomes.
- Assists to better the human conditions in terms of safe work environment, and improved health status.
- Creates a system for transparent accountability.

5.2 QI Assessment Methods and Tools

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

A mix of the following methods and tools will be used;

- Clinical and program record review
- Observation of care with a standardized instrument
- Quality of care assessments
- Interviews and focus groups
 - Patients
 - Providers
 - Managers

- Standardized checklist will be used to collect other quality measurement data e.g. audit of individual patient records, death audits and review, clinical audits, critical incidents –adverse events, mystery clients, peer reviews and self assessments.
- Competency testing
- Clinical vignettes
- Other proven tools and methods

5.3 Sources of Data

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

The sources of data include;

- The HMIS including patient data
- Human Resource Information System (HRIS) for staffing levels
- Supply Chain Management System (SCM)
- Administrative reports
- Surveys
- Facility assessments
- Client feedback system e.g. suggestion boxes, information desk, satisfaction surveys
- Operational research
- Other proven tools and methodologies

5.3.1 Client Satisfaction Surveys

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

Client satisfaction surveys will be carried out at all levels of service delivery to determine the quality of services offered in the client perspective. Facility client satisfaction surveys will be carried out biannually (December and June every year) and findings utilized for QI. National Client Satisfaction Surveys will be more comprehensive and will be carried out every two years by independent survey teams or consultants.

5.4 Quality Assessment Indicators

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

accessibility, quality assessment will describe the current level of performance with the objective of improving it. Health institutions and health facilities will use findings of quality assessments to identify gaps and design QI projects.

The quality assessment indicators will be based on three quality indicator domains; structural/input, process / output and outcome indicators (See Annex I.I for some of the quality indicators by service area). The MoH QAD will facilitate the development and dissemination of the QI indicator definition manual.

5.4.1 Structural / Input Indicators

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

5.4.2 Process Indicators

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

5.4.3 Outcome Indicators

- Waiting time and crowding at service points
- Level of utilization of services (coverage) in priority area
- Extent to which health care is delivered in a manner which maximizes resource use and avoids waste
- Client satisfaction

5.5 Data Management for QI

Data management is very important throughout the QI process. In this section we shall focus on data analysis and synthesis, communication and feedback as well as dissemination for QI.

5.5.1 Data Analysis and Synthesis

Data analysis and synthesis will be done at various levels of service delivery (National, sub-national to health facility) to enhance evidence-based decision-making. The focus of analysis will be on comparing planned results with actual ones, understand the reasons for divergences and compare the performance at different levels.

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

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

- Internal benchmarking will be used to identify best practices within an organization / health facility, to compare best practices within the organization / health facility, and to compare current practice over time. The information and data may be plotted on a control or run chart with statistically derived upper and lower control limits.
- Competitive. / External benchmarking will also be used to represent best practices elsewhere. This involves using comparative data between organizations / health facilities to judge performance and identify improvements that have proven to be successful in other organizations / health facilities.

5.5.2 Data Communication and Feedback

The MoH Health Information Division (HID) will serve as a repository and source for all service delivery data and information at national level. This implies that all health service delivery data and information should be routed through the MoH HID for validation, analysis & synthesis, and dissemination. At district level, the district / HSD database will service as a repository and source for all service delivery data and information. Systems shall be developed to link project, district and MoH databases for efficient flow of information.

5.5.3 Data Dissemination

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

The MoH will use various communication channels in order to ensure general access to data and reports. Quantitative and qualitative data will be made publicly accessible through the MoH database under the HID. The public will also be able to access health information on the MoH website, www.health.go.ug. Data will also be disseminated to the wider audience through meetings, conferences, journals and newsletters.

5.6 Performance Incentives, Recognition and Reward

“Substantial improvements in quality are most likely to be obtained when providers are highly motivated and rewarded for carefully designing and fine tuning care processes to achieve increasingly higher levels of safety, effectiveness, timeliness, efficiency and equity” (IOM, 2001:184). Both modest financial and non-monetary incentives for successful teams have been used with success in other settings.

One of the reforms that the MoH is introducing during the five-year period is Results Based Financing (RBF) in the health sector to address underutilization of health services. RBF is an umbrella term that includes output based financing, provider payment incentives, performance based inter-fiscal transfers, and incentives (vouchers) to households / individuals for adopting positive health promotive behaviours. What is common is that a principal entity provides a financial or in-kind reward, conditional on the recipient undertaking a set of pre-determined actions for achieving a pre-determined performance goal. Health workers are incentivized to maximize their efforts and consequently to increase the volume and quality of activity. The performance incentives, recognition and reward criteria should be defined and established by all organizations / facilities clearly stating what performance or contribution constitutes rewardable behavior or actions.

The MoH will use the RBF approach as a tool to facilitate implementation of the already established QI interventions other than a QI tool in itself. RBF incentives will not only be based on outputs in terms of numbers. There will be systematic verification of the quality of services and this will be included in the facility scores. The MoH RBF framework (2016) will guide implementation of RBF in Uganda.

Other tools like the Performance Management Guidelines and the Public Service Rewards and Sanctions Framework will further guide recognition and reward and organizational and individual levels. The following should be considered during criteria development;

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

5.7 M&E Activities

The M&E of the QIF&SP implementation process will measure the extent to which the set goal and strategic objectives have been attained. The QI Coordination structures elaborated above will be responsible for monitoring implementation of the QIF. M&E activities will include meetings, supervision / monitoring visits, performance reviews and evaluation.

To facilitate institutionalization of QI in the health sector all managers should as much as possible ensure integration of the above mentioned activities in overall facility or institutional M&E activities.

- Where possible QI agenda should be included in the routine management meetings and discussions documented in the minutes.
- The national supervision system including structures and checklists will be used for QI support supervision activities.
- Compilation and submission of reports to follow the established HMIS reporting timelines.
- Performance reviews at all levels to include progress in implementation of QI workplans, including sharing of best practices and challenges.

5.7.1 Monitoring at national level

The following activities will be conducted at national level:

- Monthly QAD meeting will receive and address pertinent QI issues.
- Quarterly NQICC meetings will be conducted to track progress.
- Quarterly QI supervision visits to institutions, Referral Hospitals, LGs and IPs with follow up and feedback on the supervision findings.
- Quarterly QI progress reports compiled by program and project managers and submitted to QAD.
- QI performance review at the sector review meetings.
- National QI stakeholders' meetings.
- Mid-term review and end evaluation of the QIF&SP.

5.7.2 Monitoring at Regional level

The following activities will be conducted at regional level:

- Quarterly RQIC meetings.
- Quarterly supervision visits to implementing facilities with follow up and feedback on the supervision findings.
- Quarterly QI progress reports compiled and submitted to QAD and National Program / Project Managers.
- Quarterly Regional performance review meetings.

5.7.3 Monitoring at district level

The following activities will be conducted at district level:

- Monthly DQIC meetings to track progress.
- Quarterly supervision visits to HSDs with follow up and feedback on the supervision findings.
- Quarterly QI progress reports compiled and submitted to the RQIC / Project Managers.
- Quarterly District performance review meetings.

5.7.4 Monitoring at HSD level

The following activities will be conducted at HSD:

- Monthly HSD QIC meetings.
- Quarterly supervision to health facilities with follow up and feedback on the supervision findings.
- Quarterly HSD QI progress reports compiled and submitted to the DHO.
- Quarterly HSD performance review meetings.

5.7.5 Monitoring at facility level

The following activities will be conducted at health facility level:

- Monthly health facility meetings.
- Internal supervision within health facilities.
- Quarterly facility QI progress reports compiled and submitted to the HSD.
- Facility performance review meetings.

5.8 Evaluation

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

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

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

- i) Baseline study during the preparatory design phase of the project;
- ii) Mid-term review at the mid-point in the project to assess progress against objectives and provide recommendations for corrective measures;
- iii) Final evaluation or value-for-money audit at the end of the project.

The MoH - QAD in collaboration with the specific program / project managers will be responsible for the design, management and follow-up of the QI program and project evaluations (including baseline and mid-term reviews). All projects are required to budget for periodic project evaluations.

6 Evidence Generation

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

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

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

7 Sustainability of the QI Program in Uganda

The ultimate goal of the QIF&SP is attainment of the best possible health outcomes. Once achieved this should be sustained and even driven further. This can be ensured through strong QI oriented leadership, with country-led mechanisms, operation within existing structures and frameworks, integration, maintaining client centeredness, skilled human resources and accountability.

- 1) **Leadership:** The MoH will provide overall leadership for QI in health care. The MoH will work closely with partners in mapping and defining, on a continuous basis, the roles of different institutions, desired quality outcomes of health care and the values that will guide actions. Leadership needs to empower staff, be actively involved, and continuously drive QI. All partners are to apply the QA principles of focusing on the client, use of data focusing on evidence based outcomes, systems thinking and effective communication with all stakeholders. Without the commitment and support of senior-level leadership, even the best intended projects are at great risk of not being successful. Champions of the quality initiative and QI need to be throughout the organization, but especially in leadership positions and in the team.
- 2) **Decentralization:** QI initiatives in LGs shall be delivered within the framework of decentralization and any future reforms therein. This is because the LGs have the mandate to ensure delivery of quality health services and currently serve as the most appropriate level for coordinating top-down

and bottom-up planning for organizing community involvement in planning and implementation; and for improving the coordination between government and private health care. All DPs and IPs should operate within this framework.

- 3) **Public Private Partnerships:** The private sector shall complement the public sector efforts in terms of increasing geographical access to quality health services, the scope and scale of QI initiatives implemented. In order to ensure standardized quality of services the public sector shall implement QI initiatives as guided by the national QIF.
- 4) **Integration:** QI initiatives shall be scaled up from disease specific interventions to an integrated approach aimed at health systems strengthening. All organizational and management processes related to implementation of the QIF&SP will be integrated in the national system to avoid duplication.
- 5) **Accountability:** The results of QI interventions need to be documented, tracked and shared. The Health Facility Quality of Care Assessment Program will be rolled out in all districts. Facilities shall be assessed annually and are encouraged to conduct regular self-assessments, and share findings. The MoH will also include the average district score from the annual assessments into the District League Table.
- 6) **Client-centeredness:** The client-centered principle requires the MoH to design strategies focusing on both the internal and external clients. Sensitization of clients about their roles and responsibilities as well as developing and communicating the patient and client charters should be areas of focus. This will increase demand and feedback on the quality of care.
- 7) **Multidisciplinary Teams:** Due to the complexity of health care, multidisciplinary teams and strategies are essential. Multidisciplinary teams from participating centers/units need to work closely together, taking advantage of communication strategies such as face-to-face meetings, conference calls, and dedicated e-mail list servers. They need to also utilize the guidance of trained facilitators and expert faculty throughout the process of implementing change initiatives when possible.
- 8) **Country-led monitoring and evaluation plan:** The National Strategic Plan (HSDP) key performance and program specific indicators shall provide a basis for the development of indicators for various QI initiatives. M&E activities will be guided by the national strategic plan M&E Plan.
- 9) **Skilled Human Resources:** The capabilities for implementing QI shall be addressed through a) in-service training; b) pre-service education for all health professions, including physicians, nurses, pharmacists, laboratory personnel, health managers, etc. and; c) The possibility of embedding QI into job descriptions will be explored so that it is understood that everyone participates. The MoH will promote and ensure utilization of a national in-service QI training manual and liaise with training institutions in the finalization of the pre-service QI training curriculum.

8 Five Year QI Strategic Plan 2015/16 – 2019/20 Operational Matrix

Interventions	Actions	Responsibility	Financial Year					Output Indicators	Means of Verification
			15/16	16/17	17/18	18/19	19/20		
Strategic Objective 1: To strengthen leadership capacity and support for QI throughout the health sector									
Build commitment and leadership capacity in governance, leadership and management for QI at all levels.	Train / mentor health managers in governance, leadership and management with focus on waste reduction	MoH / Partners	x	x	x	x	x	No. of health managers trained	Reports
	Develop governance, leadership & management assessments tools for waste reduction	MoH / Partners		x				Tools developed	Tools
	Develop a QI advocacy plan	MoH		x				Advocacy plan developed	Advocacy plan
	Conduct QI advocacy activities at different for a	MoH / LGs / CSOs	x	x	x	x	x	No. / type of advocacy activities conducted	Reports
Harmonize and integrate QI approaches into all service delivery areas and at all levels.	Printing and dissemination of the QIF&SP, QI Indicator Manual & QI manual for Health workers	QAD / Partners	x	x				No. of dissemination meetings held and copies printed disseminated	Availability of QI documents at facility level
	Launching of the QIF&SP, QI manual for Health workers	MoH	x					QIF&SP, QI manual for Health workers launched	Report
	Finalize the QI indicator definition manual	MoH / Partners	x					Manual developed	Manual
Strengthen planning and resource allocation for QI interventions.	Conduct joint planning for QI	MoH / LGs / CSOs	x	x	x	x	x	Joint plans developed	Plans
	Integration of QI activities in the operational workplans and budgets at all levels	MoH / HDPs / LGs / CSOs	x	x	x	x	x	QI activities integrated in operational workplans & budgets	Workplans
	Mapping of QI partners	MoH / LGs / Partners	x	x	x	x	x	QI Partner Mapping	Partner Map
Review and roll out implementation of the PIP	Disseminate the Performance Management Manual for health sector	MoH - Human Resource Department (HRD) / Partners / LGs	x	x	x	x	x	No. of districts with the PMM	Reports
	Roll out implementation of the Performance Improvement	MoH - HRD / Partners / LGs / Health Facility Managers	x	x	x	x	x	No. of districts implementing	Reports

Interventions	Actions	Responsibility	Financial Year					Output Indicators	Means of Verification
			15/16	16/17	17/18	18/19	19/20		
	Manual								
Increase awareness on time spent and saved from quality projects and how to prioritize for return on investment	Hold annual QI conference to share experiences	MoH QAD / Partners	x	x	x	x	x	QI conferences held	Reports
Strategic Objective 2: To strengthen organizational capacity for QI implementation in the health sector.									
Strengthen the national, regional and district QI coordination structures	Document and communicate implementation structures, roles and responsibilities for all stakeholders	MoH / QAD	x	x				Roles of various stakeholders documented and communicated	Records
	Establishment of Regional QI Coordination Committees	MoH / Partners	x	x				No. of RQIC established	Reports
	Support functionality of QI coordination structures at all levels	National, Regional, District and Facility managers	x	x	x	x	x	No. of functional QI Committees / teams	Reports / Minutes
Development of health workers skills to deliver quality care.	Conduct QI Training Needs Assessment	QAD	x	x	x	x	x	Training Needs Assessment conducted	Report
	Finalize and disseminate QI Training manual for in-service training	QAD	x					QI training manual finalized	Training manual
	Finalize and operationalize the pre-service QI training curriculum	MoH / HRD / MoES		x	x			No. of Training Institutions with modules incorporating QI	Concept note
	Training of health workers at all levels	MoH / DPs	x	x	x	x	x	No. of health workers trained by cadre, level and district	Reports
	Maintain a database for QI trainers and trainees	QAD	x	x	x	x	x	No. of QI trainers and trainees registered in data base	Data base
Strengthen the supply chain management system.	Orientation of health workers in SCMS	MoH/ LGs / Partners	x	x	x	x	x	No. of health workers trained	Reports
	Support supervision and mentorship in SCMS at all levels	MoH/ LGs / Partners	x	x	x	x	x	No. of supervision visits	Reports
	Conduct SCMS stakeholders meetings	MoH/ LGs / Partners	x	x	x	x	x	No. of stakeholders meetings held	Reports
	Monitor availability of essential medicines and health supplies	MoH/ LGs / Partners / Health Facility Managers	x	x	x	x	x	No. of facilities reporting stock status of vital medicines through mTrac	Reports
Establishing financial	Develop capacity of health workers in	MoH / LGs	x	x	x	x	x	Health workers trained and	Reports

Interventions	Actions	Responsibility	Financial Year					Output Indicators	Means of Verification
			15/16	16/17	17/18	18/19	19/20		
arrangements (RBF) that ensure those who achieve savings share in the gains.	RBF							equipped for RBF	
Strategic Objective 3: To improve compliance to the health sector service delivery standards.									
Increase availability and use of service delivery standards, evidence-based clinical standards, guidelines, SOPs and tools	Develop/review service delivery standards, guidelines and tools	MoH	x	x	x	x	x	No. of standards, guidelines and tools reviewed	Availability of reviewed standards, guidelines and tools
	Print and disseminate service delivery standards, support supervision guidelines and tools	MoH/ Partners		x	x			No. of standards, supervision guidelines and tools printed and disseminated	Availability of reviewed standards, guidelines and tools
Strengthen regulatory bodies to enforce regulations and licensure	Revise, harmonize and update existing Acts	Professional Councils / DPs / Cabinet	x	x	x			Acts revised	Revised Act
	Streamline, consolidate and digitize the professional and facility licensing systems	Professional Councils / DPs	x	x	x			Information systems digitalized	Digitalised information systems
	Create Critical Tools for Quality Assurance	Professional Councils / DPs		x				QA tools developed	QA tools
	Roll out the voluntary Quality Improvement System in the private health facilities		x	x	x			VQIS rolled out	Reports
Roll out health facility assessment initiatives e.g. HFQAP, SLMTA, clinical / program assessment etc	Orient and train district supervisors in the HFQAP	MoH / Partners	x	x				No. of districts oriented	Reports
	Print HFQAP assessment tools	MoH QAD / Partners	x	x	x	x	x	Assessment tools printed	Tools available
	Conduct HFQAP assessments	MoH / LGs / Partners	x	x	x	x	x	No. of districts conducting facility assessment	Reports
	Conduct HFQAP annual review meetings	MoH / LGs / Partners	x	x	x	x	x	Review meetings held	Minutes
	Orientation of health workers on clinical / program specific assessments	MoH - Clinical Services		x	x	x	x	No. of health workers oriented	Reports
	Assess and improve clinical / program specific quality	MoH - Clinical Services / QAD / Health Facility Managers	x	x	x	x	x	No. of assessments conducted	Reports
Strengthen supervision, mentorship and coaching	Conduct technical QI supervision visits	MoH/ LGs / Partners	x	x	x	x	x	Technical supervision visits conducted	Reports
	Conduct QI mentorships and coaching	MoH/ LGs / Partners	x	x	x	x	x	No. of QI mentorships and coaching visits	Reports

Interventions	Actions	Responsibility	Financial Year					Output Indicators	Means of Verification
			15/16	16/17	17/18	18/19	19/20		
Establish a national accreditation system	Define service standards, criteria and implementation arrangements	MoH / Bureaus /			x			National accreditation system developed	Documentation
	Develop / review the accreditations tools	MoH/ LGs / Partners				x	x	Tools developed	Tools in place
	Orient health facilities on the accreditation system	MoH / Partners					x	No. of health facilities oriented	Reports
	Accreditation of health facilities	Accreditation Body					x	No. of health facilities accredited	Reports
Strategic Objective 4: To improve patient safety practices in all health facilities.									
Improve infection prevention and control (IPC) mechanisms	Print and disseminate IPC guidelines and SOPs to all health facilities	QAD / Partners	x	x				No. of IPC guidelines & SOPs disseminated	Supervision reports
	Orientation of health providers on IPC practices at all levels	MoH - Clinical Services / QAD / Partners	x	x	x	x	x	No. of health providers oriented	Reports
	Integration of Facility IPC initiatives in the overall facility QI initiatives	Health Facility Managers	x	x	x	x	x	No. of QITs implementing IPC initiatives	Reports / Minutes
Roll out systems to support CQI	Develop / review guidelines / tools for clinical audits and peer reviews	MoH - Clinical Services / QAD		x				Clinical audit guidelines / tools developed	Guidelines / tools
	Orientation of health workers on clinical audits, MPDSR and peer reviews	MoH - Clinical Services		x	x	x	x	No. of health workers oriented	Reports
	Monitor implementation of clinical audits, peer reviews and MPDSR	MoH - Clinical Services / QAD / Health Facility Managers	x	x	x	x	x	No. of health facilities monitored	Reports
Strengthen and promote patient safety practices	Develop patient safety guidelines and SOPs	MoH / Partners		x	x			Guidelines & SOPs developed	Guidelines & SOPs
	Print & disseminate patient safety guidelines and SOPs	MoH / Partners		x	x	x		Guidelines disseminated	Guidelines & SOPs
	Train staff and roll out implementation of the patient safety guidelines	MoH - Clinical Services / Partners			x	x	x	No. of staff trained	Reports
Strengthen HCWM system	Print and dissemination HCWM guidelines to all health facilities	MoH - Clinical Services / Partners	x	x				No. of HCWM guidelines & SOPs printed and disseminated	Supervision reports
	Orient health providers HCWM practices at all	MoH - Clinical Services / Partners	x	x	x	x	x	No. of health providers oriented	Reports

Interventions	Actions	Responsibility	Financial Year					Output Indicators	Means of Verification
			15/16	16/17	17/18	18/19	19/20		
	levels								
	Advocate for provision of adequate amounts of HCWM commodities & infrastructure	MoH/ LGs / CSOs / Partners	x	x	x	x	x	No. of advocacy initiatives for HCWM supplies Availability of HCWM commodities & infrastructure	Reports
Strategic objective 5: To strengthen patient /client centered care in health care.									
Create awareness on rights, roles and responsibilities of patients and health workers through patient charters.	Review and disseminate patient charters in the commonly used languages	MoH / QAD		x	x			Patient charter reviewed and disseminated	Patient charters
	Sensitize patients and community on their rights, roles and responsibilities in health care & prevention	MoH / LGs / Partners / CSOs	x	x	x	x	x	No. of sensitization activities held	Reports
Institutional capacity building for patient / client centered care	Finalize, print and disseminate PCC guidelines	MoH QAD & Clinical Services		x	x			PCC guidelines disseminated	PCC guidelines
	Orient health workers on PCC	MoH / Partners		x	x	x	x	No. of health workers oriented	Reports
	Conduct facility and health worker assessments on PCC	Health facility managers		x	x	x	x	No. of facility and health workers PCC assessments conducted	Assessment Reports
Strengthen involvement of clients and community in patient management and care	Orient HUMCs / Hospital Boards on their roles including QI	MoH / Clinical Services / LGs / Partners	x	x	x	x	x	No. of HUMC members oriented	Reports
Promote transparency and accountability of the health providers	Review and disseminate institutional client charters	All health managers	x	x	x	x	x	Client charters reviewed / developed and disseminated	Client charters
	Support health facilities in development and implementation of feedback management plans	All Managers		x	x	x	x	No. of institutions with feedback management plans	Reports
	Review, print & disseminate HUMC / Hospital Board guidelines to capture QI responsibilities.	MoH / Clinical Services / QAD Partners	x					Guidelines revised include QI responsibilities	Revised guidelines
	Training of CHEWs / VHTs on QI initiatives a	MoH Health Education & Promotion / Programs / LGs / Partners / CSOs /	x	x	x	x	x	Number trained	Reports

Interventions	Actions	Responsibility	Financial Year					Output Indicators	Means of Verification
			15/16	16/17	17/18	18/19	19/20		
		CBOs							
	Document and share community QI implementation models	MoH / Partners / CSOs	x	x	x	x	x	No. of community QI models documented and shared	Reports
	Conduct community dialogue / feedback meetings	LGs / Health Facility Managers / Partners	x	x	x	x	x	No. of community dialogue / feedback meetings held	Reports
Strategic Objective 6: To strengthen the framework for documentation, reporting and sharing of QI processes and activities at all levels									
Strengthen monitoring and evaluation for QI interventions	Provide data collection and reporting tools	MoH / Partners	x	x	x	x	x	No. of health facilities with HMIS tools	Tools
	Train staff on data capture and reporting	MoH / LGs / Partners	x	x	x	x	x	No. of staff trained	Reports
	Mentorship and coaching on data management at the facility level	MoH – HID / DHOs / HSDs	x	x	x	x	x	No. of mentoring / coaching visits	Reports
	Support health care providers to adapt to new information technologies to improve service efficiencies e.g. mTrac, telemedicine	MoH / Partners	x	x	x	x	x	No. of health facilities utilizing new information technologies	Reports
	Provide routine feedback using findings to improve activities	Health Facility Managers	x	x	x	x	x	No. of facilities receiving feedback on findings	Reports
	Review and disseminate the QI indicator definition manual	MoH / LGs / Partners	x	x				QI indicator definition manual developed	Manual
	Compile and submit QI performance reports (Documentation journals & QI progress reports)	MoH / LGs / Partners / Facility Managers	x	x	x	x	x	No. of QI reports submitted	Reports
	Hold performance review meetings at different levels	MoH / LGs / Partners / Facility Managers	x	x	x	x	x	No. of performance review meetings held	Reports
	Mid and end term review of the QIF & SP implementation	MoH / Partners			x		x	Evaluations done	Reports
Strengthen QI knowledge management and information sharing	Conduct QI learning sessions	LGs / Partners	x	x	x	x	x	No. of learning sessions held	Reports
	Hold QI Stakeholders meeting	MoH / Partners / LGs / CSOs	x	x	x	x	x	No. of stakeholders meetings held	Minutes
	Hold QI conference	MoH / Partners / LGs / CSOs	x	x	x	x	x	QI conference held	Report
	Provide opportunities for peer-to-peer learning through	Managers	x	x	x	x	x	No. of learning sessions, mentoring sessions	Reports

Interventions	Actions	Responsibility	Financial Year					Output Indicators	Means of Verification
			15/16	16/17	17/18	18/19	19/20		
	placement, clinic-to-clinic mentoring & exchange visits.								
	Develop and link the QI knowledge management portal (database) to the national platform	MoH - RC / QAD / Partners	x	x	x	x	x	KM Portal developed and linked	Online presence
Strategic Objective 7: To promote implementation of innovative and evidence based models of care in Uganda									
Promote and conduct operational research for evidence based decision making	Develop a QI research QI agenda	MoH QAD / Partners	x	x	x	x	x	Research agenda developed annually	Research agenda
	Conduct intervention and operational QI research	MoH/ LGs / CSOs / Partners / Research Institutions	x	x	x	x	x	No. and types of QI Researches carried out	Study Reports
	Document and publish QI research findings	MoH/ LGs / CSOs / Partners / Research Institutions	x	x	x	x	x	No. of QI publications	Publications

9 Costing of the Strategic Plan

The QI Strategic Plan has been costed using the current market prices and rates for allowances. The total budget estimate for the 5years is UGX 24,152.5 million. Funding for the QI activities will be mainly from the respective programs, departments or institutions implementing QI and this should be integrated in their annual budgets. The MoH and other partners will mobilize resources for the unfunded interventions.

Table 2: Budget Summary

Act #	Description	Total	
		UGX Millions	%
1	Strategic Objective 1: To strengthen leadership capacity and support for QI throughout the health sector	7,139	29.6%
2	Strategic Objective 2: To strengthen organizational capacity for QI implementation in the health sector.	4,548.7	18.8%
3	Strategic Objective 3: To improve compliance to the health sector service delivery standards.	7,089.3	29.4%
4	Strategic Objective 4: To improve patient safety practices in all health facilities	1,682.3	7.0%
5	Strategic objective 5: To strengthen patient /client centered care in health care.	2,245.9	9.3%
6	Strategic Objective 6: To strengthen the framework for documentation, reporting and sharing of QI processes and activities at all levels	1,372.2	5.7%
7	Strategic Objective 7: To promote implementation of innovative and evidence based models of care in Uganda	75.6	0.3%
Grand Total		24,152.5	100%

Table 3: Annualized costing of the QI Strategic Plan

Act #	Description	2015/16	2016/17	2017/18	2018/19	2019/20	Total
1	Strategic Objective 1: To strengthen leadership capacity and support for QI throughout the health sector	1,086	1,885	1,723	1,358	1,086	7,139
1.1.1	Train / mentor health managers in governance, leadership and management with focus on waste reduction - CQI (40 participants for 5 days)	833.8	1,186.1	1,410.7	1,045.4	833.8	5,309.8
1.1.2	Develop governance, leadership & management assessment tools for waste reduction (Consultancy fees, 1 stakeholders meetings, 50 participants, 1 day)	-	52.6	-	-	-	52.6
1.1.3	Develop a QI advocacy plan (Consultancy fees, one day stakeholders meeting for 50 participants)	-	74.9	-	-	-	74.9
1.1.4	Conduct QI advocacy activities at different fora (advocacy briefs, assorted activities conducted)	-	220.0	60.0	60.0	-	340.0
1.2.1	Printing and dissemination of the QIF&SP	-	80.0	-	-	-	80.0
1.2.2	Launch the QIF&SP, QI manual for Health workers (To be launched at the QI Conference)	-	-	-	-	-	-
1.3.1	Conduct joint planning for QI (annual joint planning, national level, 40 participants, one day)	22.5	22.5	22.5	22.5	22.5	112.5
1.3.2	Integration of QI activities in the operational workplans and budgets at all levels	-	-	-	-	-	-
1.3.3	Mapping of QI partners (Consultancy fee, 1 day consensus building meeting by NQICC)	-	18.6	-	-	-	18.6
1.4.1	Disseminate the Performance Improvement Management Manual for health sector	-	-	-	-	-	-
1.4.2	Roll out implementation of the Performance Management Manual	-	-	-	-	-	-

Act #	Description	2015/16	2016/17	2017/18	2018/19	2019/20	Total
1.5.1	Hold annual QI conference to share experiences	230.1	230.1	230.1	230.1	230.1	1,150.3
2	Strategic Objective 2: To strengthen organizational capacity for QI implementation in the health sector.	810.4	1,198.4	1,274.9	779.4	485.6	4,548.7
2.1.1	Document and communicate implementation structures, roles and responsibilities for all stakeholders	-	-	-	-	-	-
2.1.2	Establishment of Regional QI Coordination Committees	136.2	213.7	70.3	70.3	70.3	560.7
2.1.3	Support functionality of QI coordination structures at all levels	-	-	-	-	-	-
2.2.1	Conduct QI Training Needs Assessment	-	-	-	-	-	-
2.2.2	Finalize and disseminate QI Training manual for in-service training (2 meetings, 20 participants, 2 days)	-	31.9	-	-	-	31.9
2.2.3	Finalize and operationalize the pre-service QI training curriculum	-	31.1	20.7	-	-	51.9
2.2.4	Operationalization of the pre-service QI training curriculum (Consultancy fees, 5 days ToT for 30 tutors)	-	-	222.1	-	-	222.1
2.2.5	Training of health workers at district level (5 days, QI training)	674.2	830.6	830.6	679.6	415.3	3,430.3
2.2.6	Maintain a database for QI trainers and trainees	-	-	-	-	-	-
2.3.1	Orientation of health workers in SCMS (regional trainings for district SCM Managers)	-	50.8	50.8	-	-	101.6
2.3.2	Support supervision and mentorship in SCMS at all levels	-	-	-	-	-	-
2.3.3	Conduct SCMS stakeholders meetings	-	-	-	-	-	-
2.3.4	Monitor availability of essential medicines and health supplies	-	-	-	-	-	-
2.4.1	Develop capacity of health workers in RBF (target district and hospital manager in 4 regional trainings, 50 participants for 2 days)	-	40.2	80.4	29.5	-	150.1
3	Strategic Objective 3: To improve compliance to the health sector service delivery standards.	1,240.1	2,834.1	1,725.5	591.8	697.8	7,089.3
3.1.1	Develop/review service delivery standards, guidelines and tools	69.1	69.1	-	-	-	138.2
3.1.2	Print and disseminate service delivery standards, guidelines and tools	-	111.3	111.3	-	-	222.5
3.2.1	Update and Revise Council Regulation	18.7	56.2	75.0	18.7	18.7	187.5
3.2.2	Streamline, Consolidate and Digitize Professional and Facility Licensing Systems	-	-	150.0	-	-	150.0
3.2.3	Professional and facility licenses	-	157.5	67.5	-	-	225.0
3.2.4	Roll out the voluntary Quality Improvement System in the private health facilities	41.3	66.3	82.5	75.0	75.0	340.0
3.3.1	Orient and train district supervisory teams in the HFQAP (5 days non-residential workshop per district)	825.2	1,996.4	887.3	-	-	3,708.8
3.3.2	Disseminate the HFQAP Implementation Manual	-	-	-	-	-	-
3.3.3	Print HFQAP assessment tools	60.0	60.0	60.0	60.0	60.0	300.0
3.3.4	Conduct annual HFQAP assessments ((1 day per facility, 24 supervisors per district, total 5 days per district). No. of health facilities range from 7 (Buliisa) to 139 (Kabale). Estimate 3,968 facilities to be assessed annually	93.0	93.0	93.0	93.0	93.0	464.8
3.3.5	Annual Referral Hospital Assessment (annually, 2 days per hospital, 6 supervisors per hospital)	49.3	49.3	49.3	49.3	49.3	246.4
3.3.6	Training of Biostatisticians in the use of the electronic database (12 Regional trainings for 2 days)	-	91.7	-	-	-	91.7
3.3.7	Conduct HFQAP annual review meetings	-	-	-	-	-	-
3.3.8	Orientation of health workers on clinical / program specific assessments	-	-	-	-	-	-
3.3.9	Assess and improve clinical / program specific quality	-	-	-	-	-	-
3.4.1	Conduct technical QI supervision, mentorship and coaching visits (quarterly to RRHs and Districts)	83.5	83.5	83.5	83.5	83.5	417.6
3.5.1	Define service standards, criteria and implementation arrangements	-	-	66.2	-	-	66.2
3.5.2	Develop / review the accreditations tools	-	-	-	16.6	16.6	33.1

Act #	Description	2015/16	2016/17	2017/18	2018/19	2019/20	Total
3.5.3	Orient health facilities on the accreditation system (4 regional trainings for District & hospital managers)	-	-	-	-	106.0	106.0
3.5.4	Accreditation of Hospitals & HC IVs	-	-	-	195.7	195.7	391.4
4	Strategic Objective 4: To improve patient safety practices in all health facilities	32.0	521.1	793.6	335.6	-	1,682.3
4.1.1	Print and disseminate IPC guidelines and SOPs to all health facilities	-	37.5	37.5	-	-	75.0
4.1.2	Orientation of health providers on IPC practices at all levels (Four regional workshops, 2 days)	-	44.8	44.8	-	-	89.6
4.1.3	Integration of Facility IPC initiatives in the overall facility QI initiatives	-	-	-	-	-	-
4.2.1	Develop / review guidelines / tools for clinical audits and peer reviews	-	-	56.7	-	-	56.7
4.2.2	Orientation of health workers on clinical audits, MPDSR and peer reviews (Regional workshops, 3 days for DHOs, Facility and ward managers)	32.0	128.2	160.2	-	-	320.4
4.2.3	Monitor implementation of clinical audits, peer reviews and MPDSR	-	-	-	-	-	-
4.3.1	Develop patient safety guidelines and SOPs	-	121.8	-	-	-	121.8
4.3.2	Print & disseminate patient safety guidelines and SOPs	-	30.0	22.5	22.5	-	75.0
4.3.3	Train staff and roll out implementation of the patient safety guidelines (2 day regional workshops, 50 participants)	-	-	184.7	184.7	-	369.4
4.4.1	Print and dissemination HCWM guidelines to all health facilities	-	-	22.5	22.5	-	45.0
4.4.2	Orient health providers HCWM practices at all levels (12 regional workshops covering all districts)	-	158.8	264.7	105.9	-	529.4
4.4.3	Advocate for provision of adequate amounts of HCWM commodities & infrastructure	-	-	-	-	-	-
5	Strategic objective 5: To strengthen patient /client centered care in health care.	336.0	629.5	548.4	366.0	366.0	2,245.9
5.1.1	Review and disseminate patient charters in the commonly used languages	-	26.4	6.8	-	-	33.1
5.1.2	Sensitize patients and community on their rights, roles and responsibilities in health care & prevention	336.0	336.0	336.0	336.0	336.0	1,680.0
5.2.1	Printing PCC Guidelines	-	-	-	-	-	-
5.2.2	Finalize PCC guidelines (stakeholder meeting - review)	-	7.1	-	-	-	7.1
5.2.3	Orient health workers on PCC (2 day regional workshops)	-	-	152.1	-	-	152.1
5.2.4	Conduct facility and health worker assessments on PCC	-	-	-	-	-	-
5.3.1	Review and disseminate institutional client charters (MoH & Referral Hospitals)	-	158.8	-	-	-	158.8
5.3.2	Support health facilities in development and implementation of feedback management plans	-	-	-	-	-	-
5.3.4	Review, print & disseminate HUMC / Hospital Board guidelines to capture QI responsibilities.	-	71.2	-	-	-	71.2
5.3.5	Training of CHEWs / VHTs on QI initiatives (On pilot basis, 2 day training, 2 non-residential workshops)	-	-	23.6	-	-	23.6
5.3.6	Document and share community QI implementation models	-	-	-	-	-	-
5.3.7	Conduct community dialogue / feedback meetings	-	-	-	-	-	-
6	Strategic Objective 6: To strengthen the framework for documentation, reporting and sharing of QI processes and activities at all levels	224.4	274.4	331.7	234.4	307.3	1,372.2
6.1.1	Provide data collection and reporting tools (Covered under the HMIS tools)	-	-	-	-	-	-
6.1.2	Train staff on data capture and reporting (during training, support supervision, mentoring)	-	-	-	-	-	-
6.1.3	Mentorship and coaching on data management at the facility level (Integrated in 3.4.1)	-	-	-	-	-	-
6.1.4	Support health care providers to adapt to new information technologies to improve service efficiencies e.g. mTrac, telemedicine (Covered by Resource Centre under the e-Health strategy)	-	-	-	-	-	-

Act #	Description	2015/16	2016/17	2017/18	2018/19	2019/20	Total
6.1.5	Provide routine feedback using findings to improve activities (covered under QI review meetings at different levels and community dialogue)	-	-	-	-	-	-
6.1.6	Review and disseminate the QI indicator definition manual	-	10.0	24.4	-	-	34.4
6.1.7	Compile and submit QI performance reports (Documentation journals & QI progress reports)	-	-	-	-	-	-
6.1.8	Hold performance review meetings at different levels	-	-	-	-	-	-
6.1.9	Mid and end term review of the QIF & SP implementation	-	-	72.9	-	72.9	145.9
6.2.1	Conduct QI learning sessions (Biannual Regional learning sessions, 8 regions, 50 participants)	161.4	161.4	161.4	161.4	161.4	807.0
6.2.2	Provide opportunities for peer-to-peer learning through placement, clinic-to-clinic mentoring & exchange visits. (Annual exchange visits, 15 participants for 2 days)	63.0	63.0	63.0	63.0	63.0	315.0
6.2.3	Develop and link the QI knowledge management portal to the national platform	-	30.0	-	-	-	30.0
6.2.4	Maintain the QI database	-	10.0	10.0	10.0	10.0	40.0
7	Strategic Objective 7: To promote implementation of innovative and evidence based models of care in Uganda	-	31.0	24.6	10.0	10.0	75.6
7.1.1	Develop a QI research QI agenda	-	21.0	14.6	-	-	35.6
7.1.2	Conduct intervention and operational QI research	-	10.0	10.0	10.0	10.0	40.0
7.1.3	Document and publish QI research findings	-	-	-	-	-	-
	Grand Total	3,729.3	7,373.1	6,422.0	3,675.0	2,953.1	24,152.5

10 References

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3. Draft Report Quality Improvement Situation Analysis in Uganda; MoH; 2011
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7. International Journal for Quality in Health Care 2009; Volume 21; Number 3
8. Study of Client Satisfaction with Health Services in Uganda. Jitta, I.; J. Arube- Wani and H. Muiyinda. (2008).
9. Formative Evaluation of Quality of Care Initiatives; MoH, 2010

11.1 QI Indicators

Hospital Quality Indicators

1. *OPD and Emergency*
 - *Waiting time for OPD & Emergency Patient*

2. *Laboratory & Imaging services*
 - *Waiting time for laboratory and imaging services*
 - *Number of reporting error/1000 investigation*
 - *% of reports co-relating with Clinical Diagnosis*
 - *% of Re - dos (repeat test/procedure).*
 - *% of adherence to safety precautions*

3. *Operation Theatre*
 - *Re exploration rate for all invasive procedures*
 - *% of rescheduling of Surgeries/procedures.*
 - *% of Operation Theatre utilization*

4. *Anesthesia Related Quality Indicators*
 - *% of Modification of anesthesia plan (after pre anesthesia assessment.)*
 - *% of unplanned ventilation after anesthesia.*
 - *% of adverse anesthesia events.*

5. *Hospital Infection Related indicators*
 - *Urinary tract infection rate*
 - *Respiratory tract infection rate.*
 - *Intravascular Device infection rate.*
 - *Surgical Site Infection rate.*

6. *Human Resource related indicators*
 - *Employee satisfaction index*
 - *Employee attrition rate.*
 - *% of employees who are aware of employee rights, responsibilities and welfare schemes.*
 - *Employee absenteeism rate*

RMNCAH Quality Indicators

1. *% of service delivery points stocked with family planning commodities according to needs.*
2. *% of clients given counseling on family planning at service delivery points*
3. *% of service providers trained in family planning and reproductive health*
4. *% of follow-up visits by contraceptive users to the total number of continued users of a particular method*
5. *% of pregnant women receiving intermittent preventive treatment under direct observation (first dose, second dose, third dose, according to national guidelines)*
6. *% of pregnant women who are due for 4th ANC visit and complete the visit.*
7. *% of newly enrolled pregnant women who receive an HIV test.*
8. *% of newly diagnosed HIV +ve pregnant women who are linked to ART clinic for enrollment*
1. *% of newly diagnosed HIV +ve pregnant women receiving ARVs for PMTCT services.*
2. *% of mothers delivered at a facility in which AMSTL was properly applied (Uterotonic given immediately after delivery of baby, controlled cord traction to deliver the placenta and rubbing the uterus to contract*
3. *% of mothers in labor who are monitored using a partograph.*
4. *% of mothers with obstetric complications referred to higher health facilities that deliver by Caesarian Section*
5. *% of mothers that die during child birth*
6. *% of maternal death reviews conducted in a month*
7. *% new mothers who return for follow up within 6 days after delivery.*
8. *% new mothers who return for follow up within at 6 weeks after delivery.*
9. *% of child deaths that occur during child birth or immediately after birth*
10. *% of perinatal death reviews conducted in a month*
11. *% of new born babies that received the recommended elements of essential new born care (Cord care; thermal care; initiate breast feeding within 30 min of birth, Vit K; TEO; BCG/Polio)*
12. *% of children under 5 assessed using IMCI guidelines during every clinic visit*
13. *% of under 5 children triaged during each visit*
14. *% of under 5 children assessed for nutritional status during each visit*
15. *# of new born babies with complications after birth e.g. asphyxia, failure to breast feed etc*
16. *% of service providers trained in adolescent friendly health services*

TB Quality Indicators

1. *Case notification rates (CNR) or case detection rates (CDR) in case they have not updated to CNR*
2. *% of eligible sputum follow ups done*
3. *% of children monitored for weight and side effects*

4. *% of TB patients offered HIV counseling*
5. *% of TB patients tested for HIV*
6. *% of TB/HIV co-infected patients on ART*
7. *% of TB/HIV co-infected patients on CPT*
8. *% of patient with a close contact of TB without TB disease on IPTT*
9. *% of patients on DOTS*
10. *% of patients on correct treatment regimen and drug doses*
11. *TB Cure rate*
12. *TB Treatment completion rate*
13. *TB Defaulter rate*
14. *TB Death rate*
15. *TB Treatment failure rate*
16. *TB Transfer out rate*

Malaria Quality Indicators

1. *% of antenatal clinic staff trained in the control of malaria during pregnancy during the past 12 months (including intermittent preventive treatment, counseling on use of insecticide-treated nets and case management for pregnant women)*
2. *% of health facilities reporting stock-out of the recommended drug for intermittent preventive treatment (currently sulfadoxine-pyrimethamine) in the past month*
3. *% of pregnant women receiving intermittent preventive treatment under direct observation (first dose, second dose, third dose, according to national guidelines)*
4. *% of OPD clinic staff trained in malaria case management during the past 12 months*
5. *% of health facilities with first and second line antimalarial drug in the past month*
6. *% of malaria cases confirmed with laboratory diagnostics (rapid diagnosis or microscopy)*
7. *% of patients with laboratory confirmed (rapid diagnosis or microscopy) malaria who received the recommended antimalarial treatment during the past one month.*
8. *% of children under five years old with fever receiving appropriate antimalarial treatment with 24 hours*
9. *% of patients with severe malaria who received the recommended antimalarial treatment during the past one month.*

HIV Counseling and Testing Indicators

1. *% of individual counseled, tested and received HIV test results*
2. *% of HIV positive individuals who are linked to HIV care and treatment services*
3. *% of HIV positive clients who are assessed for active TB*
4. *% of newly identified HIV positive clients whose CD4 testing is done*

Safe Male Circumcision Indicators

1. *% of circumcised clients who experience moderate to severe adverse events*
2. *% of circumcised clients with documented informed consent prior to circumcision*
3. *% of SMC clients who were counseled, tested and received HIV test results*

4. *% of SMC clients who test HIV positive and are linked to HIV chronic care*
5. *% of SMC clients who are screened for Sexually transmitted infections prior to circumcision*
6. *% of circumcised clients who attend at least one follow up visit within seven days of circumcision*

EMTCT and Nutrition Indicators

1. *% of pregnant women who were counseled, tested and given results*
2. *% of exposed infants whose DNA PCR results were given to caregiver (Disaggregated by 1st PCR and 2nd PCR)*
3. *% of HIV positive mothers who receive IYCF counseling at each visit*
4. *% of HIV positive mothers who receive maternal nutrition counseling*
5. *% of HIV positive mothers reporting to be adhering to recommended IYCF practices*
6. *% of HIV positive pregnant and lactating mothers who at each visit receive nutrition assessment*
7. *% of exposed infants who receive nutrition assessment every scheduled visit*
8. *% of exposed infants found to be undernourished and receive therapeutic or supplementary feeding support at any point during the reporting period*
9. *% of HIV positive mothers found to be undernourished and receive therapeutic or supplementary feeding support at any point during the reporting period*
10. *% of exposed infants with acute malnutrition at the 18- month follow-up visit*
11. *% of babies born to HIV positive mothers who have received a standard ARV regimen at birth in a given quarter.*
12. *% of HIV positive pregnant women not on HAART that are initiated on a standard ARV regimen during pregnancy, labour and delivery over the last 3 months*
13. *% of babies born to HIV positive mothers testing HIV positive on Final HIV test*
14. *% of HIV exposed babies tested for HIV at 6 weeks*
15. *% of HIV+ pregnant women enrolled in chronic care in a PMTCT setting over the last 3 months (newly identified- not already in care)*
16. *% of HIV positive babies enrolled into HIV/ART care from a PMTCT setting over the last 3 months*
17. *% of pregnant and lactating mothers adhering to ART over the last 3 months*
18. *% of HIV+ pregnant and lactating mothers started on ART that are still in care at 1, 3 ,6 and 12 months of care.*
19. *% of HIV + lactating mothers receiving FP services by 6 weeks*

Paediatric HIV/AIDS Care Indicators

1. *% of HIV positive children who have had at least 1 clinical (medical care) visit during the last 3 months.*
2. *% of HIV positive children on ART who kept their last scheduled appointment in the last 3 months.*

3. *% of HIV positive children receiving a CD4 test in the past 6 months*
4. *% of HIV positive children with Mid-Upper Arm Circumference(MUAC) assessment done*
5. *% of HIV positive children who were found to be malnourished.*
6. *% of HIV positive malnourished children who received therapeutic or supplementary feeding support.*
7. *% of HIV positive children receiving cotrimoxazole /dapson during the last 3 months.*
8. *% of HIV positive children who have been screened for history of TB contact or TB symptoms during the last 3 months.*
9. *% of HIV positive TB suspects investigated.*
10. *% of HIV positive children with TB disease receiving TB treatment or referred for treatment*
11. *% of HIV positive children on ART.*
12. *% of HIV positive children on ART who have had at least one adherence assessment in the last 3 months*
13. *% of patients on ART who are 95% adherent to ARV medicines*

HIV Adult Care Indicators

1. *% of clients failing on treatment*
2. *% of patients switched from 1st to 2nd line ARV therapy due to treatment failure*
3. *% of HIV+ patients on ART who have missed their scheduled appointments in the reporting period*
4. *% of patient on ART having viral load done*
5. *% of clients having a CD4 done in the last six months*
6. *% of HIV+ patients who are eligible and ready to start on ART and who have been started on ART*

Post Exposure Prophylaxis Indicators

1. *% of exposed individuals counseled and tested for HIV prior to ARV initiation*
2. *% of exposed individuals assessed for PEP eligibility*
3. *% of eligible exposed persons initiated on ARVs for PEP*
4. *% of clients on PEP given follow up appointments surveillance period*

Client Satisfaction Indicators

5. *% of clients who report easy access to services within the facility*
6. *% of clients who report adequate infrastructure for services delivery*
7. *% of clients who are aware of the availability of services offered*
8. *% of clients who report having received the prescribed service package.*
9. *% of clients who report receiving all the medicines prescribed during the last visit*
10. *% of clients who perceived health workers to have adequate technical competence to offer quality services*
11. *% of clients who were attended to after a short time from arriving at the facility*

- 12. % of clients who report receiving care in a timely manner.*
- 13. % of clients who reported to have received clear verbal and/or written expression from the health workers during service provision.*
- 14. % of clients who perceive treatment received as appropriate for their conditions*

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