QI Methods Empower HWF Performance

Evidence from the Uganda QI Program, V. Ojoome.
4GHFR Dublin, 15.11.17
Background

- Post conflict national recovery program
- 1993 - Concern about the poor quality of health services in the country
- New Health Sector Reforms including decentralization of health services to local governments
- Started as a National QA Program
Uganda QA Program: 1993 - 2005

- Led from the top
- Trained stakeholders: Central, regional, district
- Initiated quarterly quality improvement support supervision / monitoring visits
- Monthly QAC meetings to review reports from districts on quality of services
- Defined service standards for each level of care
- Held annual QA review meetings + studies to review performance of districts
- Regional movement, Jinja Regional training, MPH, RCQHC, Regional Association
MoH Top management under QA training, JHU, USA Dec, 1993
Uganda’s Strategies that Leave No One Behind and Address Inequity

- Provide a minimum health care service package for all. Aggressively implement Service Standards at all levels especially household and Community level. Affirmative action for vulnerable groups
- Abolish user-fees for the minimum service package to promote a FAIR distribution of the burden of health financing on households (PHC)
- Rational financial allocation of public funding for health care including PPP
- Institutionalize a Total Quality Management approach through systematic entrenchment of continuous quality improvement and performance culture in services delivery at all levels. Increase client participation and demand for quality of health services.
- Strengthen Independent Bodies, and Supportive Supervision
New OPD attendance at public and PNFP health facilities during the HSSP I

<table>
<thead>
<tr>
<th>Year</th>
<th>1999/00</th>
<th>2000/01</th>
<th>2001/02</th>
<th>2002/03</th>
<th>2003/04</th>
<th>2004/05</th>
<th>HSSP I Target</th>
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<tbody>
<tr>
<td>Attendance</td>
<td>0.4</td>
<td>0.43</td>
<td>0.6</td>
<td>0.72</td>
<td>0.79</td>
<td>0.9</td>
<td>0.7</td>
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Abolition of User Fees

Pentavalent Vaccine 3rd dose Coverage in infants during the HSSP I

<table>
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<tr>
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<th>2004/05</th>
<th>HSSP I Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage</td>
<td>41%</td>
<td>48%</td>
<td>63%</td>
<td>84%</td>
<td>83%</td>
<td>89%</td>
<td>85%</td>
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Lessons learnt

- Commitment of top leadership very important
- Changes in leadership can affect quality of services
- Improvement can be achieved and sustained if all stakeholders are committed to it
Challenges

- Inadequate funding of health services in the country – poor infrastructure, inadequate supplies & logistics
- High turnover of district leaders and staff
- Low health worker morale
- Understaffing
Background: Critical Success factors


- initiated as a project under WB funding

- TA from JHU/USA and QAP/URC

- Training a critical mass of health managers and district leaders
Quality Initiatives: assuring & improving Quality

- QA Program introduced in MOH with clear TOR and mandate

- Formed National QA Committee (QAC) from the trained MOH senior managers

- Trained all DHMTs & district leaders in QA management methods and their roles in improving the quality of services

- Developed QA manual for health workers
Quality Initiatives: assuring & improving Quality

- Initiated quarterly quality improvement support supervision / monitoring visits
- Monthly QAC meetings to review reports from districts on quality of services
- Defined service standards for each level of care
- Held annual QA review meetings + studies to review performance of districts
Outcomes

- Critical mass of MOH staff, district political leaders and DHTs trained

- Strengthened capacity for management of health services under decentralization, with increased role of & ownership by district leaders.

- Strengthened system for regular & integrated supervision & monitoring of district performance
Outcomes

- Enhanced awareness and quest for quality
- Improved immunization coverage
- Increased health service utilisation
Outcomes

- QAP institutionalized as a Department in MoH with clear mandates, structure, and Gov’t partial funding

- QA introduced in management module of MPH course at Makerere University

- With regional Partners established the Regional Centre for Quality of Health Care focusing on: Capacity Building (QA course); Promoting Better Practices; Regional Networking and Research for QI

- Participated in / or organized regional meetings on QI to promote quality initiatives in the region
Outcomes: Publications

- Inventory of available standards and distributed to districts
- QA manual for health workers in Uganda
- Supervision manual
- Paper in Bulletin of the WHO
- Annual Health Sector Performance Reports
- Presentations in national & international meetings