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TECHNICAL REPORT

Insights from a National Health Care Quality Improvement Strategy Meeting

Kampala, Uganda | March 21-22, 2011

JUNE 2011

The views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

Acknowledgements: *This compilation of the major discussion points shared during the Uganda Ministry of Health Quality Improvement Strategy Meeting for improving health care nationwide was prepared by Ms. Erica Koegler of the United States Agency for International Development (USAID) Health Care Improvement Project (HCI).*

HCI would like to thank the staff of the Ugandan Ministry of Health for their organization of and participation in the Strategy Meeting, particularly the Quality Assurance Department, as well as that of other Ugandan officials, conference participants, the USAID/Uganda Mission, USAID partner organizations, and other local partners.

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Abbreviations

ART	Antiretroviral therapy
CDC	Centers for Disease Control and Prevention
CQI	Continuous quality improvement
HCI	USAID Health Care Improvement Project
HMIS	Health Management Information System
HSSIP	Health Sector Strategic & Investment Plan 2010/11–2014/15
IHI	Institute for Healthcare Improvement
JICA	Japan International Cooperation Agency
MCH	Maternal and child health
MoH	Ministry of Health
MOPH	Ministry of Public Health
NGO	Nongovernmental organization
NHP II	The Second National Health Policy 2010/11–2014/15
NUMAT	Northern Uganda Malaria, AIDS and Tuberculosis Program
PMTCT	Preventing mother-to-child transmission of HIV
QA	Quality assurance
QAD	Quality Assurance Department, MoH Uganda
QAP	Quality Assurance Project, funded by USAID
QI	Quality improvement
QOC	Quality of Care Initiative
STAR	Strengthening Tuberculosis and AIDS Responses
SUSTAIN	Strengthening Uganda's Systems for Treating AIDS Nationally
TB	Tuberculosis
TQM	Total quality management
UCMB	Uganda Catholic Medical Bureau
URC	University Research Co., LLC
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

The Uganda Ministry of Health (MoH) Quality Improvement Strategy Meeting was convened in Kampala, Uganda, on March 21–22, 2011. The meeting provided a forum for various departments within the MoH, selected partners, and international improvement experts to share experiences, clarify the role of Government partners, and discuss lessons learned from implementing health care quality improvement initiatives at national and local levels. The MoH Quality Assurance Department (QAD) together with the United States Agency for International Development Health Care Improvement Project (HCI) organized and supported this meeting.

Dr. Henry Mwebesa, Commissioner of QAD, chaired the meeting. Dr. M. Rashad Massoud, Director of HCI and Senior Vice President of the Quality & Performance Institute, University Research Co., LLC, designed and facilitated for the meeting. Participants are listed in Appendix A.

Throughout the two days, participants shared their experiences with quality improvement (QI) efforts across multiple levels of the health sector, identified challenges and interventions while implementing QI, and made recommendations for harmonizing and sustaining QI efforts in Uganda. Examples discussed were from Uganda, Afghanistan, Sweden, Niger, South Africa, Ethiopia, Russia, and Palestine.

Several key themes emerged during the discussion:

Leadership

- The importance of leadership to guide health improvement efforts
- A need for leadership in QI at every level of the health system: central, district, community and facility
- MoH ownership of QI for sustainability
- Leadership creating a culture of improvement

Harmonization

- MoH coordination of various QI partners
- Collaboration among partners to work toward MoH strategic objectives
- The need for a harmonized approach to QI in the health sector

Infrastructure

- Partner utilization of existing MoH infrastructure: supervision, meetings, and data collection
- Developing infrastructure for QI at all levels: central, district, community, and facility
- Partner support for developing existing infrastructure
- Establishing resource centers for QI training and information sharing

Integration

- Integrating QI into all health programs and expanding beyond HIV/AIDS
- Partner integration into the existing MoH infrastructure

Priorities

- Established by the Health Sector Strategic & Investment Plan and the Second National Health Policy
- Leadership to determine the starting point for QI among objectives

The meeting succeeded in achieving the objectives established prior to gathering. QAD identified three next steps in moving forward: It will take a stewardship role in engaging top leadership and advancing improvement efforts; the national steering committee and core technical group for health improvement will be revitalized to advise the direction of efforts; and QAD will develop a National Quality Improvement strategy document to harmonize and integrate QI initiatives into MoH programs and infrastructure.

I. Introduction of the Uganda MoH Quality Improvement Strategy Meeting

The Uganda Ministry of Health (MoH) Quality Assurance Department convened multiple MoH departments and major partners in quality improvement from March 21–22, 2011, in Kampala to determine how all factors can be harmonized to improve quality in health care to achieve national health priorities. The purpose of this meeting was to engage in thoughtful conversation around an MoH strategy to improve the quality of health services at multiple levels of the organizational structure. Health and improvement experts from Uganda and other countries came together with the further articulated purpose to:

- Share experiences and ideas from different countries on successful models for leading and providing support for improving health care at the national level, including developing policies and plans for improvement;
- Exchange ideas on appropriate infrastructures that enable Ministries of Health to lead and support health care improvement;
- Clarify the role of partners in supporting the MoH in developing a QI strategy and infrastructure; and
- Stimulate a thoughtful conversation around quality improvement that would be helpful to participants in their work.

Dr. Henry Mwebesa, Commissioner Quality Assurance in the MoH, chaired the meeting, and Dr. M. Rashad Massoud, Senior Vice President of University Research Co., LLC (URC), Quality & Performance Institute and Director of the USAID Health Care Improvement Project (HCI), facilitated. The meeting opened with a speech from the Honorable Minister of Health, Dr. Stephen Mallinga, read by Dr. Richard Nduhura. The speech outlined Government health priorities and expectations for the meeting. It emphasized the importance and commitment of delivering quality health services to the people of Uganda through increasing funding to the health sector, ensuring efficiency in the use of limited resources, increasing human resources for health, ensuring the availability of medicines and supplies, and improving health infrastructure. The speech is in Appendix C.

The two-day meeting was designed around six questions:

1. What is the link between quality improvement, supervision, inspection, and monitoring and evaluation?
2. How did the improvement effort(s) you have experienced start? Who championed it? How was commitment sustained? How were improvement priorities set? What infrastructure was created to support improvement? How did it work?
3. What improvement approaches were used? How and why did you choose the particular approaches? How did they work? How did you resolve the balance between minimal standards and adopting best practices? How did you review progress? How did you communicate and coordinate activities?
4. If you were to undergo this experience(s) again, what was important that you would want to repeat?
5. If you were to undergo this experience(s) again, what proved not important that you would not repeat? Or done differently?
6. What should the MoH do to support the national improvement strategy (priority setting, method mix, and infrastructure)?

II. Design of the Quality Improvement Strategy Meeting

Dr. Massoud had designed the meeting to engage participants in thoughtful conversation around developing a national strategy for improving the quality of Ugandan health services. He had designed and facilitated two similar health improvement meetings with the Ministry of Public Health in Kabul, Afghanistan, and the Jordan Health Care Accreditation Council in Amman (Hiltebeitel et al. 2010; Dick 2011). This meeting was designed so that different countries could learn from each other: not to advise each other what to do, but rather offer examples and share learning of what has and has not worked in various settings. This arrangement allowed for the host country to make its own informed decisions based on an understanding of its unique environment and knowledge of similar efforts.

Conversation allowed participants to exchange “implicit” knowledge rather than the “explicit” knowledge that derives from the traditional seminar format with its series of presentations. Implicit knowledge is tacit and emerges only through spontaneous human interaction, whereas explicit knowledge reveals a structure and its elements. For the objectives of this meeting, the exchange of tacit knowledge was more valuable.

For all participants to be able to fully engage in informed conversation around the discussion questions, several recommended readings had been distributed to participants in advance. These readings provided insight into national QI efforts of various countries, including both successes and failures. These and other relevant readings are in the Bibliography.

The meeting began with each participant introducing him- or herself, reporting where they are from and their role in QI in health care. After the opening speech, Dr. Mwebesa introduced each session and question. Dr. Massoud guided participant conversation to ensure the objectives of the meeting were met, multiple perspectives were shared, and discussion points followed the topics that arose.

III. Background

As Minister Mallinga noted in his speech, this strategy meeting “occurred at an opportune time,” following the July 2010 launch of both the 10-year Second National Health Policy (NHP II) and the five-year Health Sector Strategic & Investment Plan 2010/11–2014/15 (HSSIP). These documents outline national priorities, including the Ministry’s commitment to increase the focus on improving the quality of services within the health sector for the people of Uganda.

NHP II: *Promoting People’s Health to Enhance Socio-economic Development* prioritizes “improvement of the health status of the people in Uganda.” Although health indicators had generally improved in the previous 10 years, indicators remained at an unsatisfactory level with disparities throughout the country. For example, life expectancy rose from 45 to 52 years between 2003 and 2008, HIV prevalence declined from 27% to 7% between 2000 and 2008, and maternal mortality declined from 527 to 435 deaths per 100,000 live births between 1995 and 2005. Despite improvements, these rates are still well below worldwide averages.

Within the national context, NHP II was informed by the National Development Plan 2010/11–2014/15, which recognizes that “improvement of people’s health is both an outcome and an input necessary for economic development.” Thus, NHP II articulates the MoH vision: *A healthy and productive population that contributes to socio-economic growth and national development and mission: To provide the highest possible level of health services to all people in Uganda through delivery of promotive, preventative, curative, palliative and rehabilitative health services at all levels.* This vision and mission align with Uganda’s 1995 Constitution guaranteeing the right of access to basic health services for all Ugandans.

The NHP II provides four priority areas to strengthen health systems:

1. Strengthening health systems in line with decentralization through training, mentoring, technical assistance, and financial support.
2. Re-conceptualizing and organizing supervision and monitoring of health systems at all levels in both public and private health sectors and improving the collection and utilization of data for evidence-based decision making at all levels.
3. Establishing a functional integration within the public sector and between the public and private sectors in health care delivery, training, and research.
4. Addressing the human resource crisis and re-defining the institutional framework for training health workers, including the mandate of all actors. Leadership and coordination mechanisms, with the aim of improving the quantity and quality of health workers’ production shall also be a priority.

The Health Sector Strategic & Investment Plan 2010/11–2014/15 states as its overall goal: *To attain a good standard of health for all people in Uganda in order to promote a healthy and productive life.* This goal is to be achieved through five specific objectives with a focus on universal coverage of quality health services, including: scaling up critical interventions for health; improving levels, equity, access, and demand for health services; accelerating quality and safety improvements in health and health services; improving the efficiency and effectiveness of health resources; and deepening health stewardship by the MoH.

IV. Quality Improvement in Uganda

A. Overview of Quality Improvement

Dr. Sarah Byakika, Assistant Commissioner Quality Assurance gave an overview of Quality Assurance in the health sector since 1994 when QA was implemented as the Quality Assurance Program. This led to the establishment of the MoH, QAD under the Directorate of Planning and Development in 1998. She highlighted the mandate, strategic objectives, core functions, current QI interventions, partners, challenges and the MoH strategic direction for QI.

B. Role of QAD

The QAD mandate was to ensure that the quality of services were within acceptable standards for the entire sector, both public and private health services. Its strategic objectives are to:

1. Ensure standards and guidelines are developed, disseminated, and used effectively at all levels.
2. Ensure regular supervision and monitoring is established and strengthened at all levels.
3. Facilitate the establishment of internal quality assurance capacity at all levels, including
4. Operations research on the quality of health services.
5. QAD's newest responsibility is coordination of sector performance monitoring and evaluation.

Monitoring and evaluation is a key element of quality improvement. Whereas the QAD began with only two staff members, it now has five full-time staff. It is responsible for ensuring that strategic objectives are met in all 112 districts; each has a District Health Officer who must be supported to ensure delivery of QI programs.

C. MoH-led Quality Improvement Initiatives

Between 2000 and 2005 the major MoH-supported QI initiative was Yellow Star Assessment Program. It focused on a range of services and had ample financial support throughout its duration. Yellow Star was implemented as a project rather than a program in that it had its own supervisory structure, reporting mechanisms, and meeting schedule. When it ended, it had not been integrated into the existing district health structure and it was not sustained.

The Ministry's Quality of Care Initiative (QOC) began in 2005 to ensure quality HIV/AIDS services and a rapid roll-out of antiretroviral therapy (ART) countrywide. A 2010 formative evaluation of this program determined that it was successful in improving the quality of HIV/AIDS services, rapidly scaling up ART, and establishing a national structure for rolling out and scaling up quality HIV/AIDS services. While QOC did increase collaboration between partners in some areas, weak coordination of partners remains at the national and district levels. Other major gaps identified include insufficient managerial involvement in services, lack of incentive for workers to continue the program, and reliance on external support, such as PEPFAR funding. While implemented well, QOC has not been properly institutionalized to ensure the continuation of quality health services.

Since 2005, other MoH-led QI initiatives have included 1) improving the quality of human resources through initiatives such as the Results-Oriented Management Approach, continuous medical education for professional development, and the Staff Motivation and Retention Strategy; 2) infection control and prevention; 3) quality control in central public health laboratories; 4) maternal and child death audits within the Reproductive Health Division; 5) the Clients Charter, which looks at management; and 6) the Patients Charter, which looks at patient's rights and responsibility in care.

D. Current Partner-supported QI Initiatives

The MoH has multiple partners for QI with various roles. Some are listed below, but QAD recognizes that it may not be aware of all QI partner projects, underscoring the need for greater coordination at the central level.

- The Capacity Project has provided support in improving human resources information and management to support evidence-based decision-making on the health workforce.
- HCI is supporting 39 districts to implement quality care for patients with chronic illnesses, provide palliative care, and improve newborn care.
- STAR (Strengthening Tuberculosis and AIDS Responses, adapted from HCI) has three programs in 28 districts.
- Japan International Cooperation Agency (JICA) focuses on infrastructure in 8 districts.
- STOP Malaria provides supportive supervision for malaria in 34 districts.
- The Uganda Catholic Medical Bureau (UCMB) uses accreditation, voluntary error reporting, checklists, and infection control.
- The Uganda Protestant Medical Bureau provides biannual workshops for performance sharing, offers rewards, and conducts internal audits.
- Jhpiego, an international non-profit health organization affiliated with Johns Hopkins University, is supporting two districts to implement Standards-Based Management and Recognition; the focus is infection control and maternal and child health.
- Many other partners are involved in some forms of quality improvement through different programs

E. Historical Perspective on Quality Assurance in Uganda

Professor Francis Omaswa, former Director General of Health Services in Uganda, who championed the establishment of the Quality Assurance Program in Uganda, delineated a history of Quality Assurance (QA) in Uganda. In the early 1990's a five member team, including Professor Omaswa and the Minister of Health at the time, were trained on QA approaches. This was at the time when there was reform in governance and decentralization was adopted as the best way to deliver quality health services. During decentralization the MoH established a steering committee to ensure ongoing support to districts. The committee met once a month to best determine how to strengthen health services at the national and district level with inclusion of the regional level. Around 1994 the Quality Assurance Program (QAP) was created to support health service delivery in a decentralized system. As roles devolved to the district, the MoH had to ensure health service provision was maintained at the same levels as before. Shortly after being created, QAP transitioned to the Quality Assurance Department under the Directorate of Planning and Development in the MoH. Professor Omaswa explained the importance of having QI led from the top ...*"If the top is not interested, it will not happen."*

V. Discussion Points for Improving Health Care Nationwide

A. Challenges for Health Care Quality Improvement in Uganda

Ministry of Health goals and objectives

Dr. Mwebesa, as the meeting Chair and Commissioner of QAD, opened the discussion with the meeting's salient question: There are various QI projects in Uganda: How can they be brought together based on the vision of the MoH?

Dr. Sarah Byakika, QAD Assistant Commissioner, stated that the MoH's goal is "To attain a good standard of health for all people of Uganda in order to promote a healthy and productive life." The HSSIP lists five strategic objectives to achieve this goal. Most pertinent for this meeting are the third objective: "to accelerate quality and safety improvements for health and health service through implementation of identified interventions" and the fifth: "to deepen stewardship of the health agenda by the MoH." Many QI interventions are already being implemented, but this work must be accelerated. The MoH, particularly QAD, needs to take the leadership role in quality assurance (QA) and QI programs in the MOH. The purpose of this meeting is to identify next steps that will contribute to the MOH's HSSIP strategy plan.

Current challenges to be addressed

Dr. Byakika delineated several challenges that need to be addressed in order for the MoH to have a well-functioning system of QI throughout the sector:

- Implementation is not well coordinated by the MoH, leading to multiple partners implementing in some districts while other districts are not implementing any QI initiatives;
- Initiatives are disease or program specific, mostly around HIV/AIDS;
- Initiatives are implemented by the same health workers, mostly focusing on HIV/AIDS;
- Initiatives have not been sustainable;
- Initiatives have not been integrated into the MoH system;
- There is a shortage of staff and high attrition; and
- QI documentation has not been streamlined, so it is difficult to measure improvement.

This meeting brought several departments of the MoH and various partners together to harmonize QI initiatives and performance measures under MoH stewardship. Greater coordination is needed in mapping and zoning to avoid concentration of partners in some districts and ensure all districts are supported. Clear roles and responsibilities for all stakeholders must be established to institutionalize a QI framework. A culture of QI should be developed among all implementers for sustainability. The MoH will look at how implementers are brought in and whether work is conducted as an initiative or as part of the system. The aim is for client involvement and best practices to be documented regularly and shared.

B. Leadership

Professor Omaswa, one of the original leaders of the QI movement in Uganda in the 1990's, continued by discussing the importance of leadership to create and direct an environment where improvement can occur throughout the system. Quality Improvement must be led from the top. *"If the top is not interested, it is not going to happen."* When the improvement work was just beginning in Uganda, the Minister of Health, Permanent Secretary, Director of Medical Services, and several others participated in a three-week QA training in the U.S. Upon returning, they knew exactly what to do. There was a mandate introducing decentralization to districts with training in the basic QA principles. A national committee was formed consisting of multiple stakeholders. This committee met monthly at the MoH headquarters to guide the design of how to support the districts. The USAID-funded Quality Assurance Project partnered with the Government to assist in decentralization; strengthen health services at the

central, district, and regional levels; create standards and guidelines; and perform quarterly visits. Dr. Emmanuel, former Commissioner Quality Assurance, worked hard to convince the MoH that QA had to be a department. Regional capacity was developed through three-week QA certificate courses with Dr. Maina Boucar (who was in attendance), Johns Hopkins and Makerere universities, and the MoH. A regional association was formed. Quarterly meetings were held where performance reports were discussed. Leaders recognized difficulties with timing and supervision and thus delegated some of the work to the Health Planning Department under a new QAD mandate. Leadership from the Permanent Secretary and Director General made sure this process took place. Senior leaders would start meetings on time and call out those who were late. A cultural change of what was acceptable took hold throughout leadership at all levels. Finally, a Regional Center for Quality of Health Care (RCQHC) was opened under the Institute of Public Health as a place where QA information and training could be shared throughout the system.

Professor Omaswa went on to urge the current MoH leadership and QAD to lead a new movement for improvement in the quality of health care nationwide. The RCQHC can be a partner in supporting the capacity development of the MoH. QAD has the task of making sure leaders throughout the system support QI. He noted that the two days of meeting provided a good opportunity for the beginning of change. A budget within the MoH for QI work would need to be supported by top leadership to indicate its importance and ensure ownership and sustainability. In the first movement for QA, a leadership change had spurred stewardship but this waned off with time. Now, there is again new leadership, coupled with partners to strengthen QI. This presents an opportunity to strategize, to start the movement for change. Key to such work is recognizing that improvement is about the overall system, not one particular program. QAD, particularly the Commissioner, can play a key role in getting top leaders on board. Leaders are very busy with many things, but consistent engagement in improving the quality of health can ensure leadership commitment to the movement.

C. Link Between QI, Supervision, Inspection, Monitoring and Evaluation

The first discussion question asked: *What is the link between quality improvement, supervision, inspection, monitoring and evaluation?* The following themes arose from the conversation.

Complementary components

Drs. Byakika and Betty Kasanka discussed how supervision, monitoring, and inspection are all complementary and have a role to play in QI.

Dr. Pierre Barker explained that every section of the health system needs attention, although different areas may be prioritized. Inspection and monitoring follow the implementation of standards across the system. When failures are discovered, improvement is desired. Targeted areas can apply rapid cycle changes for improvement. This is different than the generalized system of QA. Both improvement and assurance need to happen simultaneously. Whereas some programmatic areas need to be targeted with clear improvement objectives, others need to be watched over to assure performance and service standards do not slip.

Supportive supervision rather than policing

Dr. Ahmad Shah Shokohmand described a challenge with supervision in Afghanistan. Supervisors had traditionally acted like police rather than supportive coaches in developing health worker capacity. With training and attention directed toward this issue, supervision has been improved and supervisory and supervised staff are able to work together better.

Dr. Byakika said that supervision can be viewed in two ways: traditional inspection and supportive supervision. A decision needs to be made about which approach to use. Unfortunately, it is often the case that workers who go in to supervise end up reprimanding staff for not doing something right.

Dr. Amone Jackson suggested that when doing inspection and monitoring and evaluation, the kind of supervision being conducted needs to be looked at more closely. The quality of supportive supervision is also important. Currently, much of the support is emergency support rather than technical support. Also, if the supervisor providing technical support is not more knowledgeable and experienced than the worker being supervised, it is ineffective.

Dr. Vincent Oketcho stated that supervisors/inspectors are good at raising the flag on problems but that this does not necessarily lead to QI. This missing link is taken for granted; it can be solved by analyzing the why. Rather than just taking on the “checking” role of an inspector, the supporting role of a supervisor should be enhanced. Through supportive supervision teams can celebrate changes over time together.

Dr. Jacinta Sabiiti suggested that better communication be provided to workers who are being supervised and supported at various levels within the system.

Separate staff to carry out each component

Dr. Shokohmand pointed out that developing policy and strategy, delivering through implementation, and monitoring and supervision are all important tasks to be developed among staff in order to carry out QI. However, no one person can do all three. Capacity must be built at all levels and regions in order to be effective.

Dr. Byakika wondered about someone conducting supervision one week and acting as an inspector the next. She asked other participants whether both could be done by the same workers. Dr. Samson Kironde concurred that this was a challenge in Uganda. The same team will do supervision one day, monitoring the next, inspection a week later, and QI once these other tasks are completed.

Dr. Kayita proposed that tasks should be carried out by different actors. When supervision is carried out by the same workers who perform inspection or implement QI, it confuses the provider about what role the authority is playing.

Dr. Barker spoke about different components requiring different kinds of effort, each of which is distinct from the work that happens during improvement. Inspection looks at all the pieces being in place. Supervision determines if workers are able to do their job. The data required for inspection are different from those collected daily to inform improvement.

Improvement occurs inside the unit and inspection outside the unit

Dr. Sven-Olof Karlsson discussed how the work of improvement occurs within a unit that is delivering health services as opposed to evaluation and inspection, which is done by workers outside the care delivery system. It is important to evaluate and inspect work, and even inspection processes can be improved.

Dr. Kayita explained that QI happens at the source of service delivery and needs to be institutionalized there. The other components happen at other levels. Monitoring and evaluation occurs by others who go into facilities to determine if activities at the service point are in line with what the district planned.

Dr. Joyce Hightower distinguished among the purposes of 1) supervision for staff development and capacity, 2) inspection from outside on a specific health area to determine if functions adhere to standards, 3) monitoring to determine if improvement is on target, and 4) evaluation at the end. Monitoring determines if progress is being made to meet the end goal.

D. Starting, Championing, Sustaining, and Priority Setting in Quality Improvement

The second discussion question asked: *How did the improvement efforts(s) you have experienced start? Who championed it? How was commitment sustained? How were improvement priorities set? How did it work?*

Uganda Catholic Medical Bureau

Dr. Monicah Luwedde began this discussion by describing how Uganda Catholic Medical Bureau (UCMB) began its QI work. In 1998 UCMB changed its mandate to health system strengthening under the initiative of Dr. Daniel. He sat with Bishops (leaders) to determine objectives in accordance with the MoH. Objectives were listed in the mission statement, and this mandate has been sustained. Objectives included improving management, ensuring legal requirements were adhered to and patient satisfaction. To make sure the system worked, a hierarchy was created incorporating the Bishop and hospital leaders from different dioceses and a governing board and management. Managers developed guidelines with indicators for patient satisfaction and competence of care with continuous feedback at the facility and annual performance reviews. Managers were trained in how to operationalize the mandate. Communication of best practices has not occurred with the MoH because there is no structure for sharing. However, indicators provide evidence of improvement. Recently, UCMB has moved into voluntary error reporting.

Dr. Kayita asked how UCMB is linking activities with the district, and Ms. Luwedde responded that managers and health coordinators are encouraged to interact with the district to understand gaps.

Another participant spoke about how to get leadership on board and suggested a deliberate system of developing leaders' capacity and governance skills.

Jonkoping County Council, Sweden

Dr. Karlsson was the Chief Executive Officer of a health system in Sweden beginning in 1989. For about eight years he focused on finances before adopting a QI approach. When he was invited to attend a conference by the Institute for Healthcare Improvement (IHI) in 1997, he was convinced that QI was the right way to develop confidence in the health system. Managing for results became the new strategy. In addition to leaving the conference with a strategy, he knew that a change in culture was also necessary. People do not necessarily listen to leaders, but they do listen to their colleagues. It is very powerful when a colleague says that what they thought was impossible has indeed happened and provides a story to support it. This motivation became the infrastructure. Professional skills were not enough, so the system educated 5000 health workers in basic QI knowledge, values, and methods. By involving many people, results from many teams were transformed into big results for the entire system. In 2000, the system launched "Pursuing Perfection," with IHI support, to reach new levels of results for health care. He realized that employees needed systematic learning, so they established a QI learning center. With 25–30 specialists in different subject areas, the center prioritizes six strategic areas: access, education, clinical improvement, safety, prevention, and collaboration. Without the learning center, it would be difficult to change the system, as health care employees need to develop new skills. The first time a team visits the learning center, they have an introductory session and determine what they must do. Teams then return home to make changes. After six weeks, the team returns to the learning center for additional training and follow-up. Progress is seen continuously, but it usually takes eight months to reach intended results. Conferences may be interesting, but they lack follow-up. The learning center guarantees that learning continues. It is imperative that teams see good results to compare with others to achieve high quality. His system has achieved the best quality in the best country (Sweden) system in the world while maintaining the third lowest cost. High quality and low costs can be combined. Quality means doing things right, which removes waste and reduces cost. The learning center provides a permanent infrastructure ensuring that high quality is maintained.

Ministry of Public Health, Afghanistan

Dr. Shokohmand and Dr. Niaz Mohammad Popal reported that QI began in Afghanistan six years earlier in maternal and child (MCH) service delivery to address high mortality. Then, a couple of provinces adopted Standards-Based Management. By using the World Health Organization's (WHO's) surgical safety checklist, rates of antibiotic use fell within a year, and the hospital with the greatest success was

rewarded. There was strong Government support, particularly from the governor of one province who made many visits to facilities and the hospital. Community involvement was excellent, and health staff was responsive to community health needs. Leaders, health workers, and the community all championed and were committed to improvement. The Ministry of Public Health (MOPH) recognized that donor technical and financial support would not always be available, so it formed both a committee and a unit within MOPH to coordinate and sustain QI. A learning center has also been established to provide necessary materials, involve other provinces, and train health system workers to develop QI capacity and the ability to develop action plans.

USAID Health Care Improvement Project in Niger

Dr. Boucar explained that QI efforts in Niger began in human resources, as most efforts address care rather than those who provide it. A change package was developed at baseline with indicators to measure how to improve productivity, engagement, and retention of health workers to impact the quality of care. The change package was aligned with MoH national objectives as well as those of the facilities and service providers. By defining tasks, they could reach the objective. Standardized tools for engagement were a key aspect of measurement. QI involved the cycle of defining tasks, evaluating gaps, addressing the gaps, and evaluating the system. Within a year productivity improved, as demonstrated by the number of patients attending each facility, a decrease in patient waiting time, and health workers' engagement scores. The culture changed, and this work is being implemented throughout the country. If left as a project, improvement will not last. It is imperative that the existing system own the change.

Northern Uganda Malaria, AIDS, and Tuberculosis Program

Dr. Andrew Ocerro described how the Northern Uganda Malaria, AIDS, and Tuberculosis Program (NUMAT) began in 2006 after 20 years of civil war in northern Uganda. People were returning to their communities from camps, and HIV, TB, and malaria indicators were dismal with high rates of infant and maternal mortality from malaria. These challenges were addressed with key objectives to support coordinating structures, develop work plans, and improve three focus areas. Technical teams worked on improving the quality of services while building capacity within the existing infrastructure. Many challenges occurred along the way: stock-outs, lack of laboratory services, dissipated human resources, high turnover, and communities unaware of the services available. NUMAT partnered with the district to develop services, recruit human resources, recognize areas for non-financial incentives, and provide training and supportive supervision. People with HIV/AIDS were engaged in their own care and volunteered to do less-technical tasks in health facilities, such as registration, conducting follow-up, and providing referrals. A group of stakeholders of the various facilities met to discuss challenges. Teams of coordinators monitored and guided small teams of providers.

Institute for Healthcare Improvement, South Africa

Dr. Barker described part of South Africa's response to HIV/AIDS. The Government went to nongovernmental organizations (NGOs) asking what could be done. A QI wave approach was applied to three districts, covering 250 clinics and 18 hospitals serving five million people. The Government almost stopped the plan several times upon recognizing that the effort would not be sustainable. It worked hard with IHI to ensure a true partnership. District management was a key element, and data management systems were improved. The Government launched all programs. Quality mentors were trained, but IHI could not go into facilities without MoH supervision. Years later the results were much better, and the Government activated QI in other areas with rapid spread and adoption. Dr. Barker concluded that to make an impact at scale, capacity can be built and spread to other programs through Government leadership.

Conclusion

Dr. Massoud closed the session by pointing out an underlying theme of leadership structure and priority setting. Setting priorities for QI is not sufficient to make improvement happen. Change needs to be

introduced and support teams need to make it happen. This is the infrastructure. The distinction is between leadership setting priorities and technical teams making it happen. Partner participation can allow for good use of resources to meet MoH priorities. Dr. Massoud shared an experience from Russia where leaders decided to build a learning center as part of the QI infrastructure. Partners worked closely with the leadership and infrastructure. Improvement has been sustainable in this part of Russia for nearly a decade since project closure. Uganda is in a good position as it already has a quality unit in the MoH. Now is a good time for QAD to get the support it needs. The RCQHC also provides existing infrastructure that can be availed.

E. Approaches to Improvement

Question number three asked: *What improvement approaches were used? How and why did you choose the particular approaches? How did they work? How did you resolve the balance between minimal standards and adopting best practices? How did you review progress? How did you communicate and coordinate activities?*

5S– KAIZEN – Total Quality Management

Ms. Claire Asiimwe began by describing JICA's 3 step approach of 5S (sort, set in order, shine, standardize, sustain), which originates from the Japanese company, Toyota, Continuous Quality Improvement (Kaizen) and Total Quality Management (TQM). 5S focuses on improving the overall work environment and can be applied across all sectors. This evolves to CQI and then matures to TQM. Teams take and compare pictures of facilities at the beginning and end of each project. Benefits are visible and the approach uses available resources.

WHO Patient Safety approach

Dr. Hightower described the WHO Patient Safety approach used in Ethiopia. To defer costs, the WHO Patient Safety Programme used existing infrastructure and made a conscious effort to provide education. Multiple stakeholders agreed on applicable and practical components of community health worker education that could be applied anywhere in the country. The MoH within the Government ran and owned the program with volunteers, experts, and NGOs implementing it. It started with a general scope and became detailed for each sub-program. Awareness-raising of the program was conducted both in the health community and the community at large. Community leaders were invited to state their expectations from the program. Leadership development was conducted to ensure awareness of available resources. Site development allowed nurses to access new courses made available online by university professors. All organizations used the same materials, which had been agreed upon, and standards were made to align with evaluations. One challenge was that supervision had traditionally been seen as negative rather than developmental. Due to MoH ownership and allocation of its own funding, spread to all aspects of the system should occur in about two years.

USAID Health Care Improvement Project

Dr. Kakala Mushisho discussed the USAID Health Care Improvement Project's support for the MoH Quality of Care Initiative for HIV/AIDS care. Teams were formed at the national, regional, district, and facility levels. Facility-based health workers met at learning sessions that were facilitated by a core team of MoH, regional teams, and partners, to discuss QI principles, including the use of key indicators to measure compliance with the MoH's HIV/AIDS care standards. By the end of the first learning session, facility teams had formed and identified indicators to work on. Between learning sessions, facility staff was supported with coaching from both core and regional teams. After six months, teams met for another learning session, where each team could share its experiences and best practices and advise other teams on how to move forward.

Dr. Boucar of HCl explained that he has applied two approaches in West Africa. Twenty years ago he worked in a single facility applying a ten-step CQI method that began with defining what was needed and how to make appropriate changes. Because this took so much time even for one facility, a new

approach—the improvement collaborative—was applied. The collaborative approach helps a group of facilities to work on the same aim using a set of key issues, such as what to improve, how to know improvement has occurred, and what changes need to be made. In Niger, the MoH applied the collaborative approach and saw tremendous results in a much shorter time than if working with just one facility at a time.

Dr. Massoud made a connection between the 5S approach and the collaborative approach in that both apply CQI, but the second (based on IHI's model) allows improvement to occur at a larger scale. The collaborative approach supports shared CQI learning among 50–100 teams that come together in a structured process (including the learning sessions) to make a greater impact at scale.

IHI Breakthrough Series Collaborative

Dr. Barker asked how this kind of learning structure can be incorporated into a district structure where work is already being done. IHI uses the Plan-Do-Study-Act (PDSA) cycle, which can be done by ordinary health workers and is a disciplined way of analyzing data, incorporating changes into a plan, making changes, and evaluating what happened. The IHI Breakthrough Series Collaborative approach supports several clinics in coming together to work on the same problem rather than alone. Shared learning is accelerated learning. During the time between learning sessions, rapid cycle changes are made in individual facilities. This is powerful because it allows improvement to occur across a whole region. However, it must be monitored and championed for the process not to die out. Project quality mentors are not sustainable because the health system needs to sustain this action. In South Africa and Ghana, the work started in HIV and continued with TB. By working closely with district health management teams, regular district meetings provided a regular forum for QI discussion. If district managers know about CQI (how to ensure accurate data, how to look at data, how to address problems), QI can be sustainable. District teams can also encourage transparency and data sharing across the health system. Training can also support district managers in coaching rather than policing.

Appreciative Inquiry: Uganda MoH Nursing Services

Mrs. Enid Mwebaza spoke about the appreciative inquiry approach, where teams reflect on what has worked rather than looking at what has not. This allows teams to own their success, which is motivating. Supervisors appreciate, rather than police, workers.

Standards-based Approach: Ministry of Public Health of Afghanistan

Dr. Popal described the standards-based approach used in Afghanistan, where maternal and child mortality is a major problem. Checklists of minimum standards were employed at a small scale. Once proven effective, checklists were applied on a larger scale through the training of health workers. He has found that it is important to have specific indicators to measure throughout the system.

Dr. Shokohmand added that community involvement was a main focus. Pregnant women were going to facilities to give birth even though the facilities had closed. Through discussions with communities, they decided to fund housing for midwives so they would live closer to the community and improve maternal and child mortality rates.

USAID NuLife Project

Ms. Tamara Nyombi shared her experience with the NuLife (Food and Nutrition Interventions for Uganda) Project, which supports 54 facilities to integrate nutrition into HIV care. A simple, five-day training on seven steps to achieve good nutrition was conducted with health workers. NuLife utilized the SUSTAIN (Strengthening Uganda's Systems for Treating AIDS Nationally) project's regional QOC coordinators, pairing them with an MoH staff member. Coaching was conducted on site by both SUSTAIN and MoH supervisors. At the end of three months of applying training in their facilities, health workers met for a learning session. Nutrition has successfully been integrated into HIV care at these sites, and it was easier to build onto existing infrastructure.

Uganda Catholic Medical Bureau

Ms. Luwedde described the UCMB approach as a systematic process of measuring QI. Agreed-upon indicators are used by clinicians in 28 hospitals to look at care delivery. Training encourages the adoption of guidelines. Data are collected, and an assessment (including an assessment of patient satisfaction) is conducted quarterly. Facilities and managers are encouraged to share their data and how they solved their problems.

Discussion

Dr. Kayita pointed out that a health system requires reports on outcome indicators whereas HIV often focuses on process indicators.

Dr. Karlsson explained that QI occurs in daily work. Leadership involvement in concrete QI work at all levels will demonstrate its importance to everyone throughout the system. When he was a health system leader, he regularly met personally with each team. He would ask teams to describe two processes that were not good and how these processes could be improved. He would also ask how the system participants could work together to improve these processes. Measurement occurred monthly, and after six months, QI had been built into the facility's daily work.

Dr. Barker asked how standard-based approaches interact with standards. For the prevention of mother-to-child transmission of HIV (PMTCT), IHI has been able to narrow indicators down to six or seven critical indicators, but when a Government has a standard with 80–100 elements, the workload makes it difficult to integrate QI indicators. How can a quality program be built to merge indicators for quick movement in QI and the overall system?

Dr. Kayita explained how each sub-unit has its own set of data requirements but that different indicators are needed for QI and reporting purposes. Since it would be difficult to document improvement on all aspects, it is helpful to choose one or a few indicators to document improvement. If improvement occurs on one indicator, it usually occurs for others. When one indicator sustains its improvement, the team can focus on another indicator.

Conclusion

Dr. Massoud concluded the discussion by sharing how he employs 5S in his work environment at his desk. However, he distinguished the difference between improving one's own efficiency through an organized work environment and producing outcomes that are better for patients. His work has taken the CQI approach and adapted it for health work in over 32 developing countries. The power of the collaborative approach resides in the fact that it seems to be adaptable to any context and can improve health indicators for large populations in a relatively short period. Regarding indicators, he said that what we measure is very important. Good work may require 100 steps to produce improvement in an outcome measure, but often a small number of things that must happen accounts for most of the effect. For example, research has shown that in the practice of active management of the third stage of labor, there are three critical elements for safe delivery. Everything else has to happen, but these three are the most critical for producing a significant drop in postpartum hemorrhage. Can we tease out the critical few standards and measure them and the outcomes? This would relieve the burden of data collection.

F. QI Successes to Be Repeated

Question number four asked: *If you were to undergo this QI experience again, what was important that you would want to repeat?*

Institutionalization within the existing infrastructure

Dr. Hightower stated that it is important to utilize a captive audience when one occurs. Dr. Massoud replied that this is how institutionalization occurs within the existing infrastructure, when staff are

engaged to make improvements. In Russia he witnessed follow-up being integrated as part of the regular meetings of department heads, which heads of districts also attended, rather than having a separate project structure to support meetings for district heads. At the departmental meetings, district heads were required to publicly report progress, spurring them to make progress between meetings.

Dr. Shokohmand explained how incorporating key indicators proved to be very useful in Afghanistan as all of the good work was not being captured in the reporting system. User-friendly measurement with simple tools and key indicators saves valuable time.

Dr. Massoud asked if anyone had had experience integrating data for improvement into the regular health management information system. Dr. Barker responded that the strongest plank of improving the overall system is to work within it. Working within the existing data infrastructure should be a strong guiding principal of data collection.

Activating the community, including community health workers

Dr. Oceró described grassroots challenges in Uganda, where the number of health workers is limited and community health workers are often volunteers.

Dr. Shokohmand shared how Afghan health workers share data with the community and then send it to the district. Health workers are trained to collect quality data at multiple levels, at sites, regions, and provinces. When he visits a facility and asks a health worker why he/she is sending data to the central level, the worker replies that it is his/her job to do so.

Dr. Mwebesa shared that he would repeat a participatory approach to developing standards, involving health workers, partners, managers, and the community. He was reminded of something Professor Omaswa had said: the importance of working with all levels, including the district and facility, to identify problems together with the teams on the ground—teams that remain there to work on the problems—review for improvement, and review with the district. This allows for all stakeholders to own the problems. Existing problems are everyone's problem, not just the facilities'.

Ms. Luwedde explained how continuous supportive supervision should be repeated. If health workers are supported, they will be more engaged in their work and have ownership of the results.

Dr. Oketchó discussed how human resources for health need to be empowered through collecting self-assessments, identifying problems, measuring gaps between desired quality and existing quality, and being supported to identify solutions to bridge gaps. If health workers see that their input impacts outcomes, improvement becomes sustainable.

Culture change and leadership

Dr. Karlsson discussed how after leading QI in Sweden for several years, he realized that a principal factor was to change the culture. He is now working in Armenia and is focused on culture change. To do this, he meets with leaders and Chief Executive Officers to determine if there are meetings where staff culture and values can be discussed. Culture change should occur in tandem with the project.

Dr. Massoud pointed out that too often discussion of QI focuses on methods. Over time, it is clear that leadership is what really influences improvement. While heading improvement in Palestine, he asked the MoH to ask his director to report on progress as a part of their regular meeting. This small step helped put improvement on the Minister's agenda, and the quest for improvement then filtered down through the system. If he were in such a position again, he would make sure reports on improvement were requested at every level.

Dr. Jennifer Wanyana discussed how leaders should set an example. When midwives identified facilities that failed to meet cleanliness standards, managers asked for cleaning equipment and demonstrated how to clean ceilings and walls. Service providers appreciated this exercise. If improvement is expected to

happen at the lower level, the central team must be willing to put their hands to work to show how things are done practically. Hands-on skill-building produces an overwhelming response by participants.

Using data as evidence

Dr. Boucar stated that he would repeat conveying results through evidence and data. This allows leaders to really get involved because they see added value of evidence and data. Even if leaders are not involved in the QI work, this allows them to participate.

Dr. Popal provided an example of using data. In Afghanistan, patients were encouraged to ask their doctor if he/she had washed his/her hands but social barriers made patients uncomfortable in doing so. The QI team analyzed the situation and had doctors 1) distribute pictorial pamphlets about the importance of hand washing, to be given by clients to the providers as a reminder, and 2) ask other doctors if they had washed their hands. Patients were observed to be more comfortable with doctors themselves initiating the topic of handwashing. The cycle of collecting data, analyzing them, making a change, and collecting data again showed evidence of improvement in this priority area.

Ms. Asiimwe emphasized the importance of continuous monitoring by partners and the MoH rather than just collecting data once.

Information sharing

Dr. Hightower spoke about the importance of holding regular meetings with all improvement stakeholders, as he had done in Ethiopia. Although the intention was to determine what others were doing, it turned out that sharing information fostered relationships so that all could collaborate and move as one concerted body making improvement.

Dr. Kayita stressed the importance of peer learning, saying that a practice that should be repeated is supporting people living with HIV/AIDS to counsel others living with HIV/AIDS. People learn from each other and shared learning can result in faster learning. If leadership is only top down, it can fail, but when peers hear from their colleagues, they pick it up quickly and move forward. Benchmarking can be useful for friendly competition because one team will surpass another. A system of rewarding those who are successful can be very powerful. Appreciation does not have to be financial. In Uganda, appreciation has been expressed at music shows. Improving health systems can also be informed by innovations that are producing results outside the health sector.

Collaboration of partners

Dr. Barker compared partners working one on one with the Government or a facility to working collaboratively with several other NGOs to support the Government on a priority, a breakthrough he witnessed in South Africa. The Government was convinced that QI could accelerate improvement and asked IHI to bring together various teams. In one day, teams agreed to work around a simple QI framework, follow six indicators, and show work transparently to the Government and each other. The teams meet periodically to share information. Each system needs to find ways for NGOs to collaborate rather than compete and ultimately to assist the Government in reaching its goal of improving outcomes.

Dr. Massoud summarized the session by saying that the focus should be on understanding culture, which gets at the heart of people's value systems, rather than on which methods are employed. If values are understood, a culture can be created to align improvement with what matters to people. Taping into people's value systems motivates them to work hard for what is important to them, in this case, saving people's lives. How it is done is not important. What is done today will not be the way it is done tomorrow or what was done three years ago. Supporting health workers to do good work will help the health system do better. Furthermore, The MoH can recognize what needs to be done, harmonize areas and levels, and integrate data systems to streamline processes. Integrating work into regular meetings and regular communications allows people to be supported in the work they do. Technical

support is also important. Peer learning offers support in a way that results in a powerful movement forward and faster improvement.

G. What Not to Repeat

Question number five asked: *If you were to undergo this experience again, what proved not important that you would not want to see repeated? Or done differently?*

Insufficient training

A representative of the MoH AIDS Control Program discussed how managers must know the specifics of what is supposed to take place at the lower levels in order to properly supervise and create a culture of improvement. A regional meeting had been held during the previous week with not a single mention of quality. It is assumed that quality is there, but this should not be taken for granted. For sustainability, the QAD can find a mechanism to create the right culture for improvement once something has gone wrong. Managers do not know how to determine if improvement has occurred and need one packet for understanding this throughout all programs. This can be generic and then customized for different interventions. To facilitate this, a pre-service training for health workers on QI would make obvious the skills that are required to make changes that reflect values. Uganda has several training programs and all should have a QI component. If the Health Management Information System (HMIS) doesn't use data for improvement, can a process be created to establish the collection of such data?

Ms. Luwedde said that there is no correlation between trainings and what needs to be done for improvement. Doctors and clinical staff have technical skills, but they do not necessarily have the administrative skills to understand the costs of efficiently running a hospital. Also, high attrition rates can cause changes to be lost when staff leaves.

Dr. Massoud reported that he once trained heavily in improvement, but now QI training is reduced to the basic principles so workers can apply QI when it is needed.

Not utilizing existing infrastructure

Dr. Mwebesa stated that Uganda's supervision system is ineffective. Yellow Star had many elements to make it a good program: It involved all stakeholders, had minimum standards, and provided assessment and monitoring. However, it was not sustainable. Partner funding provided adequate funding, but at the end of the program, supervision had not been built into the existing system. If Yellow Star had been integrated into the MoH and Local Government systems, work plans, budgets, and supervision system, it could have been sustainable. If Yellow Star were redone, he would like to see it done in a sustainable way.

Dr. Popal stressed integrating QI records into the existing HMIS, because if QI is additional work, it will not take hold. Stakeholders can be convinced to find solutions through the evidence data provides and through recognition of the community making improvements. Integration should not just focus on output and processes. Policy makers and donors need to recognize the difference between high-level efforts and what exists on the ground.

Ms. Asiiimwe explained that involving leadership at all levels is important, but a mistake in the past was not involving Chief Administrative Officers.

Dr. Barker discussed how QI must be demonstrated to build confidence. In South Africa, QI started on a small scale, but then it was difficult to move on once the project ended. Today IHI doesn't take on a project unless it would contribute to the program's design and execution, so improvement is sustainable. Projects need to plan an exit strategy, once the demonstration has proven successful, that will sustain the work.

Not creating a culture for improvement

Mrs. Margaret Chota lamented not seeing changes in attitudes. Health workers are continuously going to workshops by various entities, but when supervisors visit facilities, operational changes often have not been made. More follow-up is needed to determine whether attitudes have changed.

Dr. Shokohmand said the main responsibility of high authority is to share issues with health providers. QI means being patient centered so that the patient is satisfied. Provider satisfaction is also important because the provider is responsible for implementation. In Afghanistan, the MoH has improved recognition of good staff. Recognition should be evidence-based and documented; otherwise it self-destructs.

Other components

Dr. Jackson, the MoH Assistant Commissioner Health Services, Curative, said that there are too many indicators overall so the MoH is unable to measure what is really needed. Precision in indicators would be very good. A closer look at managers and supervisors is also needed. Often times, a manager or supervisor has not had hands-on experience in the area he/she is overseeing. Additionally, many of them act as police rather than as mentors and coaches. Supervisors should also be monitored and evaluated for quality.

Dr. Byakika compared a facility that had two teams. One team provided financial incentive whereas the other team only offered refreshments during QI meetings. When both projects ended, the work of the team not offered the financial incentive was sustained, and that of the team receiving it was not.

Dr. Hightower emphasized the importance of involving patients from the beginning and how this could be incorporated into program planning.

Dr. Massoud agreed that programs should be deliberate about involving patients from the beginning. Also, there was a period when considerable time was spent developing guidelines: By the time they're complete, they are often obsolete and nothing has been accomplished to improve health care. He recently learned of an organization that spent three years developing guidelines, changing no practices or behaviors. There is a difference between what is on paper and the practices providers exercise at their work sites. A focus on changing clinical practices and behavior will have a greater impact on patients. He concluded by stressing the importance of streamlining work between the Government and its partners.

H. Recommendations

The sixth question was: *What would the MoH do to support the national improvement strategy (i.e., priority setting, method mix, and infrastructure)?*

Several members of the different MoH departments, international quality experts, and Uganda MoH partners offered recommendations:

The Ministry's Dr. Jackson stated that programs in reproductive health, malaria, TB, and HIV/AIDS as well as clinical services need to use QI to benefit patients. He suggested, first, the direct involvement of the MoH at all levels so QI will improve the whole system. Second, QAD should be strengthened so it can fully advance, coordinate, and champion QI. Third, the MoH should harmonize all QI projects, using the same language and indicators, so health outcomes addressed through QI can be interpreted to better serve patients. Fourth, the Ministry should take a closer look at who is supervising and where and how this is happening.

Dr. Kayita, also of MoH, pointed out that different MoH departments are using data in different ways, some are benchmarking while others are not. He recommended that this should be examined and harmonized in order to move forward. He also suggested that QAD should share information on what other departments are doing in QI to accelerate progress.

Dr. Shokohmand shared an experience from Afghanistan, recognizing that all quality problems cannot be addressed at once. After the QI Policy Seminar in Kabul, the MOPH formed a working group similar to QAD. They also formed a core group of all the stakeholders active in QI and a task force, chaired by the Deputy Minister of Health, which demonstrated strong leadership. These teams defined QI in health care, consensus building, and other key terms relative to the local setting. The teams also reviewed key documents to establish priority areas for the first three to five years. Then, the teams identified the objectives and strategies to have the work plan incorporate them.

Dr. Oketcho offered suggestions on priority setting. First, he recommended that QAD compile a situational analysis of the various QI stakeholders in the health system to establish the what, how, where, and the results of each. Then, QAD can create a comprehensive strategic framework that coordinates NGOs and other stakeholders.

Dr. Massoud called attention to the difference between the central role of the QAD as the executive body responsible for taking action and that of a committee; the latter is to advise, support, and make linkages to inform the executive body in its actions.

Dr. Kayita then pointed out that several HIV QI committees had been established but are dormant. These committees include a core team that coordinated technical advisers, a committee that linked different levels of the system to the districts, and a national steering committee that advised the overall system.

Ms. Jacqueline Calnan of USAID and Dr. Massoud both recommended building on existing committees to integrate new functions into existing structures. They emphasized the different roles, where a steering committee would advise the policy direction of improvement and the executive body would make decisions on the basis of that advice and take action to advance health improvement.

Dr. Sabiiti and Ms. Gorrette Nalwadda recommended that new committees incorporate all aspects of the health system (for example, TB, malaria, human resources, MCH) to the committees that were created for improvement in HIV/AIDS. These committees should also include areas that often lack attention, such as immunizations, health education, and sanitation.

Dr. Byakika stated that the original committee included all MoH departments but is no longer functioning. Also, the new committee for QI in HIV/AIDS is mostly clinically focused. To build on these, QAD will review what has happened and make a new beginning, putting in place structures delineating clear roles and responsibilities. A strategic QI framework will be developed that includes input from all QI stakeholders.

Dr. Boucar reported that a good starting point for QI is determining the central priorities and what partners can do to help achieve them. After determining priorities, establish policy, then develop national strategies, and then conduct a national evaluation of these strategies, all the while pushing partners to help the MoH to achieve the priority goal.

Dr. Massoud asked participants to consider the structure needed at the non-national levels that would foster the integration of QI within district health management. For example, should QAD ensure that QI committees are created at the district and facility levels?

Dr. Byakika responded that QI committees exist in most districts around QI for HIV/AIDS and include the District Health Officer, district representatives, and other key partners implementing HIV services. Challenges with this structure include coordinating the various partners' arrangements and broadening the approach to other technical areas.

A STAR representative said that their projects often rely on regional leaders. More improvement mentors should be trained to facilitate the skills required to implement QI. Another participant suggested looking at structures outside the Ministry to determine how those systems coordinate various technical areas.

Dr. Barker reminded participants that Uganda already has two key documents providing a roadmap, with priorities and guiding principles already laid out. The NHP II outlines the minimum package for quality health services with clearly stated priorities. The HSSIP lists guiding principles and describes how the Government wants to interact with partners. Because these key decisions are already made, a next step is for leaders to establish a monitoring plan. Uganda's appreciable capacity is demonstrated by the progress made to date. Dr. Barker has witnessed all partners coming together under a common reporting framework in South Africa and sees great opportunity for QAD to move the QI agenda forward.

Dr. Shokohmand explained how Afghanistan's QI unit (similar to QAD) has authority in an executive role and coordinates QI throughout the system. Two concerns arose in Afghanistan. The first is in implementation and regards duplication in the technical departments. The second is verticality, as the unit needs financial support from different departments and Ministries to fully advance the QI strategy.

Dr. Kayita said that with regard to the whole health system, Uganda is not very different from Afghanistan. In addition to utilizing HIV QI staff at the district level, the Department of Community Health currently supports all districts within a region and can be engaged. The district level must be brought on board, and the QI capacity of clinical officers and nurses must be built. Although structures exist on several levels, there is no existing improvement structure at the facility level, where services are delivered and the opportunity to be patient-centered exists. Implementation is the issue, not structures. If structures are not meeting, then no action or change is taking place. However, without resources supportive supervision cannot take place. He suggested that partners play an active role in supporting the district level to build capacity, not structures.

Dr. Oketcho said that the national strategy should support the District Health Team (DHT) and vice versa. District teams must be empowered to develop district strategies that feed into national strategies to avoid going into project mode.

Dr. Shokohmand also discussed the importance of community health teams in Afghanistan because weather can prohibit higher levels from visiting implementation sites at certain times in the year. Community teams are responsible for making sure the community is receiving what is needed.

Dr. Nathan Tumwesigye stated that a movement from QI in HIV to general health care QI is overdue. He asked how funds from QI in HIV can be leveraged to broaden the QI approach to general care and filtered down from the central to regional to district levels.

Dr. Hightower explained that WHO funding is health area-specific but that resources could be applied to other areas if existing programs were in place. In such cases, using existing structures is easier than creating new programs.

Dr. Byakika said that QAD is proposing re-strategizing all the existing QI initiatives to integrate all health sector priority areas in a phased approach. Integration should be guided, and each district is not meant to develop a different plan. She suggested that partners work in districts participate in the development of the national QI strategy, standards and tools so movement can occur at the same time. This will enable the QAD to coordinate, monitor and measure changes nationwide. Without harmonizing tools and standards, partners will continue to work in a piecemeal fashion. Resources need to be pooled so coordination can improve patient outcomes. Priorities moving forward include creating a national improvement framework and conducting training in the basics of QI.

Ms. Calnan said that USAID is committed to continue supporting QI initiatives but would like to see parallel commitment from the Government as well, both in action and in resources. Many partners offer different QI approaches, but the principles are the same. Partners should not be competitive but rather should work within a Uganda-designed framework.

Dr. Massoud asked participants to consider the recommended reading on Pseudoinnovation. It discusses how QI has changed in approach and terminology over the years. However, most approaches adhere to the same basic principles, which can produce tremendous results if structures are not caught up in redesigning programs based on seemingly “new” approaches.

Dr. Hightower noted that different NGOs have different timelines for proposals and funding, some of which are already in effect. Nevertheless, if NGOs are expected to work within an MoH-designated improvement framework, they will do so when plans are rewritten. For this to work, Government money should be allocated to support priorities and train regional and district staff such that NGOs will adhere to the existing infrastructure. Although this will take time to adjust, within five years all partners can be plugging into the Government framework.

Dr. Boucar reinforced that different resources can be leveraged to affect improvement comprehensively in health care through pooling and efficiency.

Dr. Massoud then summarized the discussion’s key points: infrastructure can be built on multiple levels with the executive function of QAD being a critical factor; committees can be established with different actors relevant to decision making; responsibility and accountability for QI resides with QAD; district and facility health teams need to be engaged, as this is where quality the delivery of quality can occur; a national framework developed by the country with the guidance of all key players is needed; and other experiences can support these processes.

VI. Overall Themes

A. Leadership throughout the Health System

Leadership at the central, district, and community levels

Leadership begins from the top and reaches every level of a health system. Central leadership of top MoH officials can influence the culture of a system where priorities are addressed throughout the system. In Uganda, the MoH Quality Assurance Department is the champion for ensuring that top MoH leaders actively support continuous improvement in all aspects of the health system. A central steering committee and core technical group can be rejuvenated to guide the process nationwide. District leadership is critical for ensuring that improvement occurs at the implementation level. Steering committees and core technical groups similar to those at the higher level can be enhanced at the district level. Community leadership influences how implementation of a QI strategy occurs on the ground. Similar structures and processes at the community level can increase equity countrywide.

Ministry of Health ownership

In order for improvement in health services to be continuous and sustained, existing country infrastructure must have ownership of the entire process. Government partners must work toward goals established by central leadership and integrate their processes into the existing systems of supervision, regular meetings, and data collection. An important aspect of ownership includes allocating funds for sustainable activities.

Creating a culture of improvement

Dr. Karlsson stressed that creating a culture of improvement was the most important aspect in establishing QI in Sweden among the health systems with the best indicators worldwide. He explained how leadership gives strong signals about what is important in the system and has the ability to support the system and create good conditions for improvement. The QAD in Uganda and several meeting participants agreed that a culture of QI should be created so that despite turnover, a QI culture remains and new staff enter with QI knowledge. Partners play a key role in this, and MoH leadership can determine how partners are brought in and implement their programs.

Quality improvement champions

QI champions are leaders who move and guide improvement. They are needed at every level in the health system, with QAD being the central championing body within the MoH Uganda. Their role is to set expectations for improvement, call attention to the importance of QI through regular discussion in ongoing interactions, and demonstrate how to implement QI.

B. Harmonization of Partners and QI Approaches

Coordinating partners

Several partners are working with Uganda's MoH to improve the quality of various health areas. Partners are not organized in a way that prevents duplication and ensures all districts receive support. For example, one district may have dozens of partners while another has none. Even a facility may have multiple partners or none. Partners can provide complementary services, for example, one in health workforce development and another in PMTCT. However, for equity purposes, it may be preferable to ensure some districts are not completely neglected in receiving partner support. One role of MoH, particularly QAD, can be to coordinate QI activities so improvement will occur throughout all districts. Clearly, QAD should know and be in regular contact with all partners, identifying and coordinating partner efforts to ensure quality, synergy, and equity.

Collaboration of partners

Participants agreed that partners should collaborate with the Government and pursue MoH-specified goals. However, it is their nature to compete for their survival, and it is unlikely that all partners will initiate systematic collaboration among themselves to meet Government-specified goals. The MoH can take a leadership role to help partners collaborate better to achieve both their goals and those of MoH.

Harmonizing QI approaches

Partners spoke of the various approaches they use to foster QI. They recognized that each approach uses similar principles. Harmonizing QI approaches throughout Uganda lies would improve reporting, making more data available for the analysis of improvement. If the central level can use such data to determine where improvement occurs, it can also determine what needs to be done and map the path showing how.

Harmonizing data collection

Dr. Shokohmand spoke of how valuable it had been in Afghanistan to harmonize data collection to provide an evidence base for improvement in health indicators. Uganda lacks a harmonized system for data collection of improvement indicators. Harmonized tools and guidelines across technical areas for all implementing entities can lead to comprehensive data of improvement within the health sector. These data could then be used to guide the system in determining priorities and policy.

C. Infrastructure for Health System Strengthening

Using existing infrastructure for sustainability

Yellow Star's failure to sustain improvement in the health sector demonstrates the need to use existing structures of supervision, regular meetings, and data collection. If parallel systems are established that run concurrent to Government systems, when funding stops, the system will not continue. Many participants said the health system should operate in program mode rather than project mode. Central Government leadership can determine how projects operate under governmental programs. Resources from both the central Government and supporting partners can be used to ensure all projects fit within the programmatic structures created by the MoH.

Maintaining infrastructure on all levels

For improvement projects to adhere to the central Government's program requirements, infrastructure needs to be strengthened and maintained at all MoH levels: central, district, community, and facility structures. Improvement projects should feed into national improvement programs through the systems that exist at all these levels.

Establishing resource centers for sustained change

Improvement leaders from Sweden and Afghanistan related anecdotes from their experience to emphasize the importance of establishing centers to ensure continuous improvement. Learning or resource centers can be part of the infrastructure for improvement and help create a culture of improvement through QI training for health workers at all levels. Africa's RCQHC provides training in improving the quality of health care, documenting and sharing learning of best practices, advocacy, technical support, and operations research. Situated in Makerere University in Kampala, the RCQHC offers a great opportunity for strengthening the improvement strategy within the Ugandan MoH. In addition to availing this resource, participants suggested that regional resource centers be established as part of the MoH infrastructure for sustained health improvement.

D. Integrating All Technical Areas and Partners

Improvement in all health technical areas

Historically, Uganda implemented improvement in the quality of general health services. Upon leadership change, less attention was given to improvement in all technical areas and more to that of HIV/AIDS services. Participants agreed that improvement must be expanded to all technical areas, including, but not limited to, maternal, newborn, and child health; TB; malaria; reproductive health; immunizations; and sanitation. A silo approach to improving health sites has not produced the results the MoH expects. It was recommended that the way forward is integrating improvement for all services provided at a health facility.

Integrating partners into an MoH-determined strategy

In accordance with recommendations made during this meeting and for the sustainability of health improvement, partners should operate under a national strategy that is determined by the MoH based on its priorities. Several partners agreed that it is to the benefit of the people of Uganda to function under one unified strategy, using the MoH infrastructure. One partner role can be to contribute to building the capacity of the existing infrastructure to ensure sustainability, implying a shift from improvement projects operating in project mode to all partners operating in harmony with MoH programming.

E. Priorities

The Ministry has laid out its goal and objectives in its HSSIP and NHP II documents. Because all areas cannot be improved at once, priorities should be set from among their objectives. Top leadership from the Minister of Health coupled with the revitalization of a national steering committee and core technical group for improvement can determine the starting point. QAD can serve as the executive to ensure selected priorities are carried out throughout the health sector.

VII. Conclusion and Next Steps

The Ministry of Health is committed to developing a strategy that will harmonize the various QI initiatives underway in the country and initiatives planned for the future. The USAID Health Care Improvement Project and various partners are willing to provide support to the Ministry as needed. The steering committee and core technical team will be revived to move forward in strengthening the overall health system; this will require a budget as part of the institutionalization of ongoing improvement in health care.

In response to the engaging two-day discussion and many pertinent recommendations, QAD identified the following next steps:

1. QAD will provide stewardship and engage key leaders throughout the health system from top officials in the central MoH, district leaders, and technical and community leaders, with QAD acting as the principal mover for a QI initiative throughout Uganda for the benefit of patients.
2. The policy steering committee and the technical core team for improving health will be revitalized in a way that integrates their functioning into the existing organizational structure. The role of both the steering committee and core team is to advise the direction of QI efforts now, with the objective of sustainability. The core team will advise the direction of day-to-day QI efforts in health care delivery. The steering committee will advise the direction of QI at a higher level.
3. QAD will develop a national QI strategy document to harmonize all QI initiatives and integrate initiatives and partners into the MoH infrastructure in accordance with MoH priorities. The national QI strategy will be completed and provided to the Minister of Health, Dr. Malinga, within two months.

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Appendix A: Participants in the Uganda MoH Quality Improvement Strategy Meeting

Ministry of Health of Uganda

1. Dr. Richard Nduhura, Minister of State for General Duties
2. Dr. Henry Mwebesa, Commissioner, Quality Assurance
3. Dr. Sarah Byakika, Assistant Commissioner, Quality Assurance
4. Dr. Isaac Kadowa, Principal Medical Officer, Quality Assurance Department
5. Dr. Martin Ssendyona, Senior Medical Officer, Quality Assurance Department
6. Dr. Jacinto Amandua, Commissioner, Clinical Services
7. Mrs. Margaret Chota, Commissioner, Nursing Services
8. Dr. Jackson Amone, Assistant Commissioner Health Services, Curative
9. Dr. Jennifer Wanyana, Assistant Commissioner, Reproductive Health
10. Mrs. Enid Mwebaza, Assistant Commissioner, Nursing Services
11. Dr. Jacinta Sabiiti, Senior Medical Officer, Uganda National Expanded Program on Immunization
12. Dr. Betty Kasanka, Senior Medical Officer, AIDS Control Program
13. Dr. Godfrey Kayita, Program Officer, AIDS Control Program
14. Dr. Zainab Akol, Program Manager, AIDS Control Program
15. Dr. Samuel Kasozi, Coordinator, Multi-drug Resistant Tuberculosis

USAID Uganda

16. Dr. Aleathea Musah, Manager HIV/AIDS Program
17. Dr. Seyoum Dejene, Deputy HIV/AIDS Team Leader
18. Ms. Jacqueline Calnan, Program Management Specialist, HIV/AIDS

U.S. Centers for Disease Control and Prevention

19. Mr. John Ssenkusu, CDC Uganda
20. Ms. Charmaine Matovu, Technical Advisor, CDC Uganda

Ministry of Public Health of Afghanistan

21. Dr. Ahmad Shah Shokohmand, Advisor to the Deputy Minister for Health Services
22. Dr. Niaz Mohammad Popal, QI Consultant Unit for Improving Quality in Health Care

USAID Health Care Improvement Project

23. Dr. Pierre Barker, Senior Vice President Developing Countries, Institute for Healthcare Improvement
24. Dr. Sven-Olof Karlsson, former Chief Executive, Jonkoping County Council, Sweden
25. Dr. Maina Boucar, Associate Project Director for West Africa, University Research Co., LLC, USAID Health Care Improvement Project
26. Dr. M. Rashad Massoud, Senior Vice President, Quality & Performance Institute, University Research Co., LLC, and Director of the USAID Health Care Improvement Project
27. Dr. Humphrey Megere, Chief of Party Uganda, University Research Co., LLC, USAID Health Care Improvement Project
28. Dr. Alex Kakala Mushisho, Quality Improvement Advisor, University Research Co., LLC, USAID Health Care Improvement Project
29. Ms. Erica Koegler, Technical Assistant, University Research Co., LLC, USAID Health Care Improvement Project

International Agency Representatives

30. Dr. Joyce Hightower, Regional Manager, African Partnerships for Patient Safety, WHO Patient Safety
31. Mr. Takanu Shintaro, Country Representative, JICA Uganda
32. Ms. Claire Asiimwe, In-house Consultant for Health, JICA Uganda

Implementing Partners

33. Professor Francis Omaswa, Executive Director, African Centre for Global Health and Social Transformation
34. Dr. Vincent Oketcho, Chief of Party, Capacity Program
35. Dr. Faustino Maiso, Program Officer, Capacity Program
36. Dr. Kenneth Mutesasira, Clinical Services Advisor, STAR, East-Central Uganda
37. Dr. Samson Kironde, Chief of Party, STAR, East-Central Uganda
38. Dr. Moses Walakira, Technical Director, STAR, South-Western Uganda
39. Dr. Monicah Luwedde, Quality & Patient Safety Coordinator, Uganda Catholic Medical Bureau
40. Dr. Lorna Muhairwe, Executive Director, Uganda Protestant Medical Bureau
41. Ms. Gorrette Nalwadda, Consultant, Jhpiego
42. Dr. Victoria Masembe, Country Director Uganda, AIDS Support and Technical Assistance Resources One, John Snow, Inc.
43. Dr. Nathan Tumwesigye, Chief of Party, University Research Co., LLC, SUSTAIN Project
44. Ms. Margaret Kyenkya, Chief of Party, University Research Co., LLC, NuLife Project
45. Ms. Tamara Nyombi, Nutritionist and QI Specialist, University Research Co., LLC, NuLife Project
46. Dr. Andrew Ocerro, for the Chief of Party, NUMAT
47. Dr. Paul Tumbu, Manager of Medical Care Services, Baylor Uganda
48. Ms. Regina Namata Kamoga, Country Manager Uganda, Community Health and Information Network

Appendix B: Agenda of the Uganda MoH Quality Improvement Strategy Meeting

Date: 21st–22nd March 2011

Venue: International Conference Centre, Serena Hotel

AGENDA

Time	Session	Presenter/ Responsible Person	Chair
21st March 2011, Monday			
8.00–8.30 am	<i>Arrival / Coffee</i>	Ministry of Health	MoH
8.30–9.00 am	Introductions	MoH Quality Assurance Department	
9.00–9.15 am	Welcome Remarks and Meeting Objectives	Director General, MoH	
9.15–9.30 am	Remarks by USAID Mission	S08 Team Leader	
9.30–10.00 am	Official Opening	Minister of Health	
10.00–10.30 am	COFFEE BREAK		
10.30–11.30 am	Experiences from other countries		
11.30–12.30 pm	Discussion question #1: What is the link between quality improvement, supervision, inspection and monitoring and evaluation?		
12.30–2.00 pm	LUNCH		
2.00 –4.00 pm	Discussion question #1: What is the link between quality improvement, supervision, inspection and monitoring and evaluation?		
4.00–4.30 pm	COFFEE BREAK		
4.30–5.00 pm	Discussion question #2: How did the improvement effort(s) you have experienced start? Who championed it? How was commitment sustained? How were improvement priorities set? What infrastructure was created to support improvement? How did it work?		
6.00–7.00 pm	COCKTAIL		
22nd March 2011, Tuesday			
8.00–8.30 am	Breakfast and registration		
9.30–10.30 am	Discussion question #3: What improvement approaches were used? How and why did you choose the particular approaches? How did they work? How did you resolve the balance between minimal standards and adopting best practices? How did you review progress? How did you communicate and coordinate activities?		
10.30–11.00 am	COFFEE BREAK		
11.00–12.00 am	Discussion question #4: If you were to undergo this		

	experience(s) again, what was important that you would want to repeat?		
12.00 -13.00 pm	LUNCH BREAK		
1.00–2.00 pm	Discussion question #5: If you were to undergo this experience(s) again, what proved not important that you would not want to see repeated? Or done differently?		
2.00–3.00 pm	Discussion question #6: What would the MoH do to support the national improvement strategy(Priority setting and method mix) and infrastructure		
3.00–3.30 pm	Coffee break		
3.30–4.30 pm	Process for defining a quality improvement strategy for Uganda		
4.30–5.15 pm	Concluding remarks and way forward		
5.15 –5.30 pm	CLOSING REMARKS	Ministry of Health & WHO Patient Safety	

Appendix C: National Health Care QI Meeting Opening Speech

NATIONAL HEALTH CARE QUALITY IMPROVEMENT MEETING

INTERNATIONAL CONFERENCE CENTRE SERENA: 21 – 22 MARCH 2011

**OPENING SPEECH BY THE HONORABLE MINISTER OF HEALTH, DR. STEPHEN MALLINGA,
READ BY DR. RICHARD NDUHURA, MINISTER OF STATE FOR GENERAL DUTIES**

The WHO Country Representative
The Director General Health Services
The Senior Vice President URC & Director Health Care Improvement Project
The SO8 Team Leader, USAID
Invited dignitaries from outside Uganda
Health Development Partners
Directors / Heads of Implementing Agencies
Ladies and Gentlemen

First of all, I would like to welcome you all to this very important meeting. In a special way, on behalf of Ministry of Health and the Government of Uganda, I would like to welcome our international guests to this beautiful country. I hope that after two days of hard work in this meeting, you will stay around to enjoy the beauty of Uganda and the hospitality of its people. I would also like to inform you that we have just concluded peaceful elections for His Excellency the President, Members of Parliament and other office bearers. The country is peaceful and secure. So please feel at home.

Let me now focus on the reason why we are here. This meeting has occurred at an opportune time when we have just launched our 2nd Ten-Year National Health Policy and 5-Year Health Sector Strategic and Investment Plan. Both the Policy and Investment Plan emphasize delivery of quality services to the people of Uganda.

As part of improving the quality of services offered to our population, the NRM Government is focusing on addressing the following priorities:

- Increasing funding to the health sector,
- Ensuring efficiency in resource utilization of the limited resources,
- Increasing human resources for health, i.e. numbers and skill mix,
- Ensuring availability of adequate medicines and health supplies, and
- Improving the health infrastructure (buildings, equipment and transport).

Addressing these challenges will require joint effort from Government and our Development Partners. In addition, building strong quality improvement systems will be one of the ways of overcoming some of these issues.

I have noted that during this meeting we shall share experiences of successful quality improvement models from different countries. The meeting will also assist my ministry to expedite the process of harmonizing the various quality improvement initiatives and development of a robust quality improvement strategy. I am therefore optimistic that the meeting will come up with tangible recommendations to help the ministry develop a strong quality improvement program that will support the health sector priorities, earlier mentioned.

Ladies and Gentlemen, I wish you fruitful deliberations and I will be happy to receive the meeting recommendations. I now have the pleasure to declare this meeting officially opened.

FOR GOD AND MY COUNTRY

Appendix D: National Health Care QI Meeting Closing Remarks

NATIONAL HEALTH CARE QUALITY IMPROVEMENT MEETING

CLOSING REMARKS BY PERMANENT SECRETARY MoH, READ BY DR. JACINTO AMANDUA, COMMISSIONER HEALTH SERVICES, CURATIVE - 22ND MARCH 2011

Dr. Rashad Massoud
Our International Guests
Ladies and Gentlemen

First of all, I would like to welcome our international guests to Kampala, Uganda. Ugandans are very hospitable people and I hope you had opportunity to experience this during the few days that you have been here. Uganda is of recent hosting a lot of International Conferences and meetings, which is a good development for this country. You are therefore always welcome to Uganda whenever you are invited for any meeting.

Like my Minister informed you at the beginning of this meeting, the Ministry of Health recently commissioned two very important documents:

The 2nd National Health Policy and The Health Sector Strategic and Investment Plan.

In general, both documents emphasize delivering quality health services to the population of Uganda. I am therefore very happy that this meeting has taken place at this time. From the meeting objectives and content, I can conclude that the meeting has given us good direction towards streamlining, harmonizing and strengthening structures, for quality Improvement in the Ministry of Health.

I am made to understand that it was a very interactive meeting, where experiences were shared from difference countries. On behalf of the Ministry of Health, I would like to thank our delegates from Afghanistan, Sweden, Niger, South Africa and WHO, Geneva, for sharing with us their experiences - The Best practices; what worked and what didn't work. My team has learnt a lot from your experiences and I want to implore them to adapt the lessons learnt where feasible. I have also learnt that the meeting shared a lot of lessons from local Quality Improvement Interventions going on in this country. Some of these interventions have not been shared broadly in the Ministry of Health. My immediate recommendation here is that we should have a forum for regular sharing of experiences i.e processes, achievements, and constraints met in implementing Quality Improvement interventions.

Specifically, I note that the link between quality improvement, supervision, inspection and M&E were discussed in detail. I would like to believe that we made good recommendations on this topic because it is one of the big challenges in my Ministry at present. I am therefore eager to know what this meeting has recommended.

I would like in special way to thank the Chief Facilitator for the way he handled issues on **"Improvement Approaches:- what worked; what didn't work; what would you do again and what would you not repeat"**. Again this brings out clearly real experiences of Quality Improvements in the different counties that we could all learn from. Here I would like to immediately recommend to my team in Uganda involved in coaching, and training to adapt such facilitating skills from our senior colleagues/international experts like Dr. Rashad. Let us learn to involve our participants in discussions /sharing experiences rather than "lecturing" to adults.

Finally, after the two days of such intense deliberations, am sure this August house has come up with reasonable guidance towards defining a **"Quality Improvement Strategy for Uganda"**. Top Management of the Ministry is waiting eagerly for this draft strategy for their input. I am tasking the Commissioner (Quality Assurance Department) to present this strategy to our Top Management meeting with in 2 months from today. It will not be in the spirit of Quality Improvement, to have great discussions like you have had, and then shelve the report.

If I may add my comment to this strategy now, we really must get a way of coordinating and harmonizing all the QI interventions in our sector.

Ladies and Gentlemen, let me conclude by thanking URC/HCI/USAID for funding this important meeting.

I would also like to thank Dr. Rashad for the excellent facilitation. I thank our International participants for accepting the invitation to Uganda and for sharing their experiences with us. I wish you a safe journey back to your respective capitals, but you are also invited to stay on longer, to visit our tourist attractions or even some of our health facilities if you require.

I also thank all the participants for the good deliberations. The HCI Project, Uganda, is acknowledged for the excellent logistical arrangements.

Ladies and Gentlemen, I now have the pleasure of declaring this meeting on Health Quality Improvement officially closed.

FOR GOD AND MY COUNTRY

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