Institutionalising the culture of quality of care

A team of experts highlights Quality Assurance in Uganda

The Quality Assurance Program (QAP)[1] in Uganda is one example of government-led efforts that aimed to incorporate quality of care practices within health services. While an initial reluctance for quality of care practices is commonly found within low- and middle-income countries (LMICs), Uganda's experience offers the beneficial results of quality improvement efforts within a resource-constrained setting. This article summarises the quality assurance steps taken in Uganda, highlights lessons learned, and provides recommendations for future quality assurance efforts.

The Quality Assurance Programme

Quality improvement was brought to Uganda in the early 1990s by several international organisations interested in the standardisation of quality assurance programs. As a response to the growing interest in such programs, Uganda's Ministry of Health (MoH) established its own national program to institutionalise quality improvement at all levels of the health system in 1994. The aim was to build health service leadership capacity for national and subnational administrations through the development of several quality improvement projects at the health facility and community levels. Despite historical, social, and political instability within the region, the QAP provided over two decades of valuable successes and challenges in Uganda's health care quality journey.

The QAP was created to improve the health system's capacity by defining standards of quality care, assessing needs of patients and their families, strengthening communication between health care providers and users, and using data to determine gaps in quality. As the program evolved, a division titled the Quality Assurance Unit (QAU) was developed to lead the nation's quality agenda by offering technical assistance and trainings for in-country health professionals. Workshops were provided to senior staff of the MoH, universities, and hospitals and district leaders with the intent to promote best practices.

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Within 18 months, maternal mortality among pregnant women, patient waiting time, and reported cases of measles had all been reduced. At the same time, patient satisfaction with services increased, members of district health teams (DHTs) had a sense of heightened morale, and governing bodies felt encouraged to continue further development of activities.[2]

Table 1 outlines key milestones in Uganda's journey of health care improvement.

Four years following the establishment of the QAU, the program's success prompted full commitment to the efforts by establishing the Quality Assurance Department (QAD) within the MoH. The QAD offered an expanded range of support for QA by coordinating quality of service monitoring and developing sets of standards and guidelines applicable to all levels of the health sector. Primarily, the QAD was responsible for the development of the National Health Quality Improvement Framework and Strategic Plan (QIFSP),a set of guidelines to harmonise the various quality improvement interventions in the health sector. Each allowed Uganda to better streamline capacity building activities and coordinate these activities between different implementers through the distribution of health worker manuals and trainings. The success of the first QIFSP prompted a revised version with the goal of "ensuring that by 2020, all people accessing the health care services in Uganda attain the best possible health outcomes and improved consumer satisfaction."[3]

What are we learning?

The culture of quality

The extensive development of the QIFSP ultimately formed a shared vision for the potential of quality improvement in the health system. This framework acted as a lens through which all health system activities could occur, inspiring the possibility of a culture of quality care as an accepted principle throughout the country.

There were several champions of quality improvement with sustained commitment to advocating for a culture of quality. There was strong national commitment to improving the health care system, which provided the health sector with the leadership and political support required to push the quality movement forward. This system of collaboration and multi-level engagement encouraged the involvement of several stakeholders, such as civil society, in the continuous development of quality improvement initiatives. This ultimately led to opportunities for shared learning amongst community members that highlighted the importance of continuous conversation in creating an institutional and societal culture of quality care.

1992	QA pilot program is introduced and demonstrates significant results in < 1 year.
1994	QAP is launched.
1995	The first QI manual, Quality Assurance Manual for Health Workers, is created.
1997	The manual for QI Methods for Health Workers for QI implementation is created.
1998	QAP is transitioned into the QAD under the Directorate of Planning and Development.
2000	The Yellow Star Assessment Program is implemented and runs until 2005 with the aim of providing quality care through promotion of facility utilization and client satisfaction.
2005	The HIV/AIDS Quality of Care (QoC) Program is launched to ensure quality HIV/AIDS services and rapid roll-out of ART countrywide.
2010	The QAD develops the first QIF and SP for 2010 – 2015.
2011	A National QI Coordination Committee is created to facilitate QI networking and collaboration amongst stakeholders.
2012	Development of National QI training curriculum and materials.
2013	Saving Mothers Giving Life (SMGL) is created to ensure that pregnant women have access to adequate childbirth services and emergency care.
2014-18	Health Facility QoC assessment program developed to annually assess adherence to quality standards at the health facility-level.
2015	Annual QI conferences are held. The QIF and SP 2015 – 2020 is developed from the achievements of the 2010 versions.
2016	Pocket handbook for QI methods is introduced.
2017	The name and scope of the Quality Assurance and Improvement Department (QAID) is changed to Standards, Compliance, Accreditation, and Patient Protection Department (SCAPP).
2019-	MoH agrees to host knowledge products related to QI on the knowledge management (KM) portal. Uganda joins the WHO QoC initiative to improve quality of care for mothers, newborns and children in 9 countries. National Quality Improvement initiative to close gaps hindering achievement of the HIV 90-90-90 and TB targets related to TB case identification, diagnosis, treatment success rates or cure rates, and isoniazid preventive therapy for all stable HIV patients on ART.

Table 1: Uganda's milestones in quality improvement of care

Scaling-up
Uganda's decentralised model of health service delivery encouraged a bottom-up scale-up approach where district leaders were empowered to implement and invest in quality improvement activities. Central to the concept of scaling up is synthesising key lessons so that others can benefit from these learning experiences. Engagement with the appropriate in-country stakeholders, such as heads of facilities and their staff, and higher-level ministry structures, to develop a scale-up strategy. The strategy combined the following key components: (i) defining the scale-worthy intervention(s) and result(s) that should be scaled-up; (ii) identifying level of scale (i.e., regions, districts, facilities, etc.); and (iii) identifying the communications channels, leadership, and other structures needed. The finalised scale-up strategy was built on the methodology used during the implementation phase. It is also noteworthy that champions were used as spread agents to lead the effort to extend scale-up to the remainder of the system.

Sustainability
USAID engaged stakeholders such as facility heads, leaders, implementers, and supervisory structures, to ensure successful interventions were institutionalised and productive on an ongoing basis. It was important to identify: (i) the parties responsible for completing tasks at the end of the project, (ii) the interventions which the stakeholder would like to sustain, (iii)points of integration at different health system levels, and (iv) how stakeholders can fit this practice into existing systems. This effort coupled with the financial, technical, and political support of several other development and academic partners provided the basis for the necessary advocacy and training to improve the quality of health services.

Improvement in resource-constrained settings
Low- and middle-income countries will often consider quality as secondary to availability and accessibility, but Uganda's QI journey suggests that this was not the case. Uganda expressed concern in using already limited resources for a program that they didn't have much knowledge of, but the positive results of the QI pilot program proved that these initiatives were worthy of the small investment required. Integration of quality initiatives within the overall health sector ensured efficiency of resource allocation and local capacity that contributed to the sustainability of the project. Value was additionally found in defining and measuring success to allow for effective advocacy of ongoing work. The QI team found that monitoring and evaluation of the project was key to showing the improvements in health outcomes and the reductions in costs for the health system.

Challenges

While Uganda has experienced significant success in its quality journey, there were also many challenges faced by stakeholders in their efforts to improve quality of care. These include: (i) building, maintaining, and supporting the workforce, (ii) accountability and governance, (iii) coordinating and managing partners, (iv) verticalisation, (v) funding, and (vi) sustainability. Table 2 summarises each of these challenges respectively.

Building, maintaining, and supporting the workforce	High staff turnover led to difficulties in maintaining institutional knowledge of QI. Required training for continued scale-up of QI activities required significant investment. It was viewed as difficult to convince health workers to allocate time to improvement and measurement of quality.
Accountability and governance	Concerns over the accountability of health system leadership to ensure the provision of the best quality services with the available funding.
Coordinating and managing partners	Uganda has faced difficulty in coordinating the activities of multiple organizations, rationalizing available assets, managing external influence, and facilitating sustainability of successful projects with time-limited partner support.
Verticalisation	Uganda had limited capacity at the sub-national level to ensure that multiple efforts were aligned with wider health sector policy and plans. The lack of integration presented the risk of poor use of resources and missed opportunities to maximize synergies and effectiveness.
Funding	Specific funding for QI activities also presents an important challenge, with large proportions of current budgets consisting of partner funding. The continuation of these QI activities is at risk when these projects end.
Sustainability	MoH is working to address sustainability of these efforts, particularly in the context of partner involvement, funding pressures, competing health system priorities, and difficulties maintaining a trained workforce.

Table 2: Challenges in implementing and supporting QI efforts

The way forward

There has been significant progress in improving Uganda's health care system through initiatives of quality improvement, but much more remains to be done. A continuous commitment to expanding the culture of quality from Uganda will be important to ensure that the lessons learned from the QAP and related initiatives are integrated into future QI programs.

Quality improvement in Uganda will continue to improve and evolve over time as long as a national commitment remains. Uganda recognises that full scale-up and institutionalisation of quality improvement will take time, but the lessons learned from previous initiatives provide valuable knowledge which has enabled continuous improvement. At the same time, it will be important for the Government of Uganda to allocate both financial and human resources to sustain quality improvement efforts as donor funding declines. Harmonisation and systems-thinking will be critical for creating consistency in the implementation of QI activities across all levels of the health system. Teamwork will be essential to the improvement of these activities through its ability to foster creative problem solving as issues may arise. All stakeholders involved will also need to actively keep themselves updated on the guidelines and literature of QI to ensure efficient and up-to-date mentoring and teaching. Ultimately, Uganda recognises that improving quality can result in an increase in capacity and systems output with the advantage of not requiring a massive financial investment.

The knowledge of quality improvement will continue to evolve and change the way that health systems think about providing care. Essential to this evolution will be the continuous advancement in understanding QI at all levels of care and governance. The health community will need to actively reevaluate how the approach can be improved and what can be learned from programs that have been implemented. Strategies of QI should undergo several stages of refinement with the help of the emerging evidence base that demonstrates what approaches work (e.g., investing in patient, family and community engagement).[4]

*The information in this article is attributed to a technical report prepared by the USAID ASSIST Project on Uganda's QI journey.[5]

References

1. Massoud, R., Askov, K., Reinke, J., Franco, LM., Bornstein, T., Knebel, E., MacAulay, C. 2001. A Modern Paradigm for Improving Healthcare Quality. QA Monograph Series 1(1) Bethesda, MD: Published for the U.S.Agency for International Development (USAID) by the Quality Assurance Project. Available at: www.usaidassist.org/resources/modern-paradigm-improving-healthcare-quality-0.
2. Omaswa, F., Burnham, G., Baingana, H., Mwebesa, H., Morrow, R. 1997. Introducing quality management into primary health care services in Uganda. Bulletin of the World Health Organization. 75:2. 155–161.
3. Ministry of Health. Republic of Uganda. 2016. Health Sector Quality Improvement Framework and Strategic Plan 2015/16 - 2019/20. Kampala. 13.
4. Quality Assurance Management Day 2. 2018. USAID. Video.
5. Gutierrez, R., Teshome, S., Nielsen, M. 2018. Uganda's Health Care Quality Improvement Journey. Technical Report. Published by the USAID ASSIST Project. Chevy Chase,MD: University Research Co., LLC. Available at: www.usaidassist.org/sites/default/files/usaid_assist_uganda_qi_journey_dec2018.pdf