Quality, Equity, Dignity
A Network for Improving Quality of Care for Maternal, Newborn and Child Health

Uganda

A. Background[1–6]

Core demographic data

Indicator	Value
Population size (thousands)	42,863
Total fertility rate (children per woman)	5.4
Maternal mortality ratio (MMR) (per 100,000 live births)	336
Neonatal mortality rate (NMR) (per 1,000 live births)	27
Child mortality rate (per 1,000 live births)	22
Stillbirth rate (per 1,000 live births)	16.3
Domestic general government health expenditure as percentage of gross domestic product (GDP) (%)	1
Domestic general government health expenditure per capita (in US$)	6.2

National coverage of key interventions

Intervention	%
Antenatal care (4 or more visits)	60
Skilled attendance during delivery	74
Institutional deliveries	73
Caesarean section rate	6
Initial breastfeeding (1 hour of birth)	66.1
Exclusive breastfeeding rate (of infants under age 6 months)	66
Postnatal visit for baby (within 2 days of birth, medically trained provider)	56
Postnatal care for mother (within 2 days of birth, medically trained provider)	54

B. Implementation milestones

Key: completed · in progress · not started or incomplete · no data

Milestone	Status
National leadership for quality of care (QoC)	
Supportive governance policy and structures developed or established	completed
QoC for maternal and newborn health (MNH) roadmap developed and being implemented	completed
Learning districts and facilities selected and agreed upon	completed
QoC implementation package developed	completed
Adaptation of MNH QoC standards	completed
Action: Learning sites identified and prepared	
Orientation of learning districts and facilities	in progress
District learning network established and functional (reports of visits)	in progress
QoC coaching manuals developed	in progress
Quality improvement (QI) coaches trained	in progress
On-site coaching visits occurring in learning districts	in progress
Learning and accountability: QoC MNH measurement	
QoC for MNH baseline assessment completed	in progress
Common set of MNH QoC indicators agreed upon for reporting from the learning districts	completed
Baseline data for MNH QoC common indicators collected	not started or incomplete
Common indicator data collected, used in district learning meetings, and reported upwards	completed
Identification and agreement with an academic or research Institution to facilitate documentation of lessons learned in the implementation of QoC activities	completed
Accountability and community engagement	
Mechanism for community participation integrated into QoC planning in learning districts	in progress

C. Progress at the national level (2017–2018)

National overview of QoC for MNH

National quality policy or strategy
- Health Sector QI Framework and Strategic Plan 2015-2016, 2019-2020
- Pre-existing framework that encompassed QoC
- Adapted the QoC standards
- Network incorporated in all departments

National aims
- Improved experience of care by women
- Reduction in MMR

National targets
- Reduce MMR to 211 in 2020 the reproductive, maternal, newborn, child, and adolescent health (RMNCAH) investment plan
- Stillbirth rate
- NMR
- Breastfeeding
- Experience of care for mothers

QoC technical working group (QoC TWG)
- Maternal, newborn and child health (MNCH) QoC TWG exists and with clear, well-stipulated terms of reference, objectives, and a work plan.
- 12 meetings held in 2018
- Last meeting was held in January 2019.

Joint products and activities by the QoC TWG
- Already developed:
  - Adapted National Standards for improving MNH Care provide guidelines for processes at all service delivery levels
  - Customized the Facility quality assessment (QA) tool
  - Developed newborn standards facility assessment tool
  - Agreed on the facility/district MNH QoC indicators and aligned them with global core indicators
  - Collected baseline data using the latest data capturing template (being done in the 5 selected learning districts)
  - Holding ongoing discussions to engage academic and research institutions to conduct surveys on experience of care and to provide site teams with technical support on writing skills
- Registered activities in Uganda:
  - Management
  - Infection control and prevention
  - Clinical standards
  - Information, education, and communication
  - Addressing client related issues
  - Engaging community members

Learning districts and facilities
- 6 learning districts
- 3 learning facilities per learning district
- 18 total learning facilities

District aims towards national strategy
- Reducing maternal and perinatal morbidity and mortality
- Reduce MMR by 50% (facility-based target for the learning sites by 2020)

Clinical improvement aims
- Aims vary by facility. Facilities are trying to address issues such as:
  - Evidence-based improvement aims, following a baseline assessment that revealed gaps across the majority of sites in kangaroo mother care (KMC)
  - Insufficient clinical skills for management of pre-eclampsia
  - Low postnatal care
  - Lack of helping babies breathe (lack of resuscitation)
  - Low partograph use
  - Ineffectiveness of routine antenatal care to screen for risky mothers
  - Reduction in facility-level delays and improvement in adequate and quality labour monitoring, identification of complications, and implementation of actions
  - Delivery of a complete package of essential newborn care for all babies born at the facilities
  - Improved inter-facility transport and referral systems
  - Strengthened implementation of maternal and perinatal death surveillance review and implementation of actions
  - Reduction of referral time between lower facilities' comprehensive emergency obstetric and newborn care (CEmONC) sites

Quality interventions included in the national MNH QoC package*

Interventions to build a supportive environment
- Displayed data at learning sites. Sites compare their site specific performance during performance review meetings that are held every quarter.
- Incorporated QoC into results-based financing that has been rolled out in 28 districts and is now being rolled out in 55 additional districts.
- Trained providers in clinical standards, facility assessment, and coaching skills.
- Addressed client-centred care focusing on improving experience through communication, counselling, and privacy resulting into improved facility delivery

Interventions to support change at facilities
- Availed clinical checklists/protocols as part of care and emphasise their use in the service standards and service delivery standards
- Mentored staff in selected CEmONC skills
- Had an annual QI Conference in December 2018, which is the epitome of the collaborative learning. Planning to have regional collaborative learning in April 2019 where there is sharing of good QI practices and therefore, staff will learn from this forum.

Interventions involving people, families and communities
- Conducted a community assessment
- Working on plans to explore use of the existing community fora such as Barraza and community dialogues
- Planning to have a breakfast meeting in March 2019 with civil societies and parliamentarians
- Ensured representation of patients/clients on the facility QI committees
- Have Health Unit Management Committees in all learning facilities

*Interventions have started since the last update.

D. MNH QoC baseline data for learning facilities

Baseline common indicators

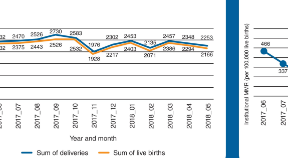
Challenges
- Slight challenge is that our national database does not pick data on the common core indicators on experience of care

Opportunities and progress made
- QoC was initiated, and leadership at all levels is supportive of QoC learning. Indicators in addition to the core indicators have been developed and translated into assessment tools that were pre-tested with data collection in progress.

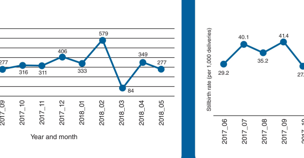
Planned activities
- Data collection is being undertaken. Analysis and dissemination are planned to inform the implementation plan.

Graphs
- The graphs below show returns from 18 learning facilities in the 6 learning districts for the period of June 2017 to May 2018. All data were extracted from DHIS2.

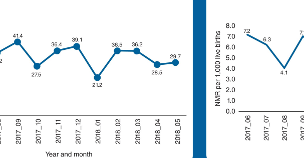
Trends in deliveries and live births



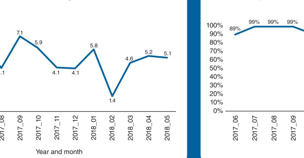
Institutional MMR



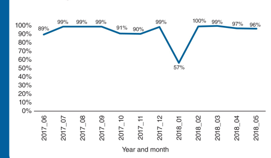
Institutional stillbirth rate



Pre-discharge NMR



Percentage of newborns breastfed in the 1st hour



E. Implementation progress in learning districts

On-site support for clinical skills and QI

Support for clinical skills

Who provides on-site support for clinical skills
- Medical doctors, midwives, anaesthetic officers, laboratory technologists/technicians at the respective working facilities
- In regional and district health facilities, the technical staff, implementing partner technical teams, and in-district champions who constitute teams provide on-site technical support and capacity building for site-based staff and improvement teams.
- Each person supports 3-5 sites
- During on-site visits, mentors engage site teams, conduct demonstrations, review previous action plans, update documentation journals, and develop new action plans.

Challenges solved implementing on-site support for clinical skills
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Unresolved challenges implementing on-site support for clinical skills
- Few site teams and coaches are trained in 5S/CQI.
- Financial constraints
- Still some untrained staff and coaches

Support for QI

Who provides on-site QI coaching
- Selected midwives provide coaching
- Few coaches have received formal coaching training, but there are plans to provide this training.
- Coaching visits will be conducted quarterly by a central team and monthly by district coaches.
- Coaches will support data/performance review to identify and support ownership of site level gaps; use monthly and quarterly assessments to identify improvement areas; conduct observations to assess implementation of recommended guidelines and key interventions; identify and discuss capacity needs gaps; and follow an action plan developed for reference during the next support visit.

Challenges solved implementing QI coaching
- Site teams lacked the documentation journals, so we provided them with adequate copies.

Unresolved challenges implementing QI coaching
- Some site teams and coaches have not been trained in 5S/CQI.
- Financial constraints

Learning for QI

Tools for capturing learning from facilities
- Improvised a template designed by the MNCH

Tools for sharing learning between facilities
- Planned to have learning sessions and later an improvement Collaborative-Harvest meeting to share and document promising practices.
- District and health sub-district data/performance review meetings (existing meetings due to financial constraints)

Challenges solved implementing a learning system
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Unresolved challenges implementing a learning system
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Measurement system for QI

Patient-level common indicator data
- District Health Information System/Health Management Information System (HMIS) provides the MMR, NMR, and fresh stillbirths (FSBs)
- Number of perinatal deaths (MSBs, FSBs, newborn death 1-7 days) occurring in the health facility
- Number of maternal deaths occurring in the health facility
- % of mothers delivered by C-section within 1 hour of decision-incision interval per month
- % of mothers with emergency complications referred within one hour of decision to referral per month
- Average decision to incision time in minutes per month
- % of mothers in active labour monitored using partograph;
- Number of women with complications referred to referral center
- % of pre-term offered KMC
- % of newborn babies resuscitated
- Number of mothers with blood pressure, pulse, and temperature recorded and appropriately acted upon
- Number of mothers who gave birth in the health facility whose progress of labour was correctly monitored on a partograph
- Number of newborns who received all four elements of essential newborn care
- Number of newborns who were not breathing spontaneously who were resuscitated

Programme-functioning data
- QI team meeting minutes and updated documentation journals are used to verify the QI team functionality
- Functionality of QI teams is evidenced on documentation of the team meetings
- District-led coaching reports and evidence of adapted promising practices on the documentation journal
- The periodic facility assessment, planned on quarterly basis, is one way by which the team is having the necessary logistics and infrastructure. Also, the health facility quality assessment tool captures this information.
- District health office and implementing partners plan support for coaching activities and ensure there is adequate documentation
- Site-level implementation of best practices following peer-to-peer experience sharing

Availability of data system for measuring QoC
- Review of the routine health management information system (HMIS) is on-going to include QoC indicators (e.g., immediate postpartum administration of uterotonics)
- Some data tools have been introduced to track indicators that are not easily collected from HMIS tools (e.g., time of referral, patient experience of care)
- Uganda is still in the process of negotiating with the responsible team to address the total list of the core MNH indicators

Challenges solved implementing a measurement system
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Unresolved challenges implementing a measurement system
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Community and stakeholder engagement

Approaches for community/stakeholder engagement
- Held inception meetings in some learning districts, after the facility baseline assessment, during which dissemination of baseline findings were shared and the team sought community stakeholders' opinions
- Participate through the Health Unit Management Committees and hospital boards to provide community feedback
- Also use of site-level suggestion boxes

Roles of community stakeholders or patient representatives
- Their roles include identifying and mobilizing resources, advocating for health care demand, and participating in micro-planning fora.

Challenges solved engaging communities and stakeholders
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Unresolved challenges engaging communities and stakeholders
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Programme management

Programmatic responsibility
- Facility-level:
  - MCH department in-charge; the lead person is head of department and chairs the MNH QoC work improvement team
  - MCH working improvement team is charged with analysis of the MNH QoC programme, identifies performance gaps, and initiates and tracks QI projects
- District-level:
  - Assistant district health officer in charge of MCH and in charge of RMNCAH program at the district level ensures proper coordination for the MNH QoC
  - At the regional level, the IPs oversee the management of the initiative but are working towards empowering the hospitals to manage the initiative
- National-level:
  - MCH Cluster Lead of the Commissioner Community Department chairs the MNH QoC Steering Committee at national-level

Challenges solved implementing program management
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Unresolved challenges implementing program management
- Revitalization of the MNCH QoC network and the MNCH QoC task force
- It was difficult to hold the MNCH QoC network meeting due to many competing meetings at the end of last year in preparation for the RMNCAH assembly.

Lessons learned implementing a QoC program

- Facility/district leadership is a key factor in the success of facility QoC. At higher-level facilities, the involvement of senior leadership is key in providing resources for improvement. The elements of leadership which have been found to be important are: Taking responsibility, being responsive, delegating tasks, having excellent communication, being motivated, being transparent, using data for decision-making, and being innovative.
- At lower-level facilities, success seems to depend on the strength of the focal person, usually a midwife. They need to be trained and acquire skills so that they are competent to: (i) provide and promote evidence-based, human-rights-based, quality, socio-culturally sensitive, and dignified care to women and newborns; (ii) facilitate physiological processes during labour and delivery to ensure a clean and positive childbirth experience; and (iii) identify and manage or refer women and/or newborns with complications.
- Strong collaboration with partners helps leverage resources to address multiple issues around a district/facility. In the case of RHITES-N Acholi, the presence of other partners addressing quality, such as the Uganda voucher plus project, has strengthened the advocacy for QoC activities.
- At the start, it is easier to implement QoC systematically by one standard at a time across several sites implementing similar indicators. Facilities can be grouped according to level and category.
- At the start of implementation, the focus should be on indicators that link processes to outcomes. These are easily measurable and can demonstrate improvement in processes and eventually outcomes. These numbers help leadership to appreciate QoC faster and more easily.
- A functioning referral system is central to the success of QoC. This systems starts with communities, facilities, and district leadership.
- Setting up a successful QoC programme requires a deliberate effort to build the capacity of the implementing team and highlight the importance of the initiative while emphasizing its basis on QI that should ideally be part of outline facility activities. This improves implementation acceptance, since it is not viewed as a new and separate initiative.
- On-going and frequent on-site technical support ensures that teams are able to sustain the momentum required to implement the initiative.

F. Example from implementation

Title
- Building skills in newborn care among frontline providers at selected sites in Acholi Northern Region with support from USAID RHITES

Background
- Evidence-based programing is key to the success in MNH care. Implementing partners, funded by the Health Development Partner, USAID, are working closely with the district health teams to improve MNH care. The Ministry of Health (MoH) regional mentors and the district team prioritized newborn care.

Goals and objectives
- Equip frontline providers with additional skills to improve the newborn care at selected six selected facilities.
- Provide mentorship on set up and functionality of a newborn care unit
- Plan and organize spaces for provision of KMC and care for very sick newborns
- Improve documentation on newborn care and data utilization for decision-making

Description of the mentorship project
- The terms of reference focused on improving newborn care by equipping frontline providers at the six selected sites with skills. An entry visit with the stakeholders was held to clarify the terms of reference, agree on the visit schedule, agree on the approach, and review the mentorship tools with mentors. Site teams where phoned and agreed on convenient days for the visit. The national newborn steering committee chairperson, 4 MoH trainers, and mentors supported the activity. Mentoring occurred at Gulu RRH, Lacor Hospital, Anaka Hospital, Kitgum Hospital, St. Joseph's Hospital Kitgum, Kalongo Hospital, and Lalogi HC IV. Mentors applied the 5S philosophy to create conducive working space, started neonatal intensive care units (NICU), and mentored on the provision of QoC for newborns.

Description of the results
1. Staff members were willing to learn and improve their weaknesses, though there was some crying among the low-level staff.
2. There has been good advocacy for the new NICU at the facility and district levels.
3. The room was identified, and the NICU was set up with 4 paediatric beds, 2 incubators, and a phototherapy machine.
4. All sick newborns are now admitted at the unit and are not scattered like before.
5. Standard operating procedures and protocols are well displayed, and drugs are easily accessible in a cupboard.
6. Waste bins were relocated to another corner to create space for a hand washing area.
7. The hospital administrator was welcoming. He discussed the challenges that the team faced on the ward and promised to work on them.

Lessons learned (both successes and challenges)
1. Need to advocate for a mother's club so that the habit of mothers sleeping in the NICU is stopped.
2. There is a need for a mentor to work with the staff members for a week, practically clean with them, and rearrange the unit with them.
3. Requisitions should be sent to the pharmacist for essential neonatal drugs like phenobarbital to be stored on the ward.
4. A standard NICU should have the following: wall clock, weighing scale, digital thermometer, baby mattresses, mobile pulse-oximeter, indoor shoes, plastic chairs, a table, neonatal stethoscope, alcohol hand rub, hand washing facility, plastic carpet, shoe rack, oxygen cylinder with oxygen prongs, ambu bag, penguin sucker, and face mask.

Sustainability and future plans
1. Establish a KMC centre for training for the Acholi Region.
2. Replace beds with baby cots.
3. Conduct continuous support and mentorships to create a positive attitude towards the functioning of the NICU.
4. Relocate equipment to NICU from stores.

Design: Inis Communication – www.iniscomunication.com

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4. United Nations Children's Fund, Division of Data Research and Policy (2018). Maternal and Newborn Health Coverage Database, New York, May 2018.
5. United Nations, Department of Economic and Social Affairs, Population Division (2017). World Population Prospects: The 2017 Revision, DVD Edition.
6. WHO Global Health Observatory data repository. http://apps.who.int/gho, 2017.

All other data received from the relevant Ministry of Health and WHO Country Offices.

Acronyms

Acronym	Meaning
FSBs	fresh stillbirths
GDP	gross domestic product
HMIS	health management information system
KMC	kangaroo mother care
MoH	Ministry of Health
MMR	maternal mortality ratio
MNCH	maternal, newborn, and child health
MNH	maternal and newborn health
NICU	neonatal intensive care unit
NMR	neonatal mortality ratio
QA	quality assurance
QI	quality improvement
QoC	quality of care
RMNCAH	reproductive, maternal, newborn, child, and adolescent health
TWG	technical working group