Government of Malawi

Ministry of Health & Population

Quality Management Policy

for the Health Sector

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Ministry of Health
P.O. Box 30377
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Malawi

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Foreword

Malawi's constitution affirms the intention of the Government to provide quality health services responsive to the needs of Malawians and in line with global best practices. During the Millennium Development Goals (MDGs) period (2000-2015), Malawi made significant progress in improving health outcomes by expanding coverage to essential health services. However, inconsistent quality of care (QoC) remains a major challenge. As a signatory to the Sustainable Development Goals (SDGs), the Government of Malawi recognizes that extra effort and resources need to be invested in fast-tracking improvements in QoC. These efforts will help accelerate progress towards achievement of Universal Health Coverage (UHC) by 2030.

The first national efforts to improve QoC and establish quality assurance systems originate from the nineties, leading to the development of a National Quality Assurance plan in 1998 and a National Quality Assurance Policy in 2005. Despite these efforts and other quality improvement initiatives, there is still fragmentation at policy and implementation levels across the health sector.

The Quality Management Policy for the Health Sector in Malawi (QM Policy) aims to enforce a holistic, systematic, and coordinated approach to improve quality of care across the health sector. The policy is in line with the Malawi Health Sector Strategic Plan (2017–2022) and the Government-wide Public Sector Reforms launched in 2015.

This policy has been developed in the most participatory way possible, building from the views of implementers and all partners working in quality management. As the QM Policy reflects the aspiration of Malawians, its implementation will be based on the principle of, "One Policy, One Strategy, and One Monitoring and Evaluation Framework." Therefore, all quality management initiatives must fully align to this policy.

The Ministry of Health wishes to assure Malawians and all stakeholders that Government has the political will to implement this QM Policy. It is our hope that this policy will lead to a more unified and coordinated effort in the delivery of high quality health services for the people of Malawi.

Hon. Atupele Austin Muluzi, MP

Minister of Health

Preface

This Quality Management Policy for the Health Sector in Malawi (QM Policy) identifies the challenges in quality management to be addressed if the aspiration of providing the best possible care within our resource constraints is to be realized. The goal of this QM Policy is to improve the quality of Malawi's health services. The Ministry of Health, through the Quality Management Directorate (QMD), will oversee policy implementation and coordinate all stakeholders contributing towards improving quality of care. Full implementation of the QM Policy will improve health outcomes, client satisfaction, and financial risk protection for the people living in Malawi. The policy will be implemented alongside other Health Sector Reforms under the Government-wide Public Sector Reform program. The success of the QM Policy assumes effective implementation of the other reforms.

I would like to thank the partners who financially contributed to the development of this QM Policy. These include Gesellschaft für Internationale Zusammenarbeit (GIZ) through EPOS Health Management, World Health Organization (WHO), the Bill and Melinda Gates Foundation (BMGF), Lighthouse Trust, UNICEF, EGPAF, Institute for Healthcare Improvement (IHI), USAID, and Mai Khanda Trust. I would also like to thank participants from other partner organizations, district and central hospitals, MOH Departments and Programs, Office of the President and Cabinet, other government ministries, the private sector, regulatory bodies, health training institutions, health professional associations, the Parliamentary Committee on Health, CSOs, community representatives, and other partners who contributed to the development of this policy through a series of consultative meetings and working sessions over a period of one year. Lastly, I want to thank the members of the QM Technical Working Group (TWG) for providing technical oversight during the process.

It is our hope that the efforts outlined throughout this Quality Management Policy for the Health Sector in Malawi will be supported and well complemented by stakeholders to ensure quality healthcare for the people of Malawi.

Dr. Dan Namarika

Secretary for Health

List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
BMGF	Bill and Melinda Gates Foundation
CHAG	Community Health Action Group
CHAM	Christian Health Association of Malawi
CHMT	Central Hospital Management Team
CMED	Central Monitoring and Evaluation Division
CBO	Community Based Organization
CQMO	Chief Quality Management Officer
CSO	Civil Society Organization
CSD	Clinical Services Directorate
DC	District Commissioner/District Council
DHMT	District Health Management Team
DHO	District Health Office
DPPD	Department of Planning and Policy Development
DHRMD	Department of Human Resource Management and Development
EHP	Essential Health Package
GIZ	Gesellschaft für Internationale Zusammenarbeit
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HMT	Hospital Management Team
HR	Human Resources
HRH	Human Resources for Health
HSSP II	Health Sector Strategic Plan II
HSWG	Health Sector Working Group
HTSS	Health Technical Support Services
IHI	Institute for Healthcare Improvement
IHRIS	Integrated Human Resource Information System
ISS	Integrated Supportive Supervision
IPC	Infection Prevention and Control
M&E	Monitoring & Evaluation
MDGs	Millennium Development Goals

MoH	Ministry of Health
MP	Member of Parliament
MPSR	Malawi Public Service Regulations
MSPA	Malawi Service Provision Assessment
NQAP	National Quality Assurance Policy
NGO	Non-Governmental Organization
ODPP	Office of Director of Public Procurement
PAM	Physical Assets Management
PMPB	Pharmacy, Medicines, and Poisons Board
PMTCT	Prevention of Mother to Child Transmission of HIV
QA	Quality Assurance
QI	Quality Improvement
QIST	Quality Improvement Support Team
QM	Quality Management
QMD	Quality Management Directorate
QMED	Quality Monitoring and Evaluation Division
QM TWG	Quality Management Technical Working Group
QMU	Quality Management Unit
QoC	Quality of Care
RHD	Reproductive Health Directorate
SDGs	Sustainable Development Goals
SH	Secretary for Health
SLAs	Service Level Agreements
SOP	Standard Operating Procedure
TWG	Technical Working Group
UHC	Universal Health Coverage
USAID	United States Agency for International Development
VHC	Village Health Council
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization
WIT	Work Improvement Team

Definitions

Accreditation: a formal process by which a recognized body, usually a non-governmental organization, assesses and recognizes that a healthcare organization meets applicable predetermined and published standards

People-Centered Care: a type of patient care that is respectful of and responsive to individual patient preferences, needs, and values and ensures that these same values guide all clinical decisions. It puts individuals, families, and the comprehensive needs of people and communities, not only diseases, at the center of health systems

Healthcare Facility Standards: these describe the structures, functions, and processes required to ensure healthcare can be delivered effectively and safely

Indicator: a quantitative or qualitative factor or variable that provides a simple and reliable means to measure achievement, to reflect changes connected to an intervention, or to help assess the performance

Licensing: the regulatory certification of facilities against legislative requirements

Performance: a measure of the results achieved and with what level of efficiency; it is the work/tasks that a person does; how s/he does it; and the results thereof

Quality: conforming to the highest level of standards and satisfying a client's needs

Quality of Care (QoC): the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge

Quality Assurance (QA): setting standards and systematically measuring compliance with those standards to improve performance

Quality Improvement (QI): the process of engaging appropriate quality management approaches, methods, and tools to close the gap between current and desired levels of performance

Quality Management (QM): the broad set of activities and strategies applying various tools, methodologies, and techniques designed to improve the quality of service delivery

Strategic Information: data used to help achieve goals and increase efficiency

Timely: the acceptable and reasonable amount of time necessary in the provision of healthcare delivery, reducing waiting time, and harmful delays for both those who receive and provide health care

Introduction

The health sector goals of the Government of Malawi are to improve the health status of all Malawians, to ensure that the population is satisfied with the health services provided, and does not suffer avoidable financial risks in the process of accessing healthcare. During the Millennium Development Goals (MDGs) period (2000-2015), Malawi made significant progress in improving access to essential health services. In 2015, Malawi signed up to the Sustainable Development Goals (SDGs) which places Universal Health Coverage (UHC) at the core of a global and national health agenda between 2015 and 2030.

To fast-track the achievement of UHC, the Government is undertaking several interrelated health sector reforms aimed at 1) sustaining and further improving access to essential health services; 2) improving the efficiency of the health system; and 3) managing quality of health services at all levels of care. The Ministry of Health recognizes that in order to achieve UHC by 2030, deliberate initiatives to improve quality of care must be implemented across the health sector in addition to sustaining current investments in improving healthcare access.

This Quality Management (QM) Policy succeeds the National Quality Assurance Policy of 2005 (NQAP 2005). The NQAP 2005 for the Malawi Health Sector aimed to provide structures for quality assurance at all levels of the healthcare delivery system. Key developments in the execution of the NQAP included the establishment of Quality Improvement Support Teams (QIST) at the district level which primarily focused on improving infection prevention and control practices.

While the NQAP was successful in creating structures, it was not cross-cutting in its design and had critical gaps leading to ineffective identification, coordination and implementation of quality initiatives. These gaps included minimal partner and stakeholder buy-in, lack of health system quality goals and associated activities, and ineffective dissemination to stakeholders and partners.

To deal with such challenges, a major decision was made in 2014 to institutionalize quality management in the health sector and provide effective leadership by creating a Quality Management Unit (QMU) in the Ministry of Health. In 2016, this unit was formalized into a full directorate, the Quality Management Directorate (QMD), with a clear mandate to provide strategic leadership and coordination of quality management initiatives across the health sector.

A comprehensive situation analysis of the health sector in Malawi identified low quality of care as a major barrier to improving health outcomes and achieving

universal health coverage[1]. Based on the situation analysis and considering developments in national and global health policy, as well as the gaps in the NQAP 2005, the Ministry of Health initiated a bottom up, highly participatory, and multi-stakeholder process in 2016 to conduct a root-cause analysis and identify priority solutions. These processes culminated into the development of this QM Policy with a broader health systems perspective.

This QM Policy identifies seven priority areas where all stakeholders in the health sector must focus their efforts and resources to address challenges affecting the quality of health services in Malawi. The priority areas are leadership, governance and accountability, human resources for health (HRH), clinical practice, client safety, people-centered care, support systems, and evidence-based decision making. Based on these priority areas, the policy specifies the policy goal, expected policy outcomes, objectives, policy statements, and strategies to improve quality of care. It further provides a monitoring and evaluation framework with outputs and performance indicators for each priority area that will guide all stakeholders when designing, implementing, and evaluating quality initiatives in the country.

1.1 Background

Malawi's health care system has four delivery levels: community, primary, secondary and tertiary, with inter-level referrals as required. Formal care is provided by three categories of providers: public, private-not-for-profit, and private-for-profit. The Ministry of Health is the largest provider of healthcare, offering about 85.8% of health services. The Christian Health Association of Malawi (CHAM) is the second largest provider offering complimentary services to the Government estimated at 11.9%. Private-for-profit providers cater for the remaining 2.3%[2].

Since 2000, provision of health services is guided by an Essential Health Package (EHP) which specifies a list of priority interventions. Government policy is to provide free EHP services at the point of delivery. Where there is no public facility within 5km radius, Ministry of Health engages with CHAM to provide free services through Service Level Agreements (SLAs)[3]. Based on the Decentralization Policy (1998), the community, primary, and secondary levels belong to the District Health System under the mandate of the District Councils. The tertiary level belongs to the Ministry of Health but reforms are currently underway to have these managed as Public Trusts by Boards of Trustees.

[1] MoH (2016) Situation Analysis of the Malawi Health Sector
[2] Malawi Service Provision Assessment Survey (2014)
[3] HSSP 2011-2016; CHAM MOU 2016

Malawi made great strides in improving health outcomes over the past decade. The maternal mortality ratio declined by 55% from 984 per 100,000 live births in 2004 to 439 per 100,000 live births in 2015/16 while infant mortality rate decreased by 36% from 66 per 1,000 live births in 2010 to 42 per 1,000 live births in 2015/16[4]., surpassing MDG target number 4[5]. Deliveries performed by skilled birth attendants increased from 57% in 2004 to 90% in 2015[4]

There has also been remarkable progress in the fight against HIV and AIDS. New annual HIV infections have decreased by 35% between 2009 and 2014[6,7]. An estimated 27,000 deaths occurred due to AIDS in 2015, a decrease of 73% from 99,000 in 2004[5]. Coverage of Prevention of Mother to Child Transmission (PMTCT) through Option B+ was scaled up from 44% in 2010 to 72% in 2014[8]. Malaria prevalence declined from 43% in 2010 to 33% in 2014[9]. These improvements in health outcomes have been attributed to huge investments in improving access, such as construction of new health facilities (particularly in rural areas), training of additional health workers, and availability of essential medicines and equipment.

Despite these notable successes, the health sector still faces many challenges. A significant proportion of the population still faces geographical, financial, and other barriers to accessing health services. The proportion of the population living outside an 8 km radius of a health facility stands at 10% in 2016[10]. Health financing is still low with per capita health sector expenditure stagnating at approximately US $39 annually since 2012[11] with increasing fragmentation of health financing pools causing coordination challenges.

In cases such as birth attendant delivery, where access to services has covered almost the entire population, health outcomes have not necessarily improved. The maternal mortality ratio of 439 deaths per 100,000 live births and neonatal mortality rate of 27 per 1,000 live births in 2015/16[12] remain unacceptably high. These high mortality rates highlight the importance of improving health service quality in addition to improving access to care.

Based on the 2016 situation analysis of the health sector and a series of stakeholder engagement workshops conducted towards the development of this policy, the

[4] MDHS 2015-16
[5] Malawi Millennium Development Goals Endline Report
[6] Malawi AIDS Response Progress Report 2015
[7] Malawi Population Based HIV Impact Assessment (MHIA) 2016
[8] Joint UN Program on HIV/AIDS UNAIDS MALAWI 2014
[9] Malawi Malaria Indicator Survey (2014)
[10] HSSP II 2017-2022
[11] NHA 2016
[12] MDHS 2015-16

following were identified as the main challenges negatively impacting the quality of healthcare in Malawi:

- **Weak leadership, governance, and social accountability:** due to inadequate management skills, lack of mentorship due to high turnover of managers, weak accountability mechanisms between stakeholders, a lack of accountability between providers and users, a weak regulatory framework, inadequate coordination of partners, and a lack of a national QM framework;

- **Weak human resource capacity:** due to insufficient funds, low staffing levels, uncoordinated capacity development, inadequate HR skills and knowledge, poor motivation of workforce, complex employment procedures, weak regulation of staff, lack of systematic staff performance appraisals, and no clear link between workload and establishment;

- **Poor clinical practices:** due to a lack of diagnostic facilities leading to overdependence on presumptive diagnosis and treatment, inadequate documentation and record keeping, long waiting times, a lack of clinical competencies, and inadequate use of standard operating procedures, protocols, and guidelines amongst service providers;

- **Inadequate client safety mechanisms:** due to a lack of systematic recognition and management of medical errors, risky infrastructure and equipment, missing danger alert signs, poor management of medicines, inadequate infection prevention, and poor waste management practices;

- **Insufficient people-centered care:** due to inadequate communication between providers and clients, inconsistent use of charters with the rights and responsibilities for the providers and clients, inadequate client feedback mechanisms, and limited client participation in their care;

- **Weak health systems:** due to frequent stock outs of essential commodities arising from a weak supply chain system, poor management of medical equipment and infrastructure, weak referral system, weak financial management systems, and weak procurement systems;

- **Inadequate research and monitoring/evaluation capacity:** due to a limited capacity to conduct relevant research, poor quality and utilization of generated data, lack of evidence-based decision making, weak administrative data systems, and ample shortfalls due to paper-based reporting.

1.2 Purpose of the Policy

The purpose of the QM Policy for the Health Sector in Malawi is to provide a framework for integrating and coordinating QA and QI initiatives across departments and partners in the health sector. This integration and coordination will contribute to addressing the gaps in quality of care, thereby contributing towards achieving Universal Health Coverage (UHC). The QMD will act as a secretariat to facilitate the coordination of these implementers in pursuing this QM Policy for the Health System of Malawi.

This policy document is intended to guide all stakeholders in the health sector of Malawi, including MoH headquarters, CHAM, central hospitals, district hospitals, and local clinics, both public and private. With the advent of the decentralization of oversight powers from the MoH to the district councils (DCs), the QM Policy outlines the shared strategies the MoH and DCs will undertake to ensure the provision of quality healthcare to all people living in Malawi.

Broad Policy Directions

2.1 Policy goal

The goal of this QM Policy is to improve quality of health services across the health system of Malawi. Improved service quality will lead to improved health status, increased client satisfaction, and financial risk protection, thereby contributing to the achievement of Malawi's national development goals.

2.2 Policy Outcomes

Ministry of Health aims to achieve the above policy goal through the delivery of the following policy outcomes:

1. All levels of healthcare have functional and effective leadership and governance structures and systems by 2022;
2. All primary level facilities, national policy institutions, as well as 90% of secondary and tertiary level health facilities have adequate numbers of staff with right competencies required to oversee and deliver high quality care by 2026;
3. 80% of health facilities achieve national accreditation standards by 2030;
4. All facilities adhere to patient safety standards and Infection Prevention and Control practices with appropriate water supply and sanitation by 2028;
5. All clients in the health system at all levels report being satisfied in all dimensions of health services rendered and received by 2024;
6. All health facilities have essential infrastructure including water, sanitation facilities, equipment, medicines and supplies, electricity and internet connectivity at all times by 2025;
7. By 2021, all decisions at each level of the health system are based on high quality information.

2.3 Policy Objectives

To achieve the above policy outcomes, this Quality Management Policy will focus on the following seven objectives with the aim of addressing the challenges in quality of care across the health sector using a health systems approach:

1. Improve health sector leadership, governance and accountability;

2. Increase capacity of human resources for health (HRH) to deliver quality health services;

3. Promote excellence in clinical practice across the continuum of care;

4. Improve client safety at all levels of healthcare;

5. Strengthen people-centered care at all levels of the health system;

6. Strengthen support systems for the delivery of quality health services;

7. Increase capacity in generation and use of accurate strategic information for evidence-based decision making and policy formulation.

2.4 Guiding Principles

The implementation of this policy will be guided by the following core principles:

Accountability: all stakeholders are answerable for their actions and there is redress when duties and commitments are not met;

Community Participation: community structures are empowered to participate in quality assurance and quality improvement initiatives in the health sector;

Effectiveness: services are provided based on scientific knowledge to all who have the potential to benefit;

Efficiency: healthcare is delivered in a manner that maximizes the impact and outputs per resource used and minimizes waste;

Equity: healthcare does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socio-economic status;

Excellence: services are provided and clients' expectations are managed consistently and in line with standards;

Compassion: the humane qualities of empathy, sensitivity, kindness, and warmth throughout all levels of the health system;

Innovation: new concepts, ideas, services, processes, and products aimed at improving quality of care are introduced;

Integrity: moral and ethical principles are followed in the provision of quality health services;

Inter-sectoral collaboration: collective actions involving appropriate stakeholders are promoted at all levels to improve quality of care;

Transparency: actions are visible, predictable, and understandable through sharing relevant and accessible information in a timely and accurate way that retains the detail and disaggregation necessary for analysis, evaluation, and participation.

Policy Priority Areas

3.1 Policy Priority Area 1: Leadership, Governance, and Accountability

Although there has been progress in strengthening leadership, governance, and accountability across the health system, these have been limited and significant gaps still exist. Weak leadership and governance still manifests primarily due to inadequate management skills, high staff turnover of managers, weak accountability mechanisms, weak regulatory framework, inadequate coordination, and lack of a national QM framework. Within a highly decentralized health system, quality of care will be constrained without stronger leadership and sound governance structures at all levels, thereby compromising the potential for achieving the goals of this policy.

Policy Statement 1: The Ministry will ensure strategies, structures, and coordination mechanisms for implementation of the Quality Management (QM) policy are in place and functional at all levels of the health system at all times

Strategies

1.1 Establish and periodically review implementation frameworks for QM in the health sector
1.2 Strengthen QM structures at all levels in the health sector
1.3 Institute systematic quality management processes at all levels
1.4 Strengthen coordination and collaboration between the Ministry of Health, regulatory bodies, professional associations, local councils, and other key players for enhanced execution of their mandates for quality management
1.5 Strengthen quality management in disaster preparedness and response at all levels
1.6 Enhance coordination of the activities of all implementing partners in the health sector in line with national quality management priorities

Policy Statement 2: The Ministry will ensure commendable performance, professional excellence, and accountability are the norm of management and staff at all levels of the health system

Strategies

1.7 Enhance capacity building in leadership, accountability, and management skills among managers at all levels
1.8 Strengthen staff participation in QM and promote teamwork at all levels
1.9 Strengthen accountability mechanisms at all levels

Policy Statement 3: The Ministry will ensure communities are empowered and are effective partners in health governance and quality management to improve health outcomes at all levels of healthcare

Strategies

1.10 Empower communities to understand their healthcare needs and demand quality of care
1.11 Strengthen community participation in QM activities
1.12 Strengthen social accountability mechanisms between the community and service providers

3.2 Policy Priority Area 2: Human Resources for Health

While the health sector has made tremendous progress in increasing the supply and capacity of human resources for health, as well as their recruitment and retention, significant challenges persist. Malawi has been experiencing a human resources for health crisis since 2004, with a 45% vacancy rate across the health sector in 2016[13] . The contributing factors to weak human resource capacity include a weak HR management system, complex and inefficient employment procedures, weak regulation of the workforce, lack of systematic staff performance appraisals, no clear link between workload and establishment, poor motivation of staff, uncoordinated trainings, and inadequate skills and knowledge.

Policy Statement 1: The Ministry will ensure the availability, appropriate distribution, and retention of competent staff at all levels of the healthcare system

Strategies

2.1 Define minimum staffing requirements in line with workload at all levels
2.2 Deploy staff according to staffing needs and norms at all levels of healthcare
2.3 Enhance knowledge and skills of human resources for health in quality management through pre- and in-service training
2.4 Introduce mechanisms for, and operationalize, the coordination of quality management trainings at all levels
2.5 Strengthen mechanisms for motivating staff

[13] HSSP II

Policy Statement 2: The Ministry will ensure human resource performance management systems are in place and functional at all levels

Strategies

2.6 Strengthen HR performance management systems
2.7 Enhance HR appraisal systems
2.8 Enforce implementation of Malawi Public Service Regulations (MPSR)

3.3 Policy Priority Area 3: Clinical Practice

Clinical practices remain suboptimal due to a lack of diagnostic facilities, overdependence on presumptive diagnosis and treatment, poor documentation and record keeping, a lack of clinical competencies, and the inadequate use of guidelines and standard operating procedures (SOPs).

Policy Statement 1: The Ministry will ensure clinical guidelines, SOPs, and standards are available and adhered to at all facilities at all times

Strategies

3.1 Ensure clinical guidelines and SOPs are available at point of care
3.2 Strengthen capacity of all health workers on the use of clinical guidelines and SOPs
3.3 Institute a systematic QI approach to ensure adherence to the clinical guidelines and SOPs at all levels
3.4 Establish a national Electronic Medical Records System, Master Patient Index, and other technologies for patient management
3.5 Reinforce integrated supportive supervision and mentoring by qualified personnel
3.6 Review and update norms and standards to improve quality of healthcare
3.7 Strengthen recognition systems for health facilities achieving compliance with quality standards

3.4 Policy Priority Area 4: Client Safety

Although significant improvements have been made in Infection Prevention and Control practices over the past decade, challenges still remain due to inadequate capacity, shortage of supplies, risky infrastructure and equipment, and missing danger alert signs. Another area of client safety that remains weak is the recognition and management of medical errors and adverse events.

Policy Statement 1: The Ministry will ensure clients and patients are safeguarded against malpractice, unqualified health workers, and harmful products

Strategies

4.1 Ensure health staff are appropriately trained, registered, and regulated
4.2 Establish systems to prevent, monitor, and manage drug resistance
4.3 Establish systems to prevent, report, and ethically manage medical errors and adverse events

Policy Statement 2: The Ministry will ensure client safety standards and guidelines are adhered to at all times including those related to the safe use of injections, invasive devices, and blood transfusions

Strategies

4.4 Develop, disseminate, and implement client safety standards
4.5 Ensure that health infrastructure is in line with safety standards
4.6 Regulate the safe use of medical technologies

Policy Statement 3: The Ministry will ensure quality Infection Prevention and Control (IPC), Antimicrobial Resistance Programs, and Water, Sanitation, and Hygiene (WASH) are integrated at each health facility

Strategies

4.7 Strengthen availability of IPC supplies and infrastructure including personal protective equipment at all levels
4.8 Enforce adherence to infection prevention and control practices including healthcare waste management
4.9 Establish and strengthen systems to monitor and manage infection prevention and control
4.10 Ensure that each health facility has access to a safe water supply and sanitation facilities at all times

3.5 Policy Priority Area 5: People-Centered Care

Although several interventions to improve people-centered care have been introduced in the past (dissemination of patient and provider rights and responsibilities, the establishment of health facility ombudsmen, introduction of suggestion boxes), significant gaps remain to fully embrace people-centered care. Patients' charters are not consistently used, communication between providers and clients is inadequate, mechanisms for receiving, analyzing and addressing client feedback are still weak, and participation of clients and their communities in the provision of care is limited.

Policy Statement 1: The Ministry will ensure the highest standards of people-centered care are implemented and reinforced at all levels in close collaboration with community and civil society

Strategies

5.1 Establish and implement structures for people-centered care at all levels
5.2 Ensure provision of respectful patient care at all levels
5.3 Strengthen communication and feedback mechanisms between clients and providers
5.4 Enhance the use of provider, patient, and service charters
5.5 Ensure equitable access to healthcare for marginalized populations

3.6 Policy Priority Area 6: Support Systems

Despite increased attention to health systems strengthening over the past decade, significant gaps still exist in the support systems such as frequent stock outs of essential medicines and supplies, inadequate facility security for medical commodities, weak management of infrastructure and medical equipment, unresponsive referral system, and weak financial and procurement systems.

Policy Statement 1: The Ministry will ensure equipment, medicine and supplies are available, equitably accessible, economical, and safe at all times

Strategies

6.1 Strengthen physical assets management at all levels
6.2 Standardize and coordinate procurement/donation, allocation, distribution, maintenance, and replacement of medical equipment and supplies
6.3 Strengthen procurement for medicines and supplies at all levels
6.4 Strengthen supply chain, inventory, and security for medicines and supplies at all levels of the health system
6.5 Ensure adherence to minimum standards of equipment, medicines, and supplies for facilities

Policy Statement 2: The Ministry will ensure safe, rapid ambulatory transport and a functional referral system are in place across the health system

Strategies

6.6 Strengthen the referral system, including timely communication
6.7 Ensure safe patient ambulatory transport

3.7 Policy Priority Area 7: Evidence-Based Decision Making

Although good progress has been made with generation of data, the utilization for decision making remains a major challenge. There is also limited capacity to conduct relevant research and translation of research findings into practice is weak.

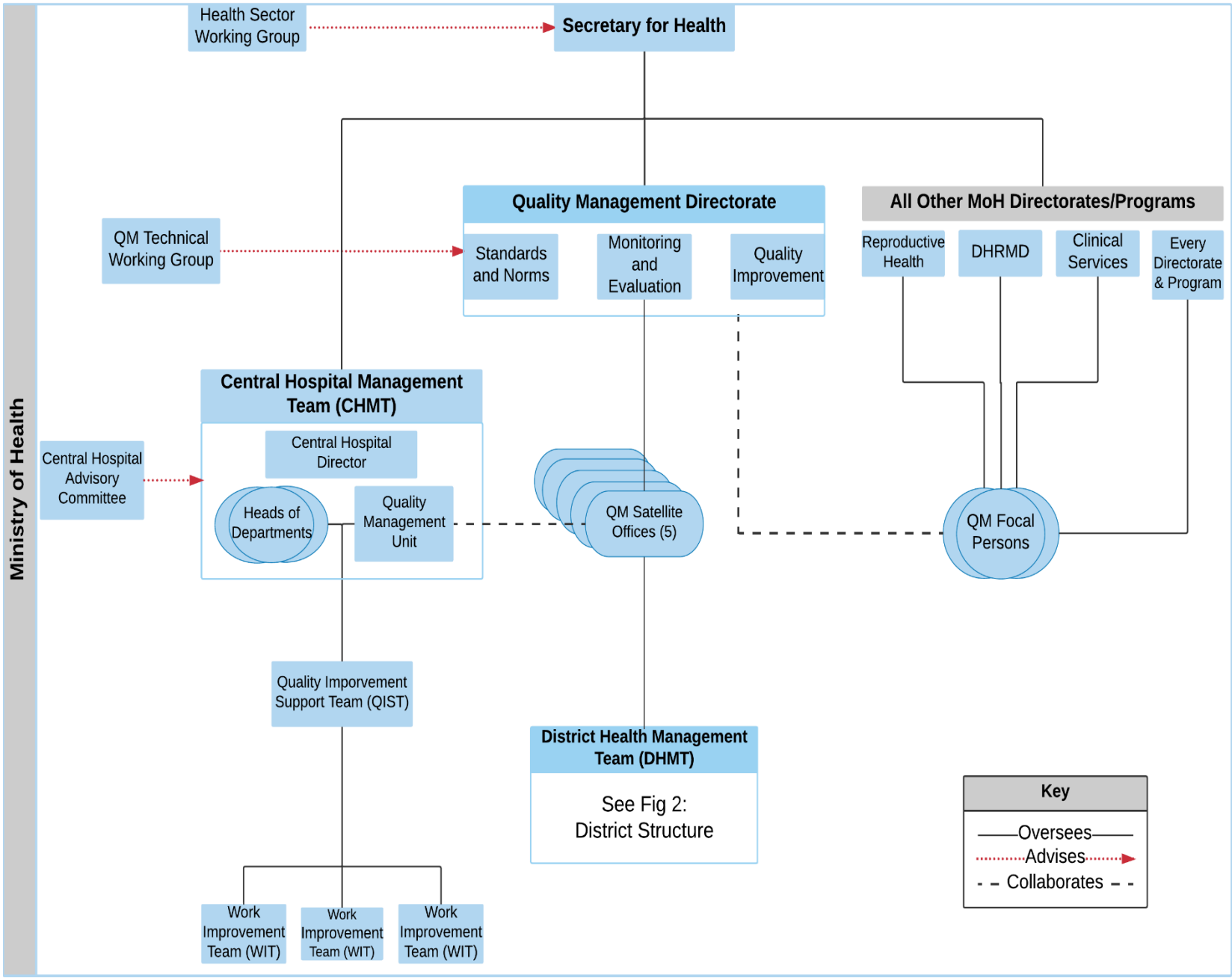
Policy Statement 1: The Ministry will ensure appropriate capacity in the generation and accurate use of data for evidence-based decision making for quality of care at all levels

Strategies

7.1 Improve the quality of health data at all levels
7.2 Strengthen data collection, analysis, interpretation, and use for planning, programming, and policy formulation
7.3 Strengthen integration and reporting of quality of care indicators within HIS
7.4 Strengthen utilization of health information at the point of care
7.5 Strengthen operational research and monitoring and evaluation at all levels
7.6 Strengthen coordination of research activities in the country
7.7 Promote a culture of information sharing and learning at all levels

Implementation Arrangements

4.1 Institutional Arrangements



District Government
District/CHAM Hospital
Local Health Facility and Community
Quality Management Satellite Office
District Council
District Health Management Team (DHMT)
Director of Health and Social Services (DHSS)
District QM Coordinator
All Other District Officers
Health & Environment Committee
District Health Stakeholder Forum
Hospital Management Team (HMT)
Hospital Director
Hospital QM Coordinator
Heads of Departments
Quality Improvement Support Team (QIST)
Work Improvement Team (WIT)
Work Improvement Team (WIT)
Hospital Advisory Committee
Health Centre Management Team
Facility In Charge
Heads of Sections
QM Focal Person
Work Improvement Teams (WIT)
Health Centre Advisory Committee
Community Health Team
Community Health Structures:
Village Health Council (VHC)
Community Health Action Group (CHAG)
Community-Based Organizations
Community
Key
Oversees
Advises
Collaborates

The Ministry of Health

The QM Policy will be implemented using established government structures at each level of the health system. There shall be designated QM officers at the National, District and the local/community levels. The Health Sector Working Group (HSWG) shall be the highest level multi-sectoral steering committee responsible for providing oversight in the implementation of the QM Policy at national level. The Quality Management Directorate (QMD) in the Ministry of Health shall oversee and provide day-to-day coordination and secretariat functions for smooth implementation of the QM Policy and shall report to the Secretary for Health who co-chairs the Health Sector Working Group.

Also at the national level, the Quality Management Technical Working Group (QM TWG) shall be the highest advisory mechanism for the QMD and be comprised of all Directors in the Ministry of Health, the Executive Director of CHAM, and representatives from the Ministry of Local Government and Rural Development, Local Authorities, Central Hospital Directors, Registrars of Regulatory Bodies, Principals of relevant Academic Institutions, Development and Implementing partners, and representatives of the community, civil society, and the private sector. The QM Director shall chair the TWG and the QM Directorate shall be the secretariat to the TWG.

The Quality Management Directorate

The Quality Management Director shall oversee three divisions of the QM Directorate, each headed by a Deputy Director: Monitoring and Evaluation, Quality Improvement, and Standards and Norms.

The Quality Monitoring and Evaluation Division (QMED) will be responsible for assessing the impact of quality initiatives, serving as a consolidated source of information on progress in quality initiatives to allow stakeholders to learn and build QM expertise. This QMED work will include monitoring all technical aspects of healthcare delivery, coordinating operational research in QoC, strengthening the use of data for decision making, assessing the effectiveness and quality of data collection and planning systems, and fast-tracking the implementation of the national QM Policy and Strategy.

The Quality Improvement Division will be responsible for identifying and supporting quality initiatives using data generated by QMED. This QI work will include strengthening QM structures, harmonizing QM frameworks and coordinating various QI approaches and initiatives across the health sector. The QI Division will play a central role in designing quality improvement projects and replicating best practices

to improve health provision. The division will also oversee capacity building and mentorship programs for facility officers to ensure uniform understanding of quality issues. The division will be responsible for devising methods and tools for obtaining feedback from stakeholders to identify performance gaps and devise appropriate interventions. Furthermore, the section will be responsible for developing and harmonizing clinical auditing tools and rolling out incentives to enhance the motivation of the health workforce.

The Standards and Norms Division will be responsible for the development, review, harmonization, promotion, and adherence of quality standards, norms, guidelines, and SOPs. This will entail identifying and defining quality frameworks with an emphasis on outcomes and associated feedback leading to error prevention. In addition, the section will be responsible for capacity building for quality management at all levels in collaboration with various directorates in the ministry and other technical experts. It will provide interface between the ministry of health and regulatory bodies on all matters regarding quality of care, standards, certification and licensing, accreditation of health facilities, and ensuring that there is efficient communication on quality assurance among stakeholders.

All MoH departments and programs will have a QM focal person to coordinate quality management activities within their technical domains to ensure alignment with this QM Policy and Strategy for the health sector in Malawi.

In order to effectively coordinate quality management nationwide, the Quality Management Directorate shall designate a Chief Quality Management Officer (CQMO), overseen by the QM Deputy Director of Quality Monitoring and Evaluation, for each of the five Quality Management Satellite Offices (North, Central West, Central East, South West, and South East) across the country. The CQMO will oversee and coordinate quality management within their designated districts and will be responsible for facilitating knowledge management and learning and scaling-up of best practices.

Central Hospitals

At the Central Hospital level, there shall be a designated Quality Management Unit with at least three full time QM officers. The Unit will oversee and coordinate QM approaches across the hospital and report to the Hospital Director. The Head of the Unit will chair the Quality Improvement Support Team (QIST) which will consist of heads from each hospital department. Heads of Departments shall lead QM interventions in their department through Work Improvement Teams (WITs).

District Government

At the District level, a dedicated full time QM Coordinator shall oversee and coordinate QM approaches across the district and report to the Director of Health and Social Services. The District Health Stakeholder Forum comprised of all health partners and program coordinators and chaired by the DC will be the advisory body for QM at district level.

District, Private, & CHAM Hospitals

At the District, Private and CHAM Hospital level, there shall be a Hospital QM Coordinator who coordinates QM approaches across the facility and in close collaboration with the District QM Coordinator provides technical backstopping to the health centers. The QM Coordinator reports to the Hospital Director/District Medical Officer. The Hospital Director will chair the Quality Improvement Support Team (QIST) which will consist of heads of each hospital department. Heads of Departments will manage QM interventions in their departments through Work Improvement Teams (WITs).

Local Health Facility and Community

At Health Centre level, there shall be a QM focal person who coordinates QM approaches at the health center and in the community and reports to the officer in charge of the facility.

At community level, the Health Centre Advisory Committees (HCAC) will be comprised of community members, service providers, and members of the Community Health Team (CHT). The HCAC shall be a key advisory structure linking the community to the facility and promoting accountability through monitoring, information sharing, awareness raising, dispute settlement, and resource mobilization. The CHT serves as the service provision body for community health workers and is comprised of several cadres of CHWs, including Health Surveillance Assistants, Community Health Nurses and Community Midwife Assistants. This group forms the link between the community health system and other key community health structures. Village Health Committees and Village Development Committees will be fora to discuss QM issues at the village level and mobilize resources for specific QM initiatives.

4.2 Implementation Plan

This QM Policy is complimented by a Quality Management Strategic Plan (2017-2022) which will guide the implementation of all listed policy strategies. This QM Strategic Plan includes core activities to be taken on by partners and stakeholders in addition to the MoH in order to achieve the aforementioned policy goal, objectives, and priority areas. Annex 1 contains the summary of these QM objectives, strategies, timelines, and institutions responsible. The timeframe for the QM Strategic Plan runs until 2022 in line with the Health Sector Strategic Plan II (HSSP II). To improve coordination and efficiency, all partners in the health sector shall develop and implement quality initiatives based on the priorities in this policy and the QM Strategic Plan. Additionally, to improve alignment, partner implementation frameworks shall be sufficiently discussed with and endorsed by relevant Government structures prior to commencement of implementation.

4.3 Monitoring and Evaluation

The implementation of this Policy will be monitored continuously through the Deputy Director of the M&E division at the Quality Management Directorate. Annex 2 contains the detailed Monitoring and Evaluation Plan for the Policy and shows outputs for each objective, performance indicators, targets, baseline, and sources of verification. Overall success of the policy will be measured by progress towards achieving the policy goal targets and the policy outcomes. Indicators and targets for each policy outcome will be developed as part of the QM framework. This QM Policy document will undergo review in 2022 as part of the final evaluation of the HSSP II (2017-2022) and will be revised accordingly.

Annex 1: Implementation Plan

Policy Priority Area 1: Leadership, Governance, and Accountability

Policy Statement 1: The Ministry will ensure strategies, structures, and coordination mechanisms for implementation of the Quality Management (QM) policy are in place and functional at all levels of the health system at all times			
Objective	**Strategy**	**Lead Institution**	**Time Frame**
Improve health sector leadership, governance, and accountability	1.1 Establish and periodically review implementation frameworks for QM in the health sector	QMD	May 2018 – May 2022
	1.2 Strengthen QM structures at all levels in the health sector	QMD	Dec 2017 – Nov 2021
	1.3 Institute systematic quality management processes at all levels	QMD	Dec 2017 – Jul 2022
	1.4 Strengthen coordination and collaboration between the Ministry of Health, regulatory bodies, professional associations, local councils and other key players for enhanced execution of their mandates for quality management	QMD	Dec 2017 – Nov 2021
	1.5 Strengthen quality management in disaster preparedness and response at all levels	QMD/ Department of Disaster Management Affairs	Dec 2018 – Dec 2021
	1.6 Enhance coordination of the activities of all implementing partners in the health sector in line with national quality management priorities	SH/Heads of Health Institutions	Mar 2018 – Jul 2022
Policy Statement 2: : The Ministry will ensure commendable performance, professional excellence and accountability are the norm of management and staff at all levels of the health system			
Improve health sector leadership, governance, and accountability	1.7 Enhance capacity building in leadership, accountability and management skills among managers at all levels	Director of DHRMD/Training Institutions	Dec 2017 – Nov 2021
	1.8 Strengthen staff participation in QM and promote teamwork at all levels	Heads of Departments	Jun 2018 – Nov 2021
	1.9 Strengthen accountability mechanisms at all levels	Office of the Ombudsman	Dec 2017 – Dec 2021

Policy Statement 3: The Ministry will ensure communities are empowered and are effective partners in health governance and quality management to improve health outcomes at all levels of healthcare			
Improve health sector leadership, governance, and accountability	1.10 Empower communities to understand their healthcare needs and demand quality of care	DCs/ Civil Society Organizations	Dec 2017 – Nov 2021
	1.11 Strengthen community participation in QM activities	Community Health Unit/DCs	Jun 2018 – Dec 2021
	1.12 Strengthen social accountability mechanisms between the community and service providers	DCs/ Civil Society Organizations/ Office of the Ombudsman	Dec 2017 – Nov 2021

Policy Priority Area 2: Human Resources for Health

Policy Statement 1: The Ministry will ensure availability, appropriate distribution, and retention of competent staff at all levels of the healthcare system			
Objective	**Strategy**	**Lead Institution**	**Time Frame**
Increase capacity of human resources for health (HRH) to deliver quality health services	2.1 Define minimum staffing requirements in line with workload at all levels	DHRMD	Dec 2017 – Nov 2019
	2.2 Deploy staff according to staffing needs and norms at all levels of healthcare	DHRMD/DCs	Dec 2018 – Nov 2021
	2.3 Enhance knowledge and skills of human resources for health in quality management through pre- and in-service training	QMD/Training Institutions	Dec 2017 – Jul 2022
	2.4 Introduce mechanisms for, and operationalize, coordination of quality management trainings at all levels	QMD	Mar 2018 – Nov 2021
	2.5 Strengthen mechanisms for motivating staff	DHRMD	Jun 2018 – Jul 2022
Policy Statement 2: The Ministry will ensure human resource performance management systems are in place and functional at all levels			
Increase capacity of human resources for health (HRH) to deliver quality health services	2.6 Strengthen HR performance management systems	DHRMD/DCs	Dec 2017 – Nov 2021
	2.7 Strengthen HR appraisal systems	Heads of Health Institutions	Dec 2017 – Jul 2022
	2.8 Enforce implementation of Malawi Public Service Regulations (MPSR)	DHRMD	Dec 2017 – Nov 2021

Policy Priority Area 3: Clinical Practice

Policy Statement 1: The Ministry will ensure clinical guidelines, SOPs, and standards are available and adhered to at all facilities at all times			
Objective	**Strategy**	**Lead Institution**	**Time Frame**
Promote excellence in clinical practice across the continuum of care	3.1 Ensure clinical guidelines and SOPs are available at point of care;	QMD/Heads of Health Institutions	Jun 2018 – Jul 2022
	3.2 Strengthen capacity of all health workers on the use of clinical guidelines and SOPs	Technical Directorates and Programs	Dec 2018 – Nov 2021
	3.3 Institute a systematic QI approach to ensure adherence to the clinical guidelines and SOPs at all levels	QMD/Heads of Health Institutions	Jun 2018 – Nov 2021
	3.4 Establish a national Electronic Medical Records System, Master Patient Index, and other technologies for patient management	CMED	Feb 2018 – Jul 2022
	3.5 Reinforce integrated supportive supervision and mentoring by qualified personnel	QMD/Heads of Health Institutions	Dec 2017 – Jul 2022
	3.6 Review and update norms and standards to improve quality of healthcare	QMD	Dec 2017 – Nov 2021
	3.7 Strengthen recognition systems for health facilities achieving compliance with quality standards	Regulatory Bodies/ QMD	Dec 2017 – Jul 2022

Policy Priority Area 4: Client Safety

Policy Statement 1: The Ministry will ensure clients and patients are safeguarded against malpractice, unqualified health workers, and harmful products			
Objective	**Strategy**	**Lead Institution**	**Time Frame**
Improve client safety at all levels of healthcare	4.1 Ensure health staff are appropriately trained, registered, and regulated	Regulatory Bodies/ DHRMD	Dec 2017 – Jul 2022
	4.2 Establish systems to prevent, monitor, and manage drug resistance	Public Health Institute of Malawi	Dec 2017 – Nov 2021
	4.3 Establish systems to prevent, report, and ethically manage medical errors and adverse events	QMD	Mar 2018 – Nov 2021
Policy Statement 2: The Ministry will ensure client safety standards and guidelines are adhered to at all times including those related to the safe use of injections, safe use of invasive devices, and blood transfusions			
Improve client safety at all levels of healthcare	4.4 Develop, disseminate, and implement client safety standards	QMD/Heads of Health Institutions	Dec 2017 – Nov 2021
	4.5 Ensure that health infrastructure is in line with safety standards	HTSS/DPPD/ Regulatory Bodies	Dec 2018 – Nov 2021
	4.6 Regulate the safe use of medical technologies	QMD/HTSS	Dec 2018 – Nov 2021
Policy Statement 3: The Ministry will ensure quality Infection Prevention and Control (IPC) programs including Water, Sanitation, and Hygiene (WASH) are in place at each health facility			
Improve client safety at all levels of healthcare	4.7 Strengthen availability of IPC supplies and infrastructure including personal protective equipment at all levels	Heads of Health Institutions	Dec 2017 – Nov 2021
	4.8 Enforce adherence to infection prevention and control practices including healthcare waste management	Regulatory Bodies/ Heads of Health Institutions	Dec 2017 – Jul 2022
	4.9 Establish and strengthen systems to monitor and manage infection prevention and control	QMD/ Public Health Institute of Malawi	Dec 2017 – Dec 2021
	4.10 Ensure that each health facility has access to a safe water supply and sanitation facilities at all times	QMD/Regulatory Bodies	May 2018 – Dec 2021

Policy Priority Area 5: People-Centered Care

Policy Statement 1: The Ministry will ensure the highest standards of people-centered care are implemented and reinforced at all levels in close collaboration with community and civil society			
Objective	**Strategy**	**Lead Institution**	**Time Frame**
Strengthen people-centered care at all levels of the health system	5.1 Establish and implement structures for people-centered care at all levels	QMD/Heads of Health Institutions	May 2018 – Jul 2022
	5.2 Ensure provision of respectful patient care at all levels	QMD/Heads of Health Institutions	Jun 2018 – Nov 2019
	5.3 Strengthen communication and feedback mechanisms between clients and providers	QMD/DC/ Ombudsman	May 2018 – Nov 2021
	5.4 Enhance the use of provider, patient, and service charters	QM Coordinator/ Ombudsman	Dec 2017 – Jul 2022
	5.5 Ensure equitable access to healthcare for marginalized populations	QMD	Dec 2018 – Nov 2019

Policy Priority Area 6: Support Systems

Policy Statement 1: The Ministry will ensure equipment, medicines, and supplies are available, equitably accessible, economical, and safe at all times			
Objective	**Strategy**	**Lead Institution**	**Time Frame**
Strengthen support systems for the delivery of quality health services	6.1 Strengthen physical assets management at all levels	Physical Assets Management (PAM)	May 2018 – Nov 2021
	6.2 Standardize and coordinate procurement/donation, allocation, distribution, maintenance, and replacement of medical equipment and supplies	Physical Assets Management (PAM)	Dec 2017 – Nov 2021
	6.3 Strengthen procurement for medicines and supplies at all levels	SH / ODPP	Dec 2017 – Nov 2021
	6.4 Strengthen supply chain, inventory, and security for medicines and supplies at all levels of the health system;	Heads of Health Institutions	Dec 2017 – Jul 2022
	6.5 Ensure adherence to minimum standards of equipment, medicines, and supplies for facilities	QMD/ HTSS/ PMPB	May 2018 – Nov 2021

Policy Statement 2: The Ministry will ensure safe, rapid ambulatory transport and a functional referral system are in place across the health system			
Strengthen support systems for the delivery of quality health services	6.6 Strengthen the referral system, including timely communication	Directorate of Clinical Services/QMD	Dec 2017 – Jul 2022
	6.7 Ensure safe patient ambulatory transport	QMD/Heads of Health Institutions	May 2018 – Dec 2021

Policy Priority Area 7: Evidence-Based Decision Making

Policy Statement 1: The Ministry will ensure appropriate capacity in generation and accurate use of data for evidence-based decision making for quality of care is strengthened at all levels			
Objective	**Strategy**	**Lead Institution**	**Time Frame**
Increase capacity in generation and use of accurate strategic information for evidence-based decision making and policy formulation	7.1 Improve the quality of health data at all levels	CMED	Dec 2017 – Nov 2021
	7.2 Strengthen data collection, analysis, interpretation, and use for planning, programming and policy formulation	CMED/DPPD	May 2018 – Nov 2021
	7.3 Strengthen integration and reporting of quality of care indicators within HIS	QMD/CMED	Dec 2017 – Nov 2021
	7.4 Strengthen utilization of health information data at the point of care	QMD/ Heads of Health Institutions	Jun 2018 – Jul 2022
	7.5 Strengthen operational research and monitoring and evaluation at all levels	Research Unit/Heads of Health Institutions	Jun 2018 – Nov 2021
	7.6 Strengthen coordination of research activities in the country	Research Unit	Dec 2017 – Nov 2021
	7.7 Promote a culture of information sharing and learning at all levels	QMD	May 2018 – Nov 2021

Annex 2: Monitoring and Evaluation Plan

Policy Priority Area 1: Leadership, Governance, and Accountability

Objective	Outcome	Performance Indicators	Baseline (Year)	Target (2022)	Data Source	Reporting Period
Improve health sector leadership, governance, and accountability	All levels of healthcare have functional and effective leadership and governance structures and systems by 2022	% of QM Health Facility Action Plans implemented	TBD	TBD	ISS	Semi-annual
		% Government budget allocated to the health sector	10.4% (2015)	15%	National Health Accounts	Annually
		% Health facilities jointly inspected by regulatory bodies in a year	0% (2016)	10%	Inspection Reports	Annually
		% Senior Managers that received QM Leadership Training	TBD	TBD	Training Reports/ database	Annually (cumulative)
		% Central MoH budget allocated to quality management	0.10% (2017-2018)	TBD	MoH Annual Budget	Annually
		Proportion of national health programs/directorates with QM included in strategic plans	TBD	100%	MoH Dept. Plans	Annually
		% Health Facilities with documentation of a recent QI activity in past 6 months	14% (2014)	90%	MSPA/ISS	Annually
		% Health facilities with functional community advisory component (Any management meetings with community participation held at least once every 6 months)	15% (2014)	70%	MSPA/ISS	Annually

Policy Priority Area 2: Human Resources for Health

Objective	Outcome	Performance Indicators	Baseline (Year)	Target (2022)	Data Source	Reporting Period
Increase capacity for human resources for health (HRH) to deliver quality health services	All primary level facilities, national policy institutions, and 90% of secondary and tertiary level health facilities have adequate numbers of staff with right competencies required to oversee and deliver high quality care by 2026	MoH Health worker density and distribution (nurse/midwife, HSA, doctor to population ratio)	Doctor: 0.21/10,000 Nurses/ Midwives: 3.4 per 10,000 Clinical Officers: 0.82 per 10,000 Medical Assistant: 0.76 per 10,000 (2017)	Doctor: 0.4/10,000 Nurses/ Midwives: 5.9 per 10,000 Clinical Officers: 0.90 per 10,000 Medical Assistant:0.80 per 10,000	IHRIS (HSSP II)	Annual
		% Health Worker Vacancy Rate (by cadre) vs. optimal establishment	TBD	TBD	IHRIS	Annually
		Staff satisfaction rate	TBD	TBD	Satisfaction Survey	2-3 years
		Health worker attrition rate	3% (2016)	TBD	IHRIS	2-3 years
		% Graduating health professionals (by cadre) absorbed by the public health system within a year	TBD	TBD	IHRIS	Annually
		% Staff Appraised with job descriptions and performance contract agreements	TBD	TBD	IHRIS	Annually
		% Health staff trained in Quality Improvement	TBD	TBD	Training Reports/ Database	Annually (Cumulative)

Policy Priority Area 3: Clinical Practice

Objective	Outcome	Performance Indicators	Baseline (Year)	Target (2022)	Data Source	Reporting Period
Promote excellence in clinical practice across the continuum of care	80% of health facilities achieve national accreditation standards by 2030	Institutional Maternal Mortality ratio	311 per 100,000 live births (2015)	156 per 100,000 live births*	HMIS (HSSP II)	Annually
		Institutional Neonatal mortality rate	12.3/1,000 live births (2015)	6.2/1,000 live births*	HMIS (HSSP II)	Annually
		Excess Inpatient death rate	TBD	TBD	HMIS	Annually
		ART retention rate	80% (2016)	80%	Integrated HIV Program Report (HSSP II)	Annually
		TB treatment success rate	84% (2015)	90%	TB Annual Report (HSSP II)	Annually
		Annual Inpatient malaria death rate	23 per 100,000 population(2015)	14 per 100,000 population	HMIS (HSSP II)	Annually
		% Facilities that meet minimum norms and standards	TBD	TBD	QM	Annually
		% District Health Officers (DHOs) supervised by CQMOs using the integrated supervision checklist	TBD	TBD	ISS	Annually
		% Facilities supervised by the DHMT using the integrated supportive supervision checklist	TBD	TBD	ISS	Annually
		% Facilities with clinical guidelines posted (IPC, IMCI)	IPC: 37% IMCI: 37%(2014)	100%	ISS/MSPA	Semi-annual
		% Facilities adhering to clinical guidelines	TBD	TBD	ISS	Semi-annual

* In RMNCAH QoC Roadmap Districts

Policy Priority Area 4: Client Safety

Objective	Outcome	Performance Indicators	Baseline (Year)	Target (2022)	Data Source	Reporting Period
Improve client safety at all levels of healthcare	All facilities adhere to patient safety standards and Infection Prevention and Control practices with appropriate water supply and sanitation by 2028	Medical Error Rate /1000 inpatient days	TBD	TBD	N/A	Annually
		Rate of hospital acquired infections per inpatient hours	TBD	TBD	N/A	TBD
		Average length of hospital stay	TBD	TBD	HMIS	Annually
		Rate of Hospital Readmission <72 hours	TBD	TBD	N/A	TBD
		% Health facilities with adequate IPC and WASH facilities	60% (2014)	90%	MSPA/ISS	Annually
		% Health facilities appropriately storing infectious waste	28% (2014)	58%	MSPA/ISS	Annually
		% Health Facilities appropriately disposing infectious waste	62% (2014)	92%	MSPA/HMIS	Annually
		% Health facilities with mechanisms for reporting hospital acquired infections	TBD	TBD	N/A	TBD
		% Health facilities with mechanisms for reporting medical errors	TBD	TBD	N/A	TBD

Policy Priority Area 5: People-Centered Care

Objective	Outcome	Performance Indicators	Baseline (Year)	Target (2022)	Data Source	Reporting Period
Strengthen people-centered care at all levels of the health system	All clients in the health system at all levels report being satisfied in all dimensions of health services rendered and received by 2024	% Clients visiting health facilities that are satisfied with health services	TBD	80%	Client Satisfaction Survey (HSSP II)	2-3 years
		% Health facilities with service charters	TBD	100%	ISS	Semi-annual
		% Health facilities with functional ombudsman	TBD	TBD	ISS	Semi-annual
		% Health Facilities with functional client feedback mechanisms (suggestion boxes, surveys, interviews, community leader meetings, letters, email, etc.)	8% (2014)	TBD	MSPA/ISS	Semi-annual
		% Complaints resolved (of those sent to MoH)	TBD	TBD	QM/ISS	Semi-annual
		% Clients surveyed reporting health worker involved them in decisions on treatment/care	TBD	TBD	Client Satisfaction Survey	2-3 years

Policy Priority Area 6: Support Systems

Objective	Outcome	Performance Indicators	Baseline (Year)	Target (2022)	Data Source	Reporting Period
Strengthen support systems for the delivery of quality health services	All health facilities have essential infrastructure including water, sanitation facilities, equipment, medicines, supplies, electricity, and internet connectivity at all times by 2025	% Health facilities with full infrastructure requirements in line with respective level of care	TBD	75%	PAMIS	Annually
		Bed Occupancy Rate	TBD	TBD	HMIS (HSSP II)	Annually
		% Health facilities with stock outs of tracer medicines	20% (2016)	5%	LMIS (HSSP II)	Annually
		% Health facilities with improved water source	94% (2014)	100%	MSPA/ PAMIS/DC	Annually
		% Health Facilities with a client latrine (flush/pour toilet, improved pit latrine, composting toilet)	37% (2014)	72%	MSPA/ PAMIS/DC	Annually
		% Health facilities with regular electricity	59% (2014)	85%	MSPA/ PAMIS/DC	Annually
		% Health Facilities with adequate communication equipment (cell phone, landline phone, short-wave radio)	76% (2014)	100%	MSPA/ PAMIS/DC	Annually
		% Health Facilities with internet connectivity (computer with internet or phone with data connection)	35% (2014)	70%	MSPA/PAMIS	Annually
		% Health Facilities up to renovation standards	TBD	TBD	PAMIS/DC	Annually
		% Health facilities with functioning equipment in line with standard equipment list	TBD	TBD	PAMIS/DC	Annually
		% Facilities with an ambulance or regular ambulance access	77% (2014)	100%	MMSPA/ISS	Annually
		% Ambulances fully equipped	TBD	TBD	ISS	Annually

Policy Priority Area 7: Evidence-Based Decision Making

Objective	Outcome	Performance Indicators	Baseline (Year)	Target (2022)	Data Source	Reporting Period
Increase capacity in generation and use of accurate strategic information for evidence-based decision making and policy formulation	By 2021, all decisions at each level of the health system are based on high quality information	% Health facilities that use data for decision making at point of care	TBD	TBD	ISS	Semi-Annual
		% Health Facilities that submit complete HMIS reports within 3 months of deadline	94.5% (2016)	99%	HMIS (HSSP II)	Monthly
		% Health facilities with QI learning circles	TBD	TBD	N/A	Annually
		% Health facilities with CPD programs	TBD	TBD	N/A	Annually
		Number of Research studies completed on management of quality of care	TBD	TBD	Research Directorate	Annually