SAFE CARE FOR LIFE: *NON-COMMUNICABLE DISEASES & PATIENT SAFETY*, THE UGANDA CATHOLIC HEALTH NETWORK'S INITIATIVES

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In May 2019, at the 72nd World Health Assembly—under resolution WHA 72.6, the World Patient Safety Day was established. This international day, calls for global solidarity and concerted action by all and partners to improve patient safety.[1]

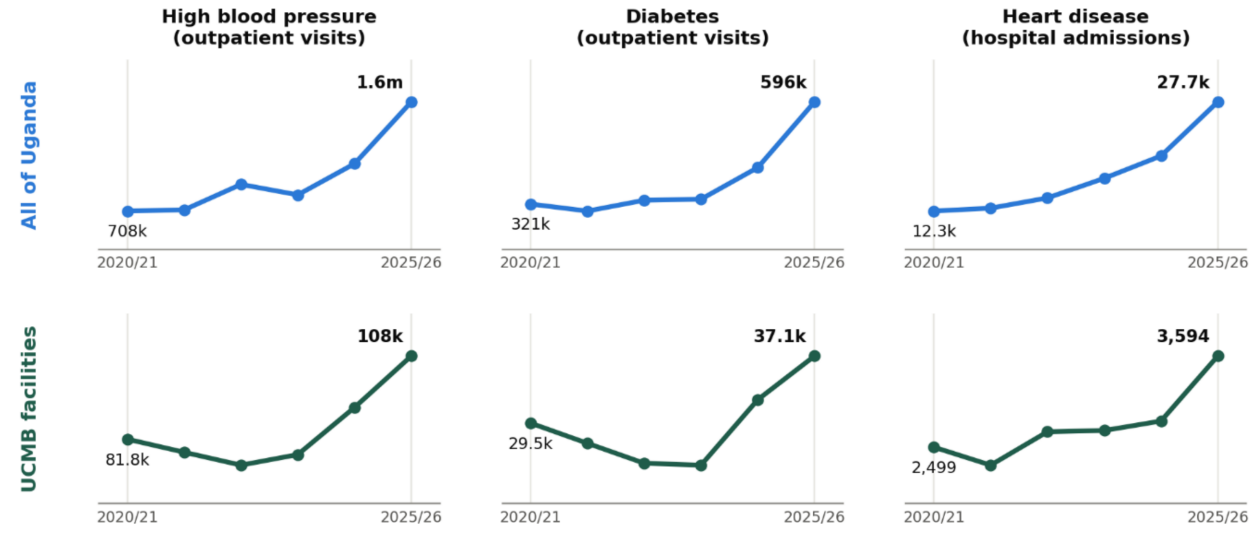
The World Patient Safety Day is commemorated every year on **September 17th** – with appropriate global rallying themes—and for this year, 2026, the theme is "*Safe Care for Non-Communicable Diseases*", with the slogan "Safe care for life!"[2].This a timely call.

The World Health Organisation (WHO) estimates that one in ten patients is harmed while receiving care, and that more than half of this harm is **preventable** and that poor countries—such as Uganda, carry the heaviest burden.[3]

In Uganda, Non-communicable diseases (NCDs) caused over a third of deaths in 2019. One in every four adults has elevated Blood Pressure and the share of raised blood sugar to the total cases has more than doubled between 2014 and 2023.[4] Uganda's Ministry of Health records show that hypertension outpatient visits have increased from 707,591 in FY 2020/21 to 1.6 million in FY 2025/26—while Diabetes visits rose from about 321,000 to almost 600,000 in the same period and admissions due to heart disease increased by 124.6% in the period. The Ministry's latest annual report also notes that hypertension now causes 4.5% of hospital deaths, up from 2.8% a year earlier.[5]

This growing burden of NCDs is equally observed by the Catholic Health Network's (UCMB network) health facilities—as shown in the graphic representation below;

The rise in NCD numbers may reflect population growth, enhanced NCD screening examinations, increased awareness & health literacy levels and better data capture and reporting, however **the risk of diagnostic, therapeutic (medication) and related patient errors—and other dangers to patient safety are likely to correspondingly increase. Delayed diagnosis, inappropriate medications abound.**



k = thousand m = million. Source: Ministry of Health DHIS2.

Medical Errors occur when there is a failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim—and may cause serious errors, minor errors, and/or near misses. A medical error may or may not cause harm. The diagnosis of NCDs is frequently prone to Diagnostic Errors (thereby endangering patient safety)—which, according to the U.S *National Academy of Medicine*, is the failure to either establish an accurate and timely explanation of the patient's health problem(s) or communicate that explanation to the patient. Diagnosis involves the collection and analysis of information/data to arrive at a conclusion, then discussions with the patient about that conclusion, and an appropriate treatment plan.

There are multiple factors that can complicate the process for patients and providers.
It may take years for symptoms to be fully understood. The time and subtleties of (intentional) watchful waiting, patients hoping their symptoms go away, comorbidities, missed appointments, and numerous other factors further expose the process to mis-steps. While what gets missed in the clinical setting includes diagnoses of cancers, fractures, and NCD-related infections, the reasons why those diagnoses are missed are less diverse. Focusing on key vulnerabilities and the most frequently missed diagnoses can significantly reduce the frequency of diagnostic error. In the U.S & Other developed countries, almost half (45%) of the events alleged a missed cancer diagnosis. Prostate, lung, breast, and colorectal cancers were the most common. It is worth noting that—although the medical community regularly debates the efficacy of various screenings—the top missed cancer types have all been promoted to the general population as "detectable.", and in one-third of the events, the patient died, with an additional 22% suffering a high-severity injury—due to a missed diagnosis.
This is tragic—and you would never wish it to occur to either you or your loved one.!

The **Uganda Catholic Medical Bureau** (UCMB)—the national leadership and coordinating office of the Catholic Church's Health Services in Uganda—providing technical oversight and coordination to 305 health facilities—78% of which are considerably high patient volume clinical centres, and 17 health professional training institutions, has been proactively providing technical guidance, oversight and support towards ensuring patient safety and clinical quality improvement **since 2004.**
This included development of training resource materials such as the Pre-Service & In-Service Training Curriculum on Patient Safety and Quality of clinical care.
While the UCMB has annually monitored quality of clinical care across the network—tracking Annual Patient Satisfaction—through exit surveys—and soon to be upgraded to Patient Experience Surveys, and Annual Drug Prescription Surveys, the tracking of patient safety indicators has been rather cumbersome and difficult partly because of fears of medical error **disclosure**—i.e. the provision information to the facility authorities, to the patient and/or family about an incident and poor **recording** & **reporting** of adverse events or errors—especially for fear of potential litigation or blame etc.
The Catholic Health Network's Mission of providing Holistic Care and perpetuating as well as upholding Christ's assertion to the people of God……" To *have life and have it abundantly (John 10:10)*"—through its healing ministry, is disrupted when clinical care betrays patient safety provisions.

On the occasion to commemorate the WORLD PATIENT SAFETY Day 2026, The UCMB reiterates its commitment to ensuring patient safety as a central focus of its unique and dedicated service profile and calls upon all accredited health service providers to respond to patient safety incidents—with attention to a key constitutive element of Catholic Health Care—of the 'Human Being' (the patient, the client or the 'service consumer'), as an *Imago Dei* (The Image of God)—whose patient safety is of paramount importance.

The Bureau encourages an aspiration to the following tenets while dealing with Patient Safety incidents;

a) **Patient Safety Incident Reporting:** Reporting (Documentation) is the key tenet and triggers the investigation and corrective/remedial process. An appropriate and structured adverse incident reporting culture—which fosters 'blame-free' environment is critical to non-repeat incidents.

b) **Incident Investigation**

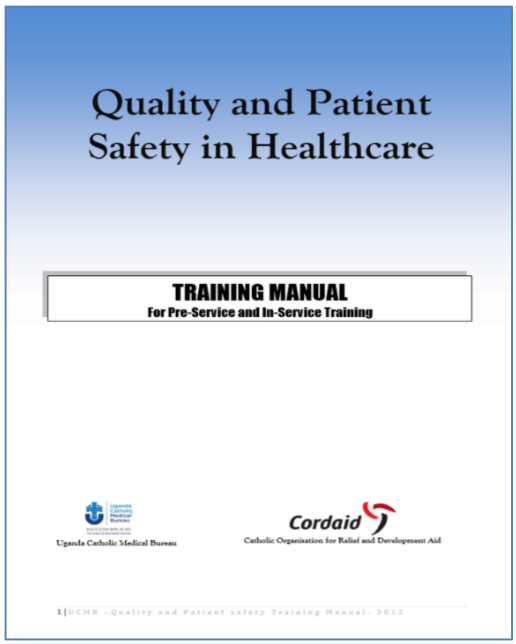
c) **Communication and Disclosure** Communication is the centerpiece of the process. Prompt, compassionate, and honest communication with the patient and family following an incident is essential. The patient and/or family should be fully and promptly informed of any incident—that is, any adverse event or serious error that reaches the patient. There is general agreement among patients and caregivers that it is not appropriate to inform patients of minor (harmless) errors. Near misses, errors that could have caused harm but were intercepted, are a special case and responses need to be individualized.

d) **Apology and Offering a Remedy:** Apology and remediation encompass a key tenet. Saying "We are sorry" without any subsequent action is inadequate because no remedy has been offered. We believe that there could be appropriate remedies suitable in specific instances.

e) **System Improvement:** The process does not end with full disclosure, apology, rapid remediation and early offer of support. Each investigation's findings are used to identify and implement system improvements.
System improvements are aimed at preventing a recurrence of system breakdowns

f) **Data Tracking and performance evaluation:** Data collected include type of patient safety incident, investigations, disclosures, financial, legal and public relations implications of the event, system improvements etc. and finally,

g) **Education and Training:** This improves transparency. Health Facilities have an obligation to provide their health care staff with the education, training, and resources to manage an incident. Among the most important is training is the communicating bad news.
Many health workers have not been adequately educated or trained in the skills needed to effectively deliver bad news, apologize, and counsel patients in distress. As a result, they often fail to communicate compassionately and effectively with their patients following an incident. Health workers are frequently inhibited in their ability to empathize with patients because of their own feelings of shame and guilt, compounded by fear of legal liability/litigation.
These problems are compounded by the fact that patients and health workers often have different perspectives on what information should be disclosed about adverse events.



As a result, clinicians may fail to meet the expectations of patients and families following an adverse event, causing misunderstanding and a breach of trust during this critical time.

Education & Training—especially, In-Service Training e.g. through CPDs or Other Short Courses would greatly improve communication and adverse event management.

The Bureau will continue building on these foundations.

Safe care is not a single act on a single day.

For a person living with an NCD, it is a promise kept at every visit, for life.

We entrust our patients and all who care for them to Christ the Healer and to Mary, Health of the Sick.

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