Improving Retention of Mother-Baby Pairs

Tested Changes and Guidance from Uganda

APRIL 2014

This change package for improving retention of mother-baby pairs was prepared by University Research Co., LLC (URC) for review by the United States Agency for International Development (USAID) and was authored by Tamara Nsubuga-Nyombi, Esther Karamagi-Nkolo, Joyce Draru, Humphrey Megere, and Amy Stern of URC through the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project and the Partnership for HIV-Free Survival (PHFS). The USAID ASSIST Project's work under PHFS is funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and made possible by the generous support of the American people through USAID.

Improving Retention of Mother-Baby Pairs: *Tested Changes and Guidance from Uganda*

April 2014

Tamara Nsubuga-Nyombi, University Research Co., LLC
Esther Karamagi-Nkolo, University Research Co., LLC
Joyce Draru, University Research Co., LLC
Humphrey Megere, University Research Co., LLC
Amy Stern, University Research Co., LLC

DISCLAIMER

The contents of this report are the sole responsibility of University Research Co., LLC (URC) and do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

Acknowledgements

This compilation of tested changes and guidance for improving retention of mother-baby pairs in care was developed for the United States Agency for International Development (USAID) by the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project. The authors acknowledge the Ministry of Health of Uganda, the Strengthening Partnerships, Results and Innovations in Nutrition Globally (SPRING) Project, the Food and Nutrition Technical Assistance III (FANTA III) Project, the AIDS Support Organisation (TASO), and the Strengthening the Tuberculosis and HIV/AIDS Response South West (STAR SW) projects for participating in the meeting to harvest these changes.

The authors thank Angella Kigonya, Juliana Nabwire, Martin Muhire and Harriet Komujuni of University Research Co., LLC (URC) for their support in facilitating the harvest meeting process through which these changes were compiled. The authors also thank Angella Kigonya and Lani Marquez of URC for their guidance and support in editing this document. The USAID ASSIST Project in Uganda would like to acknowledge the 22 health facilities, six district quality improvement teams and regional coaches who participated in the harvest meeting where the changes were discussed, evaluated and compiled. We thank the implementing partners—TASO, SPRING and FANTA III —for jointly providing technical assistance and logistical support to the health facilities. We also thank the Ministry of Health of Uganda for the coordination and overall guidance on and participation in implementing Option B+ and Nutrition Assessment Counselling and Support (NACS) services.

The USAID ASSIST Project is made possible by the generous support of the American people through USAID's Bureau for Global Health, Office of Health Systems. Support for the Partnership for HIV-Free Survival and the preparation of this report was provided by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR).

The USAID ASSIST Project is managed by URC under the terms of Cooperative Agreement Number AID-OAA-A-12-00101. URC's global partners for USAID ASSIST include: EnCompass LLC; FHI 360; Harvard University School of Public Health; HEALTHQUAL International; Institute for Healthcare Improvement; Initiatives Inc.; Johns Hopkins University Center for Communication Programs; and Women Influencing Health Education and Rule of Law (WI-HER), LLC.

For more information on the work of the USAID ASSIST Project, please visit www.usaidassist.org or write assist-info@urc-chs.com.

Recommended citation

Nsubuga-Nyombi T, Karamagi-Nkolo E, Draru J, Megere H, Stern A. 2014. Improving Retention of Mother-Baby Pairs: Tested Changes and Guidance from Uganda. Published by the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project. Bethesda, MD: University Research Co., LLC (URC).

TABLE OF CONTENTS

Acronyms ii
I. Introduction 1
Why focus on retention of mother-baby pairs in care? 1
What results did these teams achieve? 3
II. Harvest Meeting 3
III. Change Package for Retention of Mother-Baby Pairs in Care 4
Intended Use 4

Acronyms

ART	Antiretroviral therapy
ASSIST	USAID Applying Science to Strengthen and Improve Systems Project
CDC	U.S. Centers for Disease Control and Prevention
DBS	Dried blood spot
EID	Exposed infants' diagnosis
FANTA	Food and Nutrition Technical Assistance Project
FSG	Family Support Group
HC	Health center
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHFS	Partnership for HIV-Free Survival
SPRING	Strengthening Partnerships, Results and Innovations in Nutrition Globally (SPRING) Project
TASO	The AIDS Support Organisation
URC	University Research Co., LLC
USAID	United States Agency for International Department
USG	United States Government
VHT	Village health team

I. Introduction

Since April 2013, the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, together with other USAID and U.S. Centers for Disease Control and Prevention (CDC) partners—Food and Nutrition Technical Assistance (FANTA), Strengthening Partnerships, Results and Innovations in Nutrition Globally (SPRING), and the AIDS Support Organisation (TASO)--have been supporting the Ministry of Health to implement the Partnership for HIV- Free Survival (PHFS) Initiative in 22 health facilities in six districts. The PHFS initiative supports the goal of 'elimination of new HIV infections among children by 2015 and keeping their mothers alive' through scaling up an effective campaign to protect exposed infants from HIV infection and provide optimal nutrition for these infants. The PHFS work in Uganda is part of a partnership across six countries in East and Southern Africa including Lesotho, South Africa, Mozambique, Kenya, and Tanzania coordinated by the Institute for Healthcare Improvement (IHI) with support from the World Health Organization (WHO), CDC and USAID. The initiative was launched in March 2013.

The PHFS initiative was rolled out in these 22 health facilities using the quality improvement approach. Quality improvement (QI) teams were either formed or reconstituted. These QI teams have been supported through monthly coaching visits to identify gaps in care, prioritize areas for improvement, develop and test change ideas to address the gaps and implement these changes. To further facilitate the sharing and spreading of change ideas, peer-to- peer learning sessions were organized quarterly so that teams could come together and share their work. To start improvement work, teams initially focused on two key areas; data quality and the retention of mothers and their babies in care. These were the areas with the biggest gaps as initial visits to the sites showed that less than 2% of exposed infants' clinical charts were completely and accurately filled out. The primary data source, the exposed infants' diagnosis (EID) register was also not completely filled out and coaches and teams were unable to determine whether infants were still in care and receiving services. Furthermore, on examining the exposed infant diagnosis (EID) register and infant clinical charts it was discovered that less than 3% of exposed infants had been retained in care the previous months. Information on improvements on the completeness and accuracy of data are in another document.[1]

The Partnership for HIV-Free Survival:

To achieve the goals of the "Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive," the Ministry of Health, PEPFAR, and other partners in Uganda are supporting national efforts to develop and scale up interventions to provide optimal nutrition for infants and their mothers and to protect infants from HIV infection.

The Partnership for HIV Free Survival (PHFS) Initiative is being implemented in 22 health facilities in 6 districts in Uganda, supported by ASSIST, FANTA, TASO and SPRING.

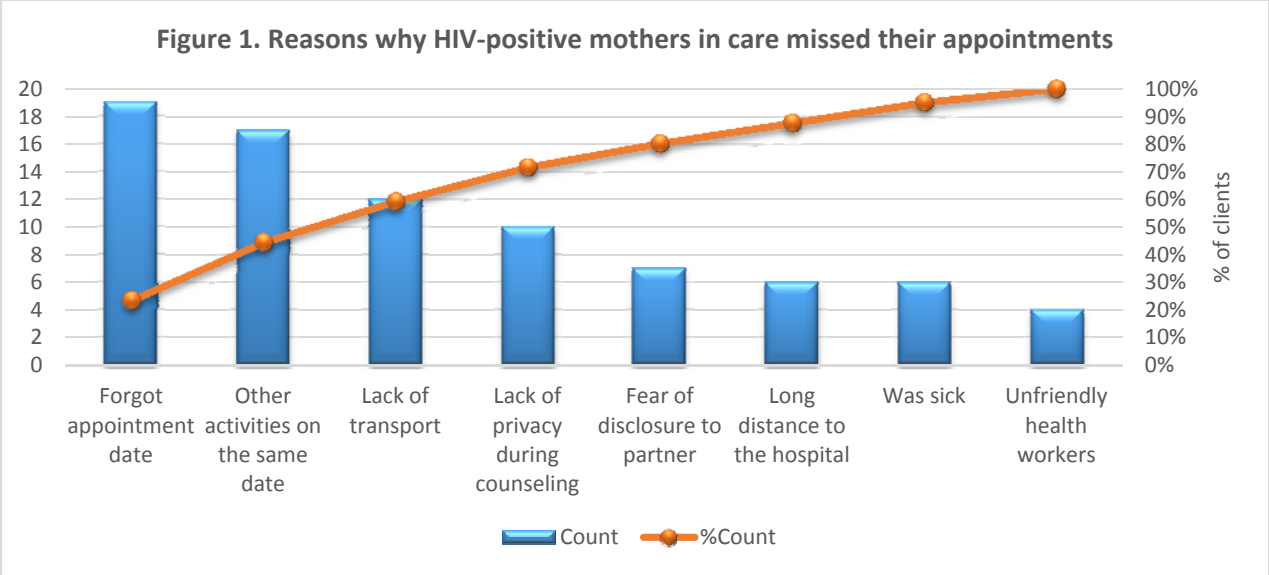
Why focus on retention of mother-baby pairs in care?

To achieve HIV-free infant survival, exposed infants and their mothers must be retained in care and access the services which contribute directly to survival such as ARVs for the mothers, and infant and

[1] Nsubuga-Nyombi T, Karamagi-Nkolo E, Draru J, Megere H, Stern A. 2014. Improving Completeness and Accuracy of Data (Data Quality): Tested Changes and Guidance from Uganda. Published by the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project. Bethesda, MD: University Research Co., LLC (URC).

young child feeding counseling. Findings at baseline in April 2013 showed that there was a gap in retention of mothers and their babies. Babies and mothers were being seen separately by different people and their care was not linked. Also, a large percentage of exposed infants who had been enrolled in EID care were lost from care and had not been seen at the facility for more than 2 months. After looking at their records and clinical charts, all the 22 health facilities decided to prioritize improving retention of mothers and their babies in care.

Efforts to improve retention started with ensuring mother-baby pairs who miss some appointments of the mother or the baby, but are still accessing other services at the facility are supported to attend mother-baby pair appointments. Subsequently, changes to bring back mother-baby pairs who have stopped attending the facility for any service were tested. To better understand the reasons why mothers and their babies were not retained in care monthly, site improvement teams asked HIV positive mothers who had missed at least one appointment why they had missed and what could be done to support them in care. The study population was HIV positive women with children ages 6 weeks to 24 months who were attending ART clinics in the selected health facilities. The age of six weeks was chosen because this is the time when the mother is expected to take the infant back to the health facility for the first dried blood spot (DBS) for HIV test. The responses from both questions are summarized in the Pareto chart in Figure 1 below. The Pareto chart showed that 80% of the problems with retention were caused by forgotten appointment dates, other activities on the date of appointment, lack of transport to the facility and lack of privacy during counselling.



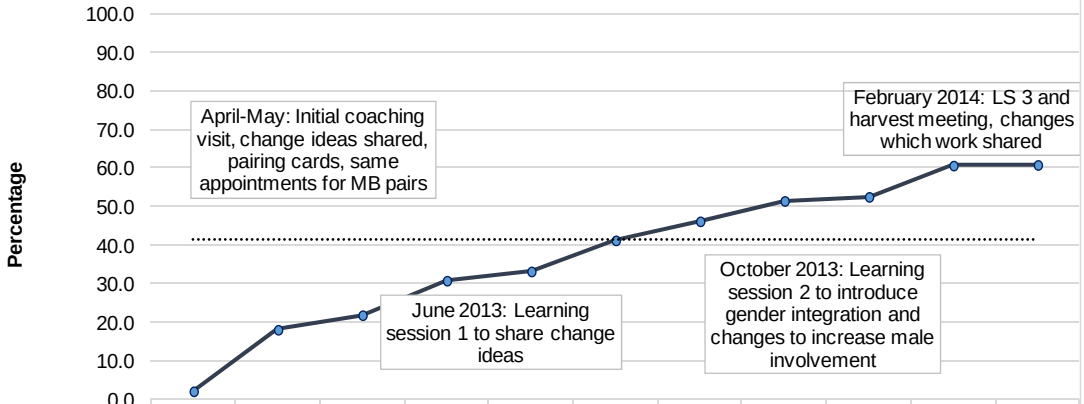
The mothers also gave suggestions on how retention could be improved. Over 77% (30 out of 41) of the mothers interviewed felt retention could be improved through continuous counselling of mothers, 54% (22 out of 41) suggested the use of reminders, 32% (13 out of 41) wanted health workers to reduce the time spent waiting at the facility and 29.3% (12 out of 41) wanted males to be involved in care. The information provided by the mothers was used to inform the types of changes and interventions which the health workers tested and implemented to improve retention of mother-baby pairs at their facilities.

To reduce loss to follow-up of mothers and their babies, health workers worked with community representatives like peer mothers and linkages facilitators to trace mothers and their babies who were lost. These community representatives tested various changes to find lost mothers and babies and bring them back to care.

What results did these teams achieve?

By February 2014, the 22 sites had all achieved strong gains in retaining mother-baby pairs in care, from 2.2% of pairs retained in care to over 60%, as seen in Figure 2 below.

Figure 2. Percentage of mother-baby (MB) pairs retained in care each month, April 2013-February 2014, 22 PHFS sites, Uganda



	Baseline	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb
		2013								2014	
% MB pairs retained in care	2.2	18.1	21.9	30.8	33.2	41.3	46.2	51.5	52.6	60.7	60.8
# of reporting sites	22	22	22	22	22	22	22	22	22	22	22
Med	41.3	41.3	41.3	41.3	41.3	41.3	41.3	41.3	41.3	41.3	41.3

The sites that participated in the demonstration phase of PHFS and that contributed to this change package are listed below.

District	Sites	Supporting implementing partner
Ntungamo district	Itojo General Hospital, Kitwe HCIV, Rubaare HCIV, Ruhaama HCIII	SPRING, STAR-SW
Kisoro district	Kisoro General Hospital, Busanza HCIV, Rubuguri HCIV, Muramba HCII	SPRING, STAR-SW
Manafwa district	Magale HCIV, Bugobero HCIV, Bubutu HCIII, Bubulo HCIV	TASO
Tororo district	Tororo General Hospital, Nagongera HCIV, Mukujju HCIV, Malaba HCIII	TASO
Jinja district	Mpumudde HCIV, Bugembe HCIV, Buwenge HCIV	TASO
Namutumba district	Namutumba HCIII, Ivukula HCIII, Magada HCIII	SPRING, STAR-EC

II. Harvest Meeting

After approximately 10 months of work, representatives from the 22 teams gathered at a harvest meeting in February 2014 to reflect on their results, discuss both the successful and unsuccessful changes and

related evidence which had led to the results, and develop their “best advice” based on their experience that could guide other facility teams to improve retention of mother-baby pairs.

In small groups, teams discussed the changes which they had tested, whether these changes had been successful or not and related these changes to the results they had for each of the focus areas. These changes were discussed further in plenary to exhaust the list generated. The groups then evaluated these changes and scored them on the basis of evidence from pilot tests, relative importance, and level of simplicity and how scalable these changes were.

The teams participating in the mini-harvest meeting also reflected on their high-level advice to other teams who wanted to improve retention of mother-baby pairs in care. They recommended:

1) First, whenever an improvement team sets out to improve retention or follow-up, start with finding out the reasons why their clients are not coming back and then try to address these specific reasons rather than making assumptions as to why clients are not returning for care.
2) Start by addressing the gaps in retention within the facility, e.g. finding mothers and their babies who might be coming for immunization but not HIV care and linking them to care, and re-organizing clinics to be more efficient. These gaps are easiest to address and can help to achieve results more quickly.
3) HIV-positive mothers and their babies need to be linked or paired. One of the easiest ways of doing this is to simply keep the mothers’ and baby’s’ clinical charts together at all times.

III. Change Package for Retention of Mother-Baby Pairs in Care

Intended Use

This change package is intended to provide other quality improvement teams that will be starting on improvement work in PHFS a general idea of areas that have to be considered when improving retention of mother-baby pairs in care and a few changes that were successful in those areas. Teams may not necessarily replicate these change ideas, rather, they should adapt them to suit their clinics.

Table 1 summarizes how the participants in the harvest meeting evaluated the changes and list the key changes implemented in order of ranking, beginning with the highest rated change.

All the parameters (evidence from pilot tests, relative importance, simplicity and scalability were scored 1-5 by the participants. A score of 1 for any of the parameters meant that there was insufficient evidence from the pilot, the change was not important, it was too complex, or was not scalable. A score of 5 meant that there was strong evidence from the pilot test or that the change was very important, simple and scalable. The average score from all the groups is represented in Table 1. Table 2 provides a comprehensive list of all the change ideas tested, with notes on the number of sites that implemented the change, the results, and specific steps to implement the change.

Teams interested in improving retention in care might start off by reviewing the prioritized list of changes to implement in Table 1. Teams should refer to Table 2 to identify change ideas that respond to specific barriers to retention that they have identified and then use the suggestions for implementing the change in the last column. Table 2 provides details on how each of the changes in Table 1 were implemented.

As a final word, we recommend that facilities aiming to improve retention of mother-baby care in PMTCT should test changes in each of the following areas

1. Changes to follow up mother-baby pairs in the community
2. Changes that improve the efficiency of the mother-baby pair clinic
3. Changes that improve and maintain the quality improvement and technical competence of the staff

Table 1. Rank-ordered changes to improve retention of mother-baby pairs in care

Change to improve retention of mother-baby pairs in care	Evidence from pilot tests	Relative importance	Simplicity (not difficult or complex)	Scalability	Total rating
Mother and baby seen together in the clinic on the same appointment date	5	5	4.8	4.8	19.6
Priority given to MB pairs	4.2	4.6	4.6	4.6	18
Write appointment date on medicine bottle	3.4	4.8	4.6	4.6	17.4
Give mother and baby just enough drugs that will last to the next appointment	3.6	4.6	4.6	4.4	17.2
Pair mothers' and babies' cards together and clinicians/ dispensers remind them of appointments	4	4.5	4.3	4.3	17.1
New clients seen where they are tested	4.25	4.25	3.5	5	17
Provide a special clinic day for mothers and children to be seen	3.4	4.6	4	4	15.6
Give mother and baby the same appointment date only	3.8	5	3.2	3.4	15.4
Expert patients follow up lost mothers and mothers who miss their appointments	4	5	3	3.2	15.2
Asking mothers to come with their babies before services are provided	3.4	3.4	3.6	3.6	14
Use of mentor mothers to trace, counsel and return mother baby pairs to care	3	4.2	3	2.4	12.6
Phone calls	2.8	4.8	2.3	2	11.9
Involving service providers in regular meetings	3	3	2.5	3	11.5
Male involvement in Family Support Groups (FSG)	2.8	4.8	1.6	1.8	11

We recommend these because all facilities that tried out changes in these categories observed significant improvement in retention of mother-baby pairs. Conversely, where these changes were not implemented, improvement in retention was not seen.

Improvement work on retention should be preceded by review and improvements in data quality. It's otherwise not possible to accurately know the mother-baby pairs who should be in care and who receive the PMTCT services each month.

Table 2. Detailed change package for improving retention of mother-baby pairs at 22 demonstration facilities in Uganda

Change concept	Specific problem being addressed	Change tested and number of sites which tested/ implemented the change	Change successful? Yes/No? Evidence of successful change	How exactly was change tested/ implemented (where, who, how, when, resources required, etc.)?
Follow-up	Mothers forget their appointment dates and miss appointments	Phone calls to mothers who miss appointments or are lost in care **Number of sites implementing this change: 11**	10 of the 11 sites saw improvement after rolling out this change from Aug to Sept '13: Nagongera: 22% to 70% Bubutu: 18% to 82%, Kisoro: 82 % to 84%	• Contact implementing partner or hospital administration and request for a phone that is dedicated to calling up clients who are lost to follow up • Make sure that mother's telephone number is correctly recorded on ART or EID clinical charts • Each clinic day, draw up a list of clients expected to come, if they miss their appointment, then call them up to remind them
		Call mother and do a follow up visit at home **Number of sites implementing this change: 8**	All 8 sites saw improvement after rolling out this change. Namutumba, Magada, Malaba, Nagongera, Bugembe, Kisoro, Mukujju, Bubutu	• Identify mothers who have not kept appointment • Ask the implementing partner to provide phones and / or air time to call mothers who missed • Compile clients contact and map residences in their charts • Obtain client consent to home visits and place in the chart • Use expert patients and VHTs to track the patients • The implementing partner met the expert clients' transportation costs • Assign VHT and expert patients responsibility for specific wards/villages
		Use Expert Patients or mentor mothers to educate and counsel mothers on appointment keeping **Number of sites implementing this change: 10**	All 10 sites that implemented this change showed improvement. Magada HCIII: 67% Aug '13 to 76% Oct '13 Muramba HCIII: 66% to 80% Mukujju HCIV: 21.3% Oct	• Orient expert patients on keeping appointments and how to communicate to mothers • Conduct community dialogues to understand the clients challenges

Change concept	Specific problem being addressed	Change tested and number of sites which tested/ implemented the change	Change successful? Yes/No? Evidence of successful change	How exactly was change tested/ implemented (where, who, how, when, resources required, etc.)?
			'13 to 60% Nov '13 Rubuguri HCIV: 57% June '13 to 92% Oct '13 Rubuguri: 57.7% June '13 to 86.2% Dec '13 Bubutu Magada: 67% Aug '13 to 78% Jan '14	
		Write the appointment date on the mother's medicine bottle so that she can remember Number of sites implementing this change: 1	Ruhaama HCIII rolled out this change and registered improvement in retention	• Appointment date for the next visit is written on mother's medicine bottle so that she can remember when the next appointment is
Follow-up, cont.	**Mothers do not bring their babies to the facility and so they cannot be assessed**	**Inform mothers of their appointment dates before they leave the clinic Number of sites implementing this change: 22**	All 22 health facilities which implemented this change reported improvement, e.g., Kitwe HCIV 28% to 64%	• The service provider reminds the client about their next appointment and shows where it is written on the patient held card
	Mothers are afraid of being stigmatized and so do not return to the clinic	Use mentor mothers or peers to counsel and support these mothers **Number of sites implementing this change: 8**	This change was associated with improvement in all the sites which rolled it out, e.g. Mukujju: 21% in Oct'13 to 60% in Dec' 13	• Form family support groups • Use the support group to get feedback on clients challenges to attending clinic • Train mentor mothers to facilitate the support group • Counsel and home visits to address any challenges • Provide health education in the clinic and ask the mother to make a choice of where she wishes to seek care for herself and her baby
	Little family support for the mothers to return to the	Priority is given to those who come as a family to get services	All 11 sites which rolled out this change reported improvement in retention Nagongera, Mukujju,	• Organize the clinic so that all services to be provided to the family are available • Inform mothers about the new change, speak to the men about the possibility of getting

Change concept	Specific problem being addressed	Change tested and number of sites which tested/ implemented the change	Change successful? Yes/No? Evidence of successful change	How exactly was change tested/ implemented (where, who, how, when, resources required, etc.)?
	clinic due to lack of partner support	**Number of sites implementing this change: 11**	Bugembe, Busanza, Buwenge, Rubuguri, Tororo, Malaba, Kisoro, Mpumudde, Kitwe	treatment and care as a family • When mothers, babies and their fathers come to the clinic, provide them with services within the shortest time possible • Make use of the existing family support groups to encourage families to seek care
	Lack of male involvement in care and support of their partners and children	Use male expert clients to involve other known men in care to attend as a family unit **Number of sites implementing this change: 7**	All the 7 sites which implemented this change saw improvement in their retention, e.g.,: Magada 67% in Oct. '13 to 87% in Nov. '13 Ivukula 68.5% in Oct '13 to 85.3% in Nov. '13	• Discuss male involvement with male expert clients and ask them to identify known men in care • Expert clients talk to men known to be in care about the benefits of attending clinics as a family
Improving efficiency	Mothers and babies were given different appointment dates for different services in the clinics	Give the same appointment date for mother and her baby **Number of sites implementing this change: 22**	All the 22 sites that rolled out this change saw increase in retention, e.g.: Ivukula HCIII: 57% in April '13 to 80% in Aug '13 Bugobero HCIV: 13.7% in July '13 to 44.6% in Nov '13 Kitwe: 20% in May '13 to 27% in July '13 Kisoro 2% in May '13 to 81% in July '13	• Trace the mothers' and babies' cards and pair them together • Give both mothers and their babies the same appointment date to return to the facility for care • Communicate the change to all mothers and health care providers so that they are aware and prepared to receive both mothers and babies • Organize the clinic so that both mothers and babies files, drugs and any items required for care are in the same place, integrate services. • Choose a market date that is more convenient so that transport costs are lower especially in rural areas
	Files retrieval of clients difficult resulting in long waiting times; also mother and baby's	Keep baby and mother cards together to improve retrieval for both mother and child **Number of sites testing/implementing this change: 22**	All 22 health facilities registered improvement when they implemented this change, e.g.: Bugembe HCIV: 10% in Apr '13 to 36 % Aug '13 Nagongera HCIV: 22% in	• Look at the baby's card to find the mother's ART number- this means that all exposed babies' charts should be filled out correctly with the mother's ART number • Retrieve the mother's care card • Mothers who are already in the ART clinic had

Change concept	Specific problem being addressed	Change tested and number of sites which tested/ implemented the change	Change successful? Yes/No? Evidence of successful change	How exactly was change tested/ implemented (where, who, how, when, resources required, etc.)?
	records not linked so that health provider can provide services to the pair		Apr '13 to 39% Aug '13 Muramba HCIII: 41% in Apr '13 to 70% in Aug '13	their files moved from the clinic to the MCH clinic • Stick/file/ staple child's card to the mother's card or file • File these in a separate cabinet • The cabinet kept in the EID room for those with a separate clinic • Give mother and baby same clinic code
		Color coding the files **Number of sites testing/implementing this change: 1**	No improvement d in the one site that tried this change	Failed due to lack of sustained supplies of files • Files delivered late
	Long waiting hours due to lack of effective triaging system	New clients attended to where they have been tested **Number of sites testing/implementing this change: 2**	Both sites that tested this change reported improvement in retention: Bugembe: 52% in Oct '13 to 69% in Jan '14 Kisoro: 73% in Oct '13 to 97% in Jan '14	• Files were put in the test area to enroll new clients immediately
		Create special day for EID **Number of sites testing/implementing this change: 3**	All the sites which rolled out this change registered improvement, e.g.: Nagongera: 22% to 97%	• Explained to the mothers need for a special clinic • Organized a special day without other active clinic • Offer immunization on the selected day • Select a day (market day) when transport is cheaper
		Priority given to mother and baby pairs to get service **Number of sites implementing this change: 4**	Bubutu 18% in June '13 to 82% in Dec. '13 Rubuguri 57% in June '13 to 86.2% in Dec '13 Mpumudde HCIV: 21% in June '13 to 56% in Sept '13	• Explain to the clients on the need to see the mothers and babies • When mothers and their babies come to the facility, or as a family (including father of the baby), the health workers provide services to them first so that they do not wait long

Change concept	Specific problem being addressed	Change tested and number of sites which tested/ implemented the change	Change successful? Yes/No? Evidence of successful change	How exactly was change tested/ implemented (where, who, how, when, resources required, etc.)?
Technical competence	Poor attitudes of health workers and lack of knowledge of guidelines	Involve the service providers in regular meetings **Number of sites implementing this change: 2**	2 of the sites that implemented this change registered improvement when they rolled out this change e.g., Rubuguri HCIV: 57.5% to 92.9% by October 2013	• Set up a QI team meeting to identify challenges, solutions, • Assign individuals roles and duties e.g. filling charts, register completion, • Team leader supports team members to do their assigned work by cross checking on them • Conduct continuing medical education on selected areas such as Option B+ and infant and young child feeding, nutritional counseling • Motivation of staff using incentives (Coaching and rotational attendance of Learning session) • Orientation of new staff of expected roles • Exchange visits to learn best practices from sites
		Give mother just enough drugs for the period of time they are expected back. **Number of sites implementing this change: 7**	All the 7 sites which implemented this change had improvement: Malaba, Kisoro, Rubaare, Kitwe, Nagongera, Busanza, Tororo	• Review the clients records and give right amount of drugs to ensure clients do not keep lot of balance • The clinician cross check the clients medicines to count the pill balance • Write pill balance in the patients charts • Use pill balance to decide amount of drugs to give to the clients • Some examples are : if the mother delivers, then give just six pills to take them up to the baby's 7 day checkup when they have to come back for review and get a refill

USAID APPLYING SCIENCE TO STRENGTHEN AND IMPROVE SYSTEMS PROJECT

University Research Co., LLC
7200 Wisconsin Avenue, Suite 600
Bethesda, MD 20814

Tel: (301) 654-8338
Fax: (301) 941-8427
www.usaidassist.org