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USAID
ASSIST PROJECT
*Applying Science to Strengthen
and Improve Systems*

USAID ASSIST Project

Uganda Country Report FY14

Cooperative Agreement Number:

AID-OAA-A-12-00101

Performance Period:

October 1, 2013 – September 30, 2014

DECEMBER 2014

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DISCLAIMER

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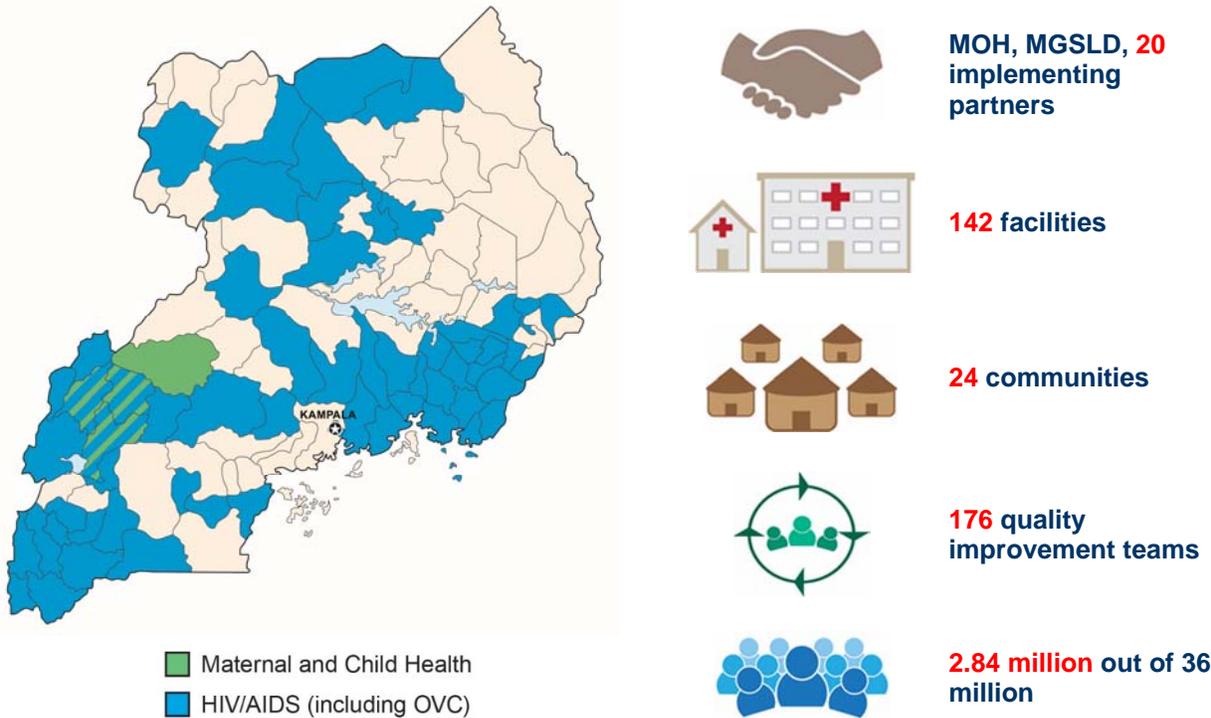
Abbreviations

AIDS	Acquired immunodeficiency syndrome
AMTSL	Active management of the third stage of labor
ART	Antiretroviral therapy
ASSIST	USAID Applying Science to Strengthen and Improve Systems Project
COR	Continuum of response
CSO	Civil society organizations
EID	Early infant diagnosis
EMTCT	Elimination of mother-to-child transmission of HIV
ENC	Essential newborn care
EQA	External quality assessment
FP	Family planning
FY	Fiscal year
HC	Health center
HCT	HIV counselling and testing
HIV	Human immunodeficiency virus
IP	Implementing partner
IYCF	Infant and young child feeding
KCCA	Kampala Capital City Authority
MGLSD	Ministry of Gender, Labor and Social Development
MNCH	Maternal, newborn, and child health
MOH	Ministry of Health
MUWR	Makerere University Walter Reed Project
NACS	Nutrition assessment, counselling, and support
NSPPI	National Strategic Program Plan for OVC
NTF	National Task Force
NTLP	National Tuberculosis Leprosy Program
NU-HITES	The Northern Uganda Health Integration for Enhanced Services Project
OVC	Orphans and vulnerable children
PEPFAR	U.S. President’s Emergency Plan for AIDS Relief
PHFS	Partnership for HIV-Free Survival
PLHIV	Persons living with HIV
PMTCT	Prevention of mother-to-child transmission of HIV
PNC	Postnatal care
QI	Quality improvement
SCORE	Sustainable, Comprehensive Responses for Vulnerable Children and their Families
SMaCKM	Safe male circumcision knowledge management study
SMC	Safe male circumcision
SMGL	Saving Mothers Giving Life
SPRING	Strengthening Results and Innovations in Nutrition Globally
STAR	Strengthening HIV AIDS and Tuberculosis Responses
TASO	The AIDS Support Organization
TB	Tuberculosis
TOT	Training of trainers
TWG	Technical working group
UPHS	Uganda Private Health Support Program
URC	University Research Co., LLC
USAID	United States Agency for International Development
USG	United States Government
VSLA	Village savings and loan association

1 Introduction

The USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project started work in Uganda in October 2012, following on many years of technical support from the USAID Health Care Improvement and Quality Assurance projects. With funding from the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), USAID ASSIST provides support to the Ministry of Health (MOH), districts, US Government (USG) implementing partners, and health facilities to improve the quality of services provided through the HIV continuum of response, improve the quality of safe male circumcision services, improve TB case detection and treatment and TB-HIV care, and implement the Partnership for HIV-Free Survival (PHFS). ASSIST also supports the MOH to apply improvement methods to deliver quality maternal and newborn health services and to integrate family planning services in primary care and referral facilities. The overall aim is to learn and apply the lessons learned from the demonstration facilities to other sites. In Uganda, ASSIST is also working with the Ministry of Gender, Labor, and Social Development (MGLSD), partners involved in the care and support of orphans and vulnerable children (OVC), civil society organizations (CSOs), districts, sub-districts, and villages to apply quality standards to improve services for vulnerable children.

Scale of USAID ASSIST’s Work in Uganda



2 Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
1. Improve HIV care (Continuum of Response)	<ul style="list-style-type: none"> Build capacity of MOH facilities and USG partners to improve quality of HIV and AIDS services along the continuum of response 	Work with 10 USG implementing partners (IPs) in 49 facilities in 41 districts in the South western, Eastern, East central, Central and Northern regions of Uganda. Public, private not-	x	

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
	<ul style="list-style-type: none"> Build capacity of USG partners to improve quality of HIV services at the community level Test the effectiveness and efficiency of applying the Chronic Care Model to improve the continuum of response 	<p>for-profit and private facilities will be engaged in this work at the level of health centers III to general hospitals</p> <p>Work with 2 USG partners who requested ASSIST support at the community level in three districts (Mitooma, Kamuli, and Bugiri); 24 villages will be covered in total</p> <p>3 intervention sites in Mityana District and 3 control (late intervention) sites in Nakaseke District</p>		
2. Safe Male Circumcision (SMC)	<ul style="list-style-type: none"> Improve the quality and safety of SMC services through building the capacity of USG implementing partners to identify and address gaps within the SMC program Support MOH to have and to roll out standard SMC tools that support efforts to improve the quality of SMC services Once the process of developing a standard SMC training manual commences, ensure quality improvement (QI) is integrated into this manual and SMC trainings thereafter Generate new knowledge related to SMC 	30 "intense support" sites in 26 districts directly supported by USAID ASSIST and selected extra IP sites; in FY14 quarter 4, 19 more "intense support" sites were added	x	
3. Partnership for HIV-Free Survival	<ul style="list-style-type: none"> Achieve HIV-free survival for infants Learn how best to improve the quality of pre and postnatal elimination of mother-to-child transmission (EMTCT) care, including nutrition interventions Build capacity of implementing partners to use the QI approach to integrate and improve the quality of EMTCT and nutrition work 	<p>22 health facilities in 6 districts in 2 regions</p> <p>22 health facilities in 6 districts in 2 regions</p> <p>4 implementing partners [AIDS Support Organization (TASO); Strengthening HIV AIDS and Tuberculosis Responses (STAR EC, STAR SW), Strengthening Partnerships Results and Innovations in Nutrition Globally (SPRING) in 22 demonstration sites</p>	x	
4. Improve TB care	<ul style="list-style-type: none"> Build capacity of the implementing partners in rolling out provision of quality TB services with special focus on Track TB Project Build capacity of Districts and MOH National Tuberculosis Leprosy Program (NTLP) in rolling out provision of quality TB care using the CQI Generate new knowledge related to TB 	7 facilities supported by Track TB Project in Kampala	x	
5. Improve maternal, newborn, and	<ul style="list-style-type: none"> Build capacity of USG partners through joint onsite coach visits and quarterly peer to peer learning meetings to continuously learn how to improve the 	20 high-volume facilities of 4 SMGL districts, plus light support to 10 spread sites in 6 new (SMGL phase II) districts	x	

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Activity
child health	<p>quality of MNCH services in the Saving Mothers Giving Life (SMGL) districts of Uganda in FY14</p> <ul style="list-style-type: none"> • Coordination of the QI cluster of the SMGL partnership through monthly QI cluster meetings, bi monthly inter cluster meetings, and development of the working document for the QI cluster. • Build capacity of MOH through engaging the district health teams in joint onsite coach visits and quarterly learning meetings to enable them learn how to improve the quality of MNCH services in the 4 SMGL districts of Uganda. • Generate new knowledge and best practices in improving the quality of MNCH services as part of the continuous learning and adapting agenda • Build capacity of MOH to provide quality newborn health services • Provide technical support to MOH to plan and integrate newborn health care in national plans and strategies • Provide technical support to MOH to ensure that functional newborn health data systems are set up • Build the capacity of partners to support districts to scale-up provision of quality newborn health care services 	<p>National level (MOH) 24 health experts (TOTs) 7 health regions 10 partners supporting newborn health</p> <p>Continuous mapping to track adoption and scaling-up of interventions by partners</p>		
6. Integrate family planning (FP) into maternal, newborn, and child health	<ul style="list-style-type: none"> • Build capacity of Marie Stopes Uganda to improve the quality of family planning services by involving them in monthly site coaching sessions, quarterly peer-to-peer QI learning sessions, QI performance reviews, and the QI cluster co-ordination meetings. • Generate new knowledge on integrating FP into MNCH. This will be done through learning sessions and during site coaching 	<p>6 facilities supported by Marie Stopes Uganda in the 4 SMGL districts of western Uganda</p> <p>18 sites of the 4 SMGL districts</p>	x	
7. Improve quality of OVC services	<ul style="list-style-type: none"> • Provide technical support to MGLSD and partners to employ proven modern QI approaches to ensure continuous improvement in quality of services received by every OVC in Uganda • Build the capacity of MGLSD to provide a coordinated approach to improving the quality of services for OVC • Generate knowledge on how to improve compliance to OVC standards for improved quality of OVC services 	<p>11 sub counties in 4 districts 10 CSOs, 10 sub county OVC coordination committee 24 villages</p> <p>National levels (Ministry to provide information on expected partners)</p> <p>10 CSOs, 4 districts, 11 sub-counties</p>	x	

3 Key Activities, Accomplishments, and Results

Activity 1 (a). Improve HIV care (Continuum of Response)

BACKGROUND

Uganda has an HIV prevalence rate of 7.4%, and approximately 1.6 million people living with HIV (UNAIDS, 2013). The HIV continuum of response (COR) supports all levels of the health system to take steps to ensure that the people who are HIV-negative remain negative, and those who are positive are identified and enrolled into care early, are retained in care, and adhere to their anti-retroviral therapy (ART) to remain well enough to perform normal daily functions.

To improve the HIV continuum of response, USAID ASSIST:

- Builds the capacity of USG implementing partners to continuously improve the quality of services at the communities, sites and districts that they support. USAID ASSIST managed a collaborative of selected USG partner supported health facilities spread across the country. Each partner selected some sites to participate in this collaborative effort. In the facilities, ASSIST worked with the IP staff to improve the continuum of response to HIV. At the community level, ASSIST supported community improvement team to address aims related to improving patient retention and adherence to ART. Community improvement teams were formed at the village level in accordance with the community health systems model, which brings together existing community structures (e.g., linkage facilitators including Village Health Teams, Community Support Agents, persons living with HIV/AIDS, treatment supporters, local and religious leaders, and community-based HIV groups and other existing committees) to support health objectives.
- Builds the capacity of the MOH to coordinate and oversee implementation of national QI plans and strategies. ASSIST is supporting the implementation of the national QI and strategic plan framework in Renzori Region as a way of contributing to the institutionalization of QI in the Ugandan health sector. The work is looking in particular at the pivotal role that leaders play in mobilizing and maximizing resources to ensure patients receive good quality health care.
- Generate new knowledge and best practices in quality improvement as part of the continuous learning and adapting agenda. An important area of learning for ASSIST is how to apply the Chronic Care Model to HIV care delivery in Uganda. The intervention activity begun in Mityana District in 2013 was extended in 2014 to the former control district of Nakaseke.

ACCOMPLISHMENTS

- **Conducted learning sessions.** The first learning session was held for all 49 facilities in the first quarter. During the second quarter, ASSIST conducted an additional learning session for 13 selected facilities implementing COR activities.
- **Conducted coaching sessions.** Supported facility QI teams to develop action plans, implement them, and get a common understanding on the prevention care for the clients who test negative in the facilities. Specific activities included:
 - Supported Northern Uganda Health Integration for Enhanced Services staff and facility teams at 10 facilities whose goal was to provide high quality HIV care services by focusing on the HIV COR cascade processes, identifying any gaps, and addressing them through developing and implementing appropriate action plans/items (March 2014).
 - Worked with two private facilities supported by Uganda Private Health Services Project in the usage of the recommended MOH client appointment book (January 2014).
 - Supported selected sites to test changes to improve identification of HIV-positive children by improving HIV testing among children of HIV-positive clients in outpatient departments, pediatric wards, and HIV clinics, to understand retention of the mother/baby pair in Early Infant Diagnosis (EID) program (February 2014).
- **Held three stakeholders' meetings** (Quarter 3). Held stakeholders' meetings with IPs, district health teams, and facility leaders. The meetings were aimed at engaging stakeholders to share experiences and challenges in implementing the HIV COR and to plan for improvement work in the COR sites.
- **Harvest meeting** (September 2014). Conducted a harvest meeting to document the changes which sites have implemented to improve the coverage indicators in the COR. These changes will be organized into a change package and shared with partners for spread.

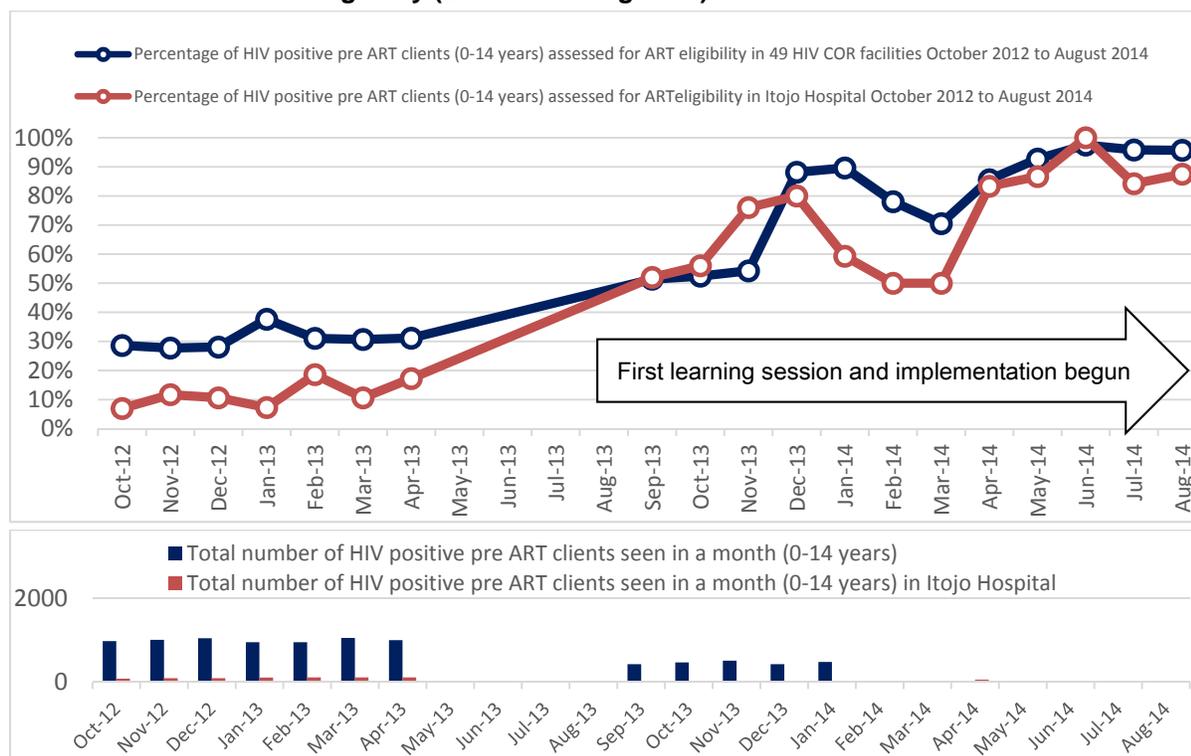
RESULTS

Improvement in Key Indicators

Activity	Indicator	Baseline	Last value	Magnitude of Improvement (percentage points)
Improve HIV Care (COR)	% newly tested HIV-positive linked and enrolled into HIV care, during review period	70% (May 2013) 38 sites	76% (Aug 2014) 45 sites	6
	% HIV-positive pre-ART clients started on ART in a month (15+yrs)	79% (May 2013) 41 sites	75% (Aug 2014) 45 sites	-4
	% HIV-positive pre-ART clients started on ART in a month (0-14yrs)	80% (May 2013) 40 sites	88% (Aug 2014) 45 sites	8
	% HIV-positive babies (0-2yrs) enrolled in care that have been started on ART	78% (May 2013) 41 sites	88% (Aug 2014) 45 sites	10
	% HIV-positive children on ART that have been retained in care (0-14yrs)	84% (May 2013) 24 sites	85% (Aug 2014) 45 sites	1
	% TB/HIV co-infected clients that are on ART	63% (May 2013) 45 sites	86% (Aug 2014) 45 sites	23
	% TB/HIV co-infected clients completing TB treatment	41% (May 2013) 42 sites	64% (Aug 2014) 45 sites	23
	% HIV-positive pregnant mothers keeping clinic appointments	88% (May 2013) 34 sites	83% (Aug 2014) 45 sites	-5
	% HIV-positive lactating mothers keeping clinic appointments	85% (May 2013) 25 sites	89% (Aug 2014) 45 sites	4

- Increased proportion of clients tested for HIV for the 1st and 2nd time in the past 12 months.**
 The proportion of clients tested for HIV increased from 44% in one site in November 2013 to 84% in 48 sites in July 2014. Some changes which sites tested to improve this area included: Increasing testing points; assigning a focal person to review and update registers; assigning linkage facilitator to register and provide post-test counselling; physically escorting clients from HIV counselling and testing (HCT) points to ART clinics; use referral forms; and increasing contact time with clients so as to give adequate information and attend to new clients before older clients.
- Improved assessment of children less than 15 years for ART in HIV COR facilities.** Figure 1 shows improvement in the percentage of HIV-positive children (0-14 years) who were assessed for ART eligibility. Change ideas to improve this indicator included: improved identification of HIV-positive children among the clients less than 15 years coming for services to the facilities by opening new HCT points in outpatient departments especially for children; implementing HCT in pediatric wards; and implementing an HIV clinic for children of HIV-positive clients.

Figure 1: Percentage of HIV-positive pre-ART clients (ages 0-14 years) seen in a month that have been assessed for ART eligibility (Oct 2012 – Aug 2014)



SPREAD OF IMPROVEMENT

The indicators for coverage, retention, and clinical outcomes did not significantly improve across the intervention in FY14. The plan is to continue to improve in these areas and to integrate the lessons learned in the Partnership for HIV-Free Survival into the COR. Thereafter, the COR change package will be developed before spreading to more sites.

Activity 1 (b). Continuum of HIV care, treatment, and support (community component)

ACCOMPLISHMENTS

- **Identified the top 10 villages in Mitooma health center IV catchment area (STAR SW region) where missed HIV visits commonly occurred** (Quarter 2). Data on HIV appointments from clinic records of 381 persons living with HIV (PLHIV) was analysed to identify villages where missed HIV appointments were concentrated.
- **Conducted QI training for community teams in 10 villages in Mitooma District** (Quarter 2).
- **Developed a standard community linkage and follow-up process for PLHIV in a learning session.** At the health facility, the process begins by a PLHIV visit to the health facility; review PLHIV on appointment by location; and listing PLHIV for linkage to community support and feedback. At the community level, the process begins by collecting lists of PLHIV with follow-up consent, follow-up by Village Health Teams and Community Support Agents, and feedback.
- **Conducted coaching sessions on a monthly basis.** ASSIST supported coaching sessions in 18 villages and three health facilities. An orientation meeting for eight district-based coaches for community activities was held. Thereafter, independent sessions were held in 12 villages and two health facilities and districts. At least 216 community personnel and 30 facility-based expert patients were reached. About 95% of community-based improvement teams in the East Central region of Uganda reached a team maturity score of 3.0. This implies that in addition to testing changes in more than one improvement area, collecting data, and having observable evidence of improvement, teams described changes being tested and met on a monthly basis. About 60% of the teams in the South Western region attained a team maturity score of 2.5.

RESULTS

- **There has been an improvement in following up PLHIV within the community.** This was tested in 7 villages between July and August 2014. Of those lost to follow-up, 68% were traced in the community. Of a total number of 15 PLHIV traced, 73% were found alive but had stopped treatment, 20% were dead, and 7% had self-transferred elsewhere/to other health facility. Of the patients found alive, 11 (91%) were referred back to care by community personnel.
- **Tracing HIV patients lost to follow-up.** Some improvements were observed in tracing HIV patients lost to follow-up (no show in HIV care for more than three consecutive months) and appointment keeping for HIV care (Figure 2).
- **Addressed gender gaps:** Figure 3 shows that the proportion of women followed up in the three villages [Buwanzu and Kulingo (Kamuli District) and Nkusi (Bugiri District)] was higher compared to men. Reasons cited for the lower proportions among men included stigma due to non-disclosure of HIV status to families or friends. As a result of the changes tested, there is an effort to trace both men and women.

Figure 2: Tracing HIV patients on ART lost to follow-up, 7 villages, Mitooma, Kamuli, and Bugiri districts (July – August 2014)

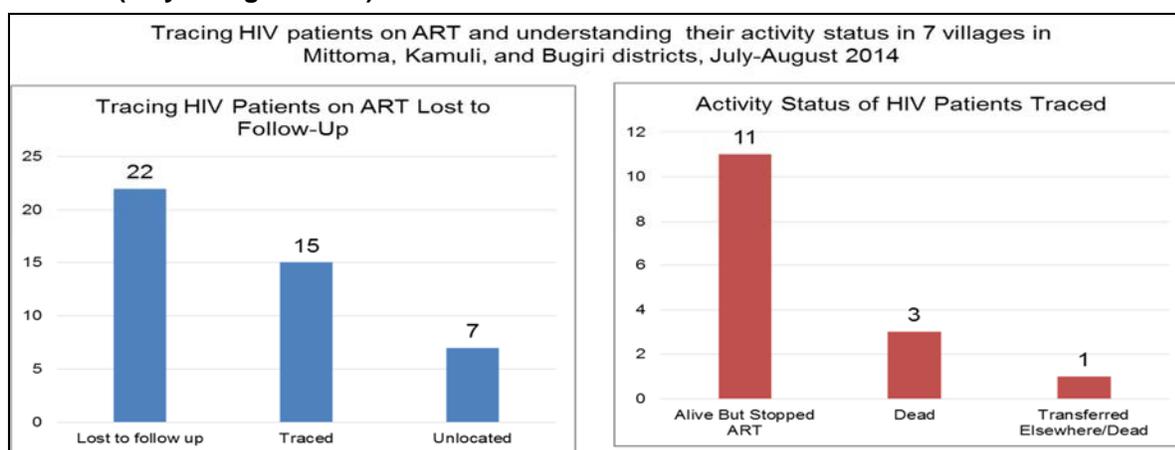
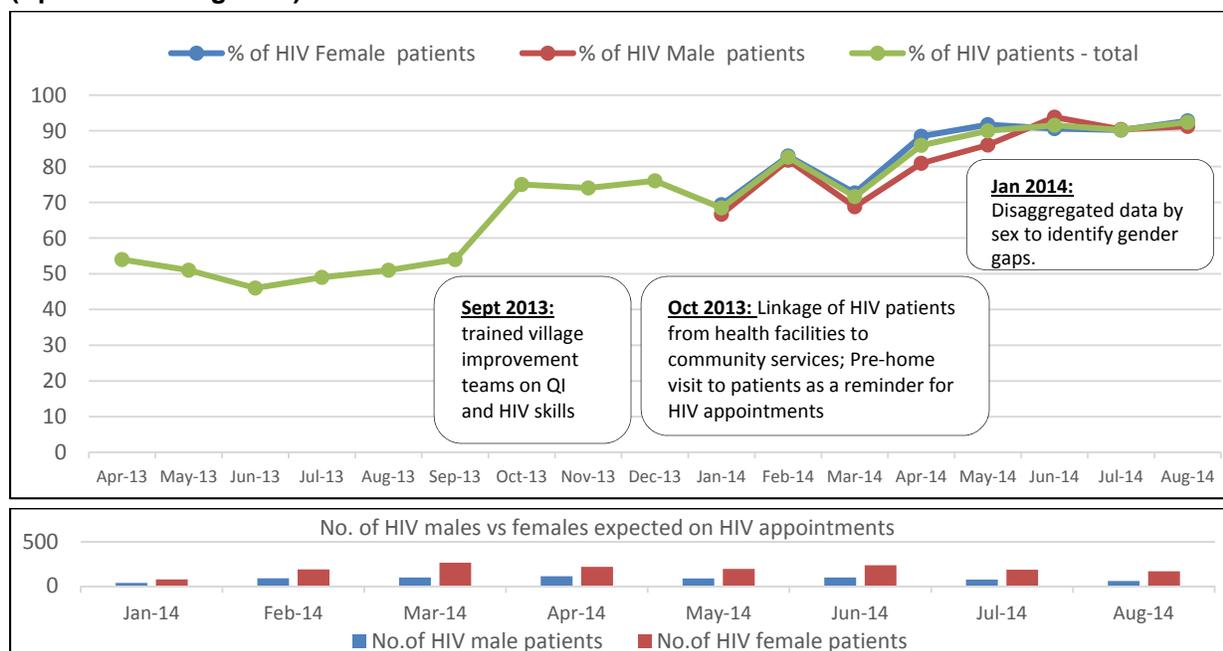


Figure 3: Percentage of HIV patients on ART keeping appointment, Kamuli and Bugiri districts (April 2013 – Aug 2014)



SPREAD OF IMPROVEMENT

For the community level work, ASSIST will spread to 10 new villages in 6 months within the same three districts in two regions. To spread improvement practices, USAID ASSIST will utilize the wave sequence approach and spread agents (coaches participating in the 20 demonstration communities).

Activity 1(c). Testing the effectiveness and efficiency of applying the Chronic Care Model (CCM)

ACCOMPLISHMENTS AND RESULTS

- **Conducted the first learning session for 3 sites in Mityana District** (Quarter 1).
- **Carried out four coaching visits** (Quarters 1-2). Sites continued to work on improving the quality of records and reducing patients' wait times. Since September 2013, these have improved from 78% of complete medical records to an average of 91% in December 2013. The percentage of clients on ART who wait less than 30 minutes between service points increased from 58% September 2013 to 88% in December 2013.
- **Supported sustainability of improvements** (Quarter 3). Teams in Mityana sites were supported to sustain improvement gains and also spread beyond HIV chronic care. Despite not supporting these teams since March 2014, they have maintained improvement work. One facility, St. Padre Pio Health Center III, has gone on to implement quality improvement in the operating theater and maternity departments since April 2014. Staff in these sections regularly meet to review data and develop changes to address gaps. They were also oriented on use of a documentation journal by the HIV chronic care team to enable them to document their improvement work. The team has also formed an infection control committee to help identify and address issues related to infection control. Mityana and Nakaseke hospital chronic care teams plan to institute the same changes used in HIV care to improve diabetic care since they have diabetic clinics in place.
- **Addressed human performance factors through orientation of expert patients** (Quarter 3). At least one expert patient at each of the facilities in Nakaseke District participated in the quality improvement orientation training, getting an opportunity to share and learn from fellow patients from Mityana. At the end of the orientation, these expert patients were assigned roles back at their facilities like it was done in Mityana, such as pre-packing drugs a day before, triaging patients, file retrieval, and patient registration, roles which were previously done by health workers.
- **A comparison study carried out between May 2013 and February 2014 of the intervention district (Mityana) with the control district (Nakaseke)** was completed and showed that retention improved by 22% in the intervention district compared to 4% in the control district. Patients' outcomes improved by 24% in Mityana compared to 1% in Nakaseke. This improvement is associated with the impact of quality improvement and chronic care approaches.

SPREAD OF IMPROVEMENT

In FY15, we will write up the work and develop the chronic care tool kit that will consist of the expert patient guidance document, chronic care implementation spread strategy, case studies, and success stories. We will publish these documents and also conduct a dissemination meeting involving various stakeholders, IPs, health providers, and the MOH.

Activity 2. Safe Male Circumcision

BACKGROUND

Safe male circumcision (SMC) is an effective and proven procedure which in clinical trials reduces female-to-male transmission of HIV by 60%. Moreover, it is estimated that if 80% of men aged 15-49 years old in Southern and Eastern Africa are circumcised, this can result in averting up to 3.4 million new infections in the region (UNAIDS 2014).

The MOH developed a policy on safe male circumcision in 2010 and minimum standards of SMC care in 2011 to guide health facilities in conducting safe male circumcision as part of a comprehensive HIV prevention strategy. The government is planning on circumcising 4.2 million men before the end of 2016.

In April 2012 an interagency PEPFAR team performed an external quality assessment (EQA) of the PEPFAR-supported SMC programs in Uganda based on the expanded version of the recommended World Health Organization (WHO) male circumcision services quality assessment toolkit. Several gaps

were identified among which was lack of a process for regular monitoring of SMC service quality, lack of comprehensive documentation, lack of standardized provider competency assessments, and lack of a standardized way of client postoperative follow up and management of adverse events. A follow-up assessment in December 2012 identified serious quality gaps in counseling, SMC-related data capture, informed consent process, postoperative follow-up, adverse events monitoring and reporting, emergency preparedness, and use of sedation and general anesthesia.

In FY14 ASSIST built on the solid foundation from work done in FY13 – harmonized and approved MOH assessment and monitoring and evaluation (M&E) tools, trained IP staff, formed and trained facility QI teams. In FY14, ASSIST has focused on supporting the sites in the intense phase to sustain their improvements and to disseminate the MOH tools.

ACCOMPLISHMENTS

- **Conducted learning sessions.** A peer-to-peer learning session for all 30 sites was conducted in November 2013. Its main objective was to provide an opportunity for QI teams to share experiences and learn from each other and to harvest best practices to spread to other sites.
- **Participated in an EQA led by inter-agency PEPFAR team** (November 2013). This was a follow-on to the previous EQA conducted in 2012. ASSIST participated in the EQA through working with IPs to address the gaps identified at the 2012 EQA. Results after the 2013 EQA indicated that there had been marked improvement in the indicators being assessed in the period between the two EQAs.
- **Supported the National Safe Male Circumcision Task Force (NTF)** As part of its technical support to the MOH, USAID ASSIST supported the MOH to convene three SMC NTF meetings which provided oversight to the national SMC program.
- **Conducted monthly coaching sessions in collaboration with implementing partners to all the 30 sites.** Coaching sessions were conducted monthly in all 30 intense support facilities. QI teams were supported to test and implement changes to address quality of SMC. During Q4 an additional 19 new sites were taken on for intense support.
- **In collaboration with implementing partners, district health officials, and the MOH, all sites were supported to come up with changes for improving SMC quality indicators** (Quarter 3).
- **Conducted joint PEPFAR SMC data quality assessment** (July 2014). An inter-agency PEPFAR team conducted a data quality assessment at selected SMC sites in Uganda. ASSIST actively participated in this exercise by working with the PEPFAR team to identify sites for the data quality assessment. Preliminary results indicated that ASSIST-supported sites had better data management systems in place. The assessment team also noted poor spread of best practices from ASSIST-supported sites to other IP sites.

RESULTS

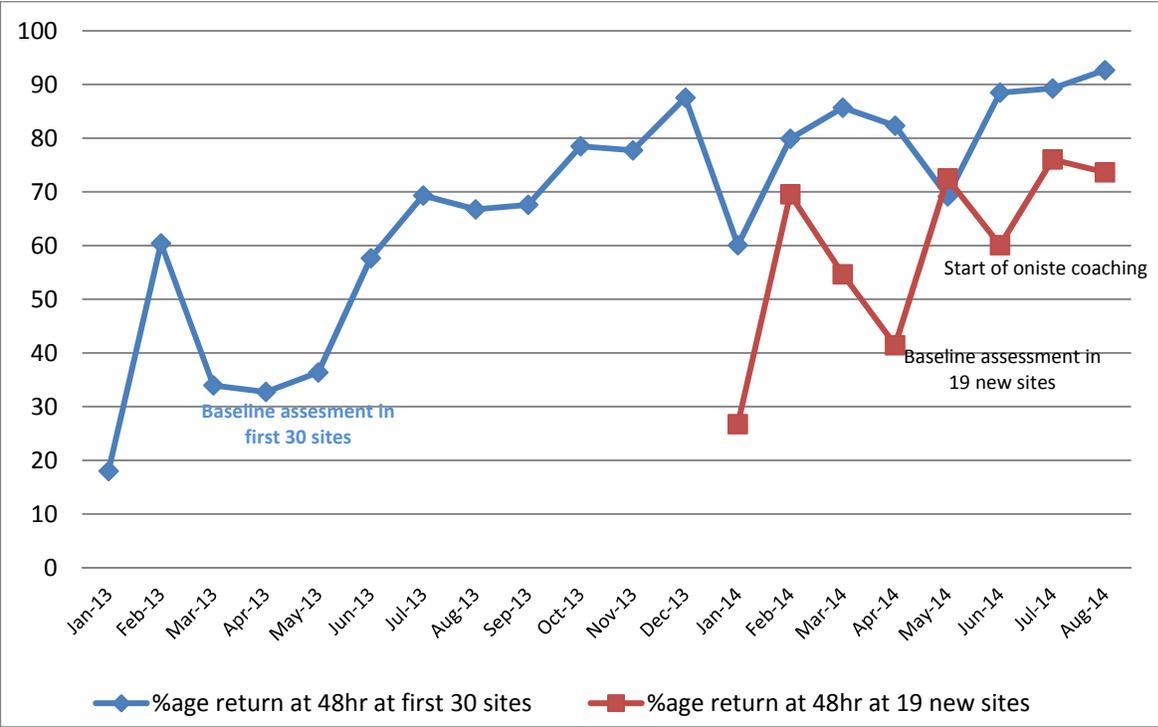
Improvement in Key Indicators

Activity	Indicator	Baseline	Last value	Magnitude of Improvement (percentage points)
Safe Male Circumcision	% of clients that return within 48 hrs post operation	58% (Oct 2012) 4 sites	91% (Sept 14) 21 sites	33
	% of SMC sites that meet the minimum quality standards	10% (May 2013) 4 sites	54% (Sept 14) 30 sites	44
	% of clients that experience moderate to severe adverse events	0.5% (Oct 2012) 8 sites	0.4% (Sept 2014) 29 sites	-0.1
	% of clients who were counselled tested and received HIV test result within SMC setting	73% (Oct 2012) 11 sites	100% (Sept 2014) 29 sites	27
	% of clients that are assessed for sexually transmitted infection prior to circumcision	81% (Jan 2013) 11 sites	100% (Sept 2014) 29 sites	19

Activity	Indicator	Baseline	Last value	Magnitude of Improvement (percentage points)
	% of SMC clients with documented informed consent prior to circumcision	83% (Jan 2013) 14 sites	100% (Sept 2014) 29 sites	17
	% clients of safe male circumcision that return for review after circumcision	58% (Oct 2012) 4 sites	93% (Aug 2014) 17 sites	35

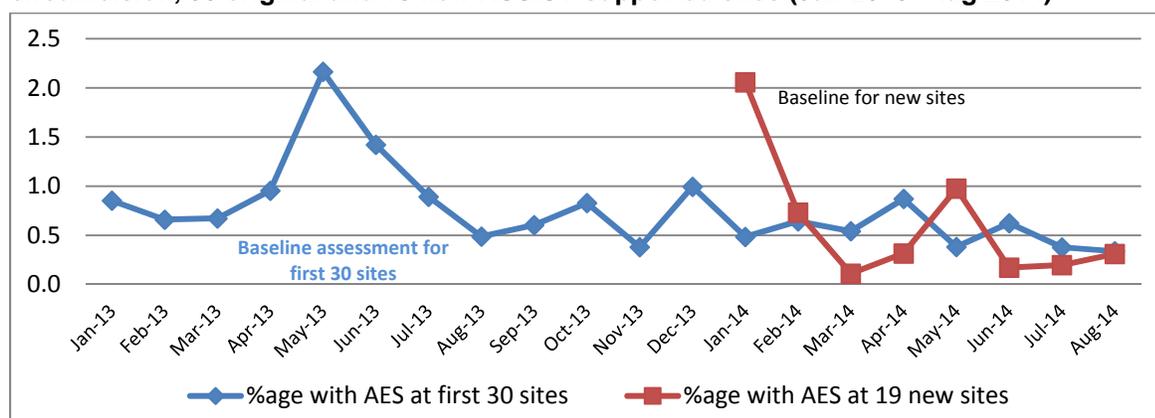
- Improved percentage of SMC clients returning for follow-up.** At baseline, most sites did not know the importance of client follow-up, and clients were told to only return in case they had a problem. Health workers were oriented on the importance of follow-up, and as a result, incorporated the importance of follow-up in their group education sessions emphasizing that clients should return for bandage removal. As shown in Figure 4, with this change, follow-up improved to 92% (Aug 2014). The drop in May 2014 was as a result of one site scaling up circumcision through outreach with over 3000 clients getting circumcised in one month but the site was not well prepared to follow up the clients (Figure 4). Although client follow-up has improved, it remains a major problem in the spread sites. This is an indication of poor or lack of spread by IPs beyond the intense support sites visited by ASSIST.

Figure 4: Percentage of clients returning for review after 48 hours after SMC, first 30 and 19 new ASSIST-supported sites (Jan 2013 – Aug 2014)



- Improved percentage of clients who experience adverse events:** Figure 5 shows that whereas since July 2013, the rate of adverse events had been maintained below 1% in the initial 30 demonstration sites, in the scale-up sites the rate started above 2% and declined to 0.4% in September 2014.

Figure 5: Percentage of clients who experience moderate to severe adverse events after circumcision, 30 original and 19 new ASSIST-supported sites (Jan 2013- Aug 2014)



SPREAD OF IMPROVEMENT

The activity will be scaled from 30 sites to 165 sites. Fifty sites will receive intense support from USAID ASSIST whereas 115 sites will be supported through district based and regional coaches. A *Change package to improve quality of safe male circumcision in Uganda* will be scaled up to the 115 sites. The scale up will start in January 2015 and receive support from ASSIST until September 2016.

Activity 3. Partnership for HIV-Free Survival

BACKGROUND

The aim of PHFS is to support countries to achieve elimination of mother-to-child transmission of HIV through reliable implementation of postnatal EMTCT practices. To achieve the goals of the “Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive,” PEPFAR and other partners are supporting national efforts to develop and scale up interventions to provide optimal nutrition for infants and their mothers, as well as to protect infants from HIV infection. In Uganda, PHFS is being implemented with ASSIST support to 22 health facilities in six districts countrywide. Members of the partnership in Uganda include USAID ASSIST, FANTA, TASO, and SPRING.

The 2010 WHO PMTCT guidelines, including the Guidelines on HIV and Infant Feeding, provide guidance on how the continuum of care can be strengthened and improved for HIV-infected mothers and their exposed infants. Still, much work has yet to be done to effectively and extensively implement these guidelines. Using QI methods, the PHFS is supporting the implementation of existing protocols and nutritional assessment and counseling services (NACS) to promote essential steps of postnatal mother-infant care, which lead to improved nutritional and HIV care for the HIV-exposed infants over the first 24 months of life.

In FY13, ASSIST worked with the PHFS partners to understand the current performance through baseline assessment, and commenced improvement work at the 22 facilities in six districts, which generated a package of process level changes that have been seen to contribute to elimination of mother-to-child transmission of HIV and reduction in malnutrition in HIV-positive mothers and their exposed babies. This constituted the learning phase of this work. Most of FY14 was used to conclude this learning phase, and begin the spread phase to scale up lessons learned to the rest of the sites in the six districts.

ACCOMPLISHMENTS

- **Hosted and participated in the PHFS regional meeting** (Quarter 1). ASSIST prepared for and hosted the PHFS regional conference in Kampala, Uganda, attended by 80 participants. Participants included country teams from Kenya and Tanzania, partners within the PHFS, and the MOH. The purpose was to review the implementation of the PHFS across countries, share lessons learned, and address challenges.
- **Conducted monthly coaching sessions.** Conducted 10 joint monthly coaching visits to all 22 health facilities. Discussions focused on improving the special visits for mother-baby pairs where they

- receive additional services based on the age of the exposed baby.
- **Conducted learning sessions** (Quarters 2 and 4). Held two learning sessions for all 22 health facilities.
- **Conducted first harvest meeting** (February 2014). The harvest meeting included identification of successful and unsuccessful changes; evaluation by teams to identify teams' "best advice" for new teams related to data quality, retention of mother-baby pairs, and routine visits.
- **Facilitated three knowledge handover meetings** (April, March and July 2014). Two knowledge handover meetings were held in the South Western region in Ntungamo and Kisoro districts. Four teams from the demonstration phase and 24 additional health facilities in the spread phase were brought together to share and learn from the demonstration sites. One knowledge handover meeting was held between three demonstration sites and four spread sites in Namutumba District.
- **Developed and disseminated change packages.** Developed and disseminated three change packages on improving the quality of EMTCT data, improving retention of mother-baby pairs in care, and improving the quality of services provided at routine visits for mother-baby pairs. These change packages have been shared widely and will be used in the spread phase to scale up to new sites what we have learned in the initial sites.
- **Conducted knowledge handover session to COR team** (Quarter 4). Part of the PHFS spread strategy is to spread what has worked to improve the quality of EMTCT care to the sites that are working on the COR collaborative. To facilitate this spread, a knowledge handover session was held between the PHFS and COR teams at a demonstration site in Namutumba.
- **Held first learning session for spread sites in Namutumba District** (Quarter 4). The purpose of the learning session was to facilitate the spread of change ideas for the first focus areas of the PHFS in new sites that are just starting out with improvement work.

RESULTS

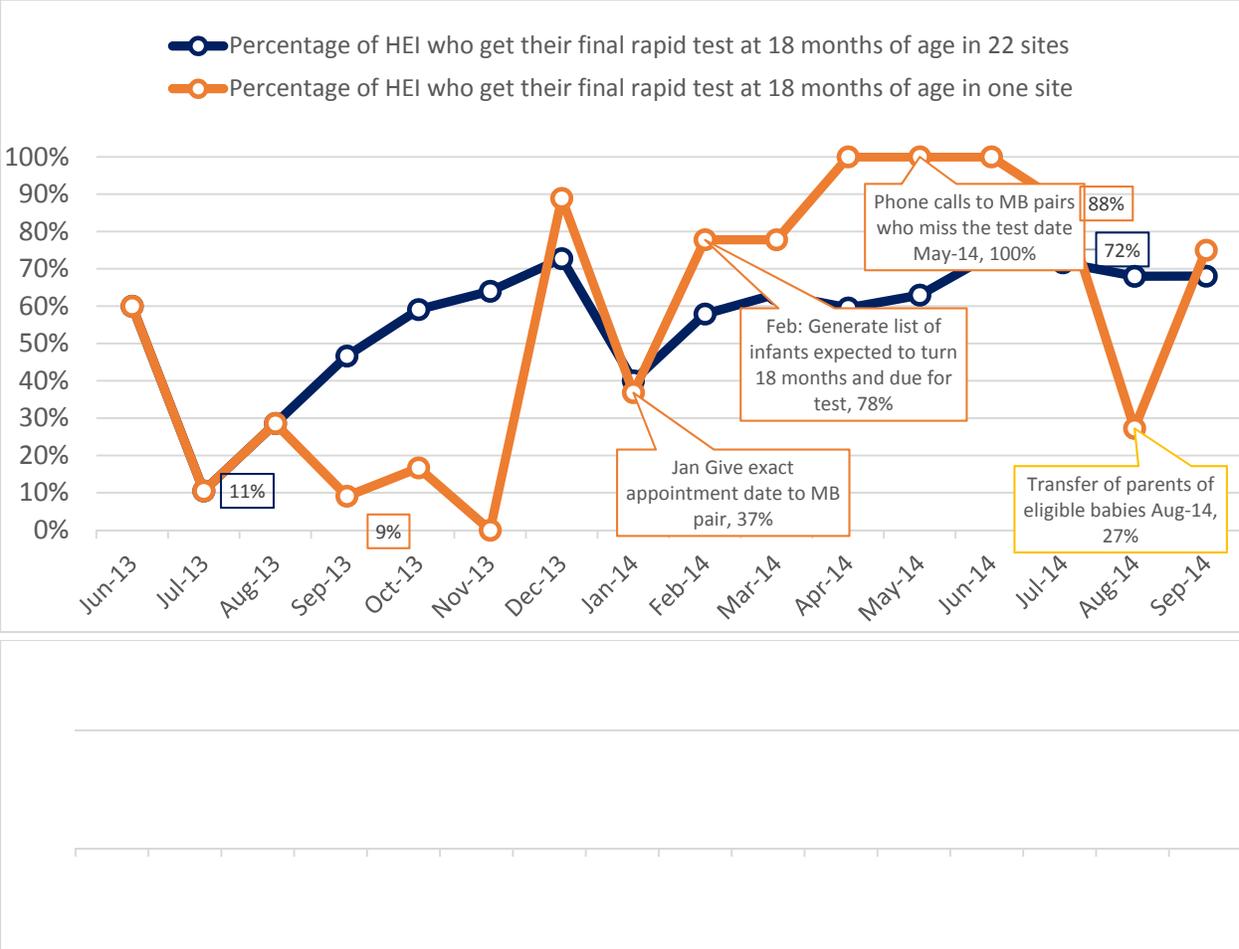
Improvement in Key Indicators

Activity	Indicator	Baseline	Last value	Magnitude of Improvement (percentage points)
Partnership for HIV-Free Survival	% of HIV-negative women retested for HIV as per national guidelines	12% (April 2013) 5 sites	93% (Sept 2014) 22 sites	81
	% of HIV-exposed babies who were given ART prophylaxis	12% (April 2013) 15 sites	100% (Sept 2014) 22 sites	88
	% of HIV-positive pregnant women initiated on ART	83% (April 2013) 20 sites	96% (Aug 2014) 22 sites	13
	% of HIV-positive mothers who receive IYCF counselling at each visit	23.7% (April 2013) 15 sites	100% (Sept 2014) 22 sites	76.3
	% of HIV-positive mothers who receive maternal nutrition counselling at each visit	23.3% (April 2013) 15 sites	99.8% (Sept 2014) 22 sites	76.5
	% of exposed infants reporting to be adhering to recommended IYCF practices	73.3% (April 2013) 20 sites	97% (Sept 2014) 22 sites	23.7
	% of HIV-positive pregnant and lactating mothers who receive nutrition assessment every month	20.4% (April 2013) 19 sites	99% (Sept 2014) 22 sites	78.6
	% of exposed infants who receive nutrition assessment every month	32.4% (April 2013) 16 sites	99.8% (Sept 2014) 22 sites	67.4
	% of HIV-positive mothers who are found to be malnourished during the reporting period	0.88% (April 2013) 11 sites	1.1% (Sept 2014) 22 sites	0.22
	% of exposed infants found to be undernourished and receive therapeutic or supplementary feeding support at any point	100% (April 2013) 3 sites	15.8% (Sept 2014) 22 sites	-84.2

Activity	Indicator	Baseline	Last value	Magnitude of Improvement (percentage points)
	during the reporting period			
	% of HIV-positive mothers found to be undernourished and receive therapeutic or supplementary feeding support at any point during the reporting period	0% (April 2013) 1 site	33.3% (Sept 2014) 22 sites	33.3
	% of exposed infants who are found to be malnourished at any point during the reporting period	5% (April 2013) 1 site	1.3% (Sept 2014) 22 sites	-3.7
	% of mother-baby pairs retained in care each month	7.9% (April 2013) 1 site	79.7% (Sept 2014) 22 sites	71.8

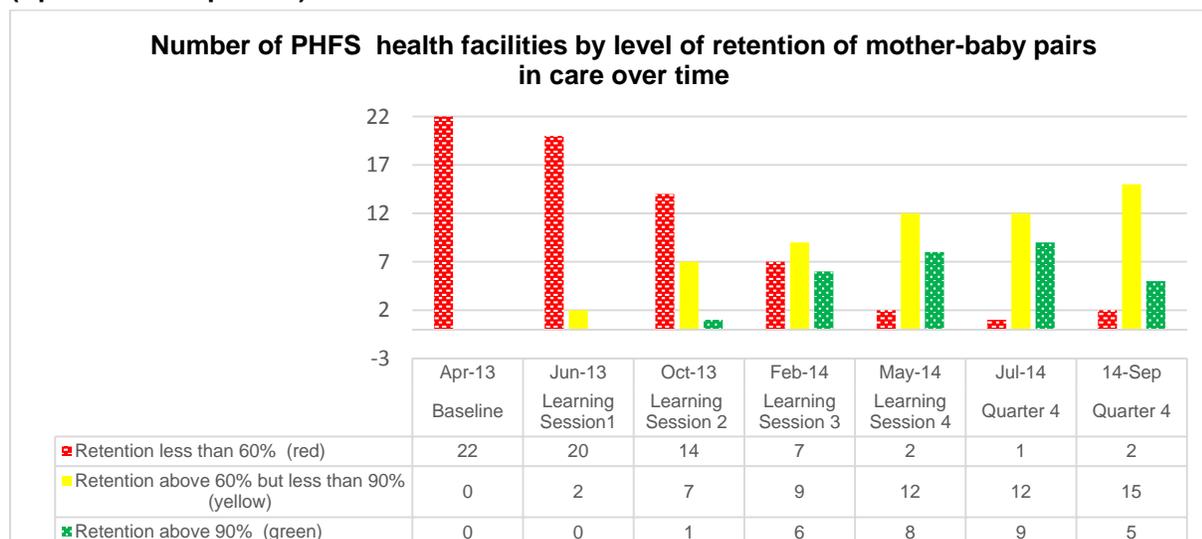
- Increased the proportion of HIV-exposed babies who received a final rapid test at 18 months.** The proportion of HIV-exposed babies who got a final rapid test at 18 months of age increased from 11% in one site in June 2013 to 75% in 22 sites in September 2014 (Figure 6). Some changes which sites tested included: synchronizing the appointment for the baby and the mother to ensure they return to the health facility at the same time; generating a list of those infants expected to come for the final rapid test; and making phone calls to the mothers who miss their paired appointments.

Figure 6: Percentage of HIV-exposed infants who get their final test at 18 months of age in 22 sites and 1 site (June 2013- Sept 2014)



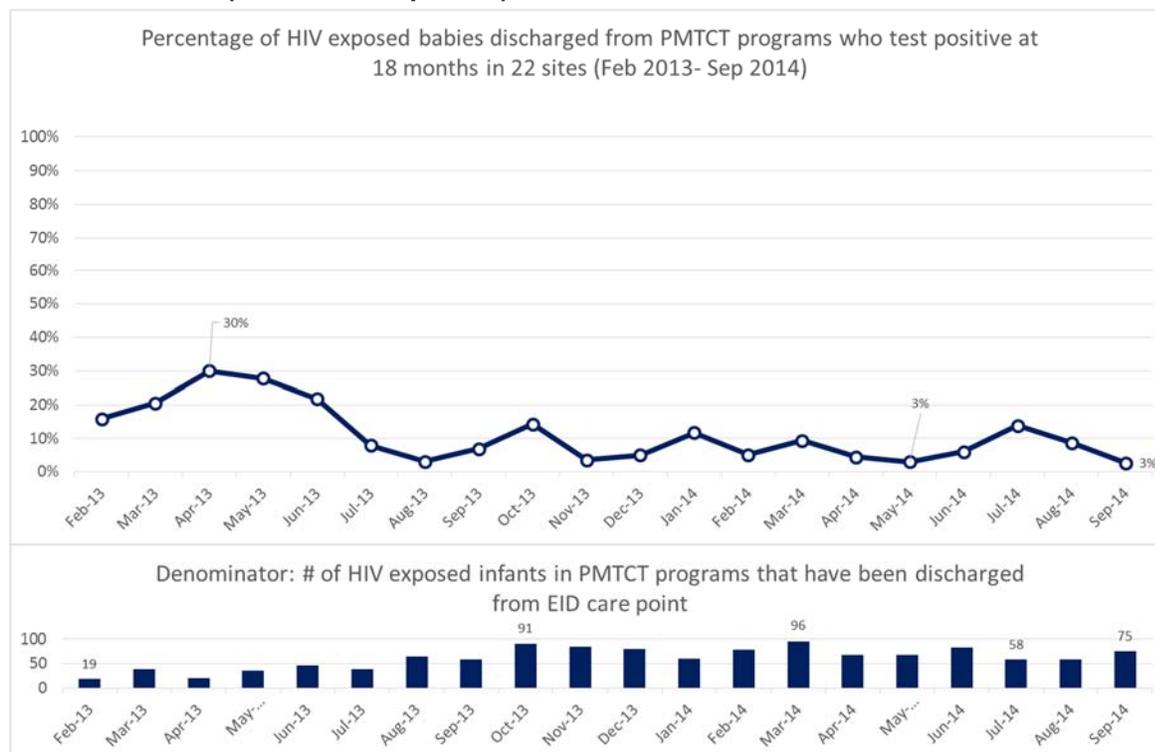
- Retention of mother-baby pairs in care:** Overall, 1,224 of the expected 1800 (68%) mother-baby pairs were retained in care, compared to the 39 (2%) at baseline in April 2013. As of September 2014, 5 health facilities were retaining over 90% of mother-baby pairs in care, 15 sites retained between 60 and 90% of their mother-baby pairs in care, and only two sites retained less than 60% of mother-baby pairs (Figure 7).

Figure 7: Progress in retaining over 60% of mother-baby pairs in care in 22 PHFS sites over time (April 2013 – Sept 2014)



- Reduction in the number of HIV-exposed infants who are discharged as HIV-positive at 18 months.** Figure 8 shows a reduction from 30% in April 2013 in 7 sites to 3% in September 2014 in 22 sites.

Figure 8: Percentage of HIV-exposed infants discharged from PMTCT who test positive at 18 months, 22 sites (Feb 2013 – Sept 2014)



- **Increased mother-baby pairs who receive a standard package of care at routine visits each visit.** As of February 2014, 98% of mother-baby pairs who came to the health facilities received a standard package of care. The standard package of care includes ART for the mother, cotrimoxazole or nevirapine for the baby, nutrition assessment for the pair, infant and young child feeding counselling, and an appointment for the next visit. Changes tested included: placing reminder notes on the wall to remind clinicians and midwives about the services and updating the cards; filling out mother and babies' cards completely before the pairs leave the clinic; on job training of health workers and expert clients to provide services such as nutrition assessment using mid-upper arm circumference and on infant and young child feeding guidelines; counter book/ form to keep a record of who received all the services; informing mothers about the services to expect; merging EID and ART clinics; and dispensing drugs in the same area where mother-baby pairs are seen.

SPREAD OF IMPROVEMENT

The lessons learned from the demonstration phase of implementation will be spread to additional health facilities via three prongs:

- **1st prong:** Using existing TASO and SPRING structures, we will support scale up to all the PMTCT health facilities in the six initial districts.
 - Through this prong, we will spread to 108 health facilities in Tororo, Jinja, Namutumba, Ntungamo, Kisoro, and Manafwa districts (will commence October 2014). USAID ASSIST staff will not provide direct coaching to these 108 sites. Instead, USAID ASSIST staff will train a network of MOH and TASO/SPRING coaches in these districts and meet with them at least quarterly to monitor and support progress of the spread. Materials developed in the demonstration phase will be used.
- **2nd prong:** USAID ASSIST will leverage existing QI structures in Continuum of Response sites supported by USAID ASSIST. In this way, we will spread to the 47 additional health facilities in 38 districts supported by eight USG IPs [STAR E, STAR EC, STAR SW, The Northern Uganda Health Integration for Enhanced Services (NU-HITES), Uganda Private Health Support Program (UPHS), Uganda Supporting Public Sector Workplaces to Expand Action and Responses Against HIV/AIDS (SPEAR), The MildMay Centre, and Makerere University Walter Reed Project (MUWRP)]. USAID ASSIST COR coaches will directly support these sites as part of the PMTCT component of the COR. These 49 sites will then serve as model sites for the USAID IPs (commenced September 2014).
- **3rd prong:** Through the MOH, USAID ASSIST proposes spread to all PMTCT sites in Uganda, starting with those most in need of these services. This prong will start with activities to strengthen the MOH ownership of the knowledge management products developed in the demonstration phase, beginning with sharing the products with the MCH technical working group and the MOH Senior Management. Endorsement at these levels will be followed by detailed planning of the phasing of the scale-up across the country by the MOH technical team, USAID ASSIST, and other national level PMTCT stakeholders. Districts with a high prevalence of HIV (5.1-10%) and poor coverage of EID services (<50% of eligible health facilities providing EID services) will be prioritized. These activities commenced in October 2014 and will extend to September 2016.

Activity 4. Improve TB care

BACKGROUND

The 2010 Global WHO Report ranked Uganda 16th among the 22 high TB burden countries. Strains resistant to first-line TB drugs have developed in the country. Like most of Sub-Saharan Africa, Uganda is battling with the dual tuberculosis and HIV epidemics. The HIV prevalence in the general population is 7.3%. It is estimated that about 60% of TB patients are co-infected with HIV (AIDS Indicator Survey, 2011). The dual epidemic has resulted in a four-fold increase in the notification numbers of TB cases. Furthermore, TB stands as the number one killer of HIV patients. The clinical presentation of TB among dually infected persons has changed, and this has a bearing on the clinical management and design of public health interventions to respond to the dual epidemic.

ASSIST is partnering with the MOH to improve the quality of TB care. Overall, the project is aiming to ensure that all TB patients receive good quality care (i.e., they access appropriate care, complete treatment, and attain treatment success). ASSIST will spread lessons learned among implementing partner projects and test new innovations to further improve care in FY15.

ACCOMPLISHMENTS

- **Finalized baseline data collection** (January 2013).
- **Conducted QI training for Kampala Capital City Authority (KCCA) based health care workers** (January 2014). ASSIST trained 25 KCCA staff from six health facilities and division offices in QI.
- **Conducted facility coaching session on a monthly basis** (Jan – Sept 2014) with six facilities, 68 facility-based health care workers, and five KCCA TB division supervisors. Focus was on increasing the number of TB cases notified at the health facilities through supporting facilities to: Introduce triaging for cough and other symptoms suggestive of TB at care entry points (e.g., outpatient departments, HIV clinic, ANC clinics, and in-patients) using an intensified case finding tool; improve linkage of confirmed TB cases and enrollment into TB care; and improve documentation of TB services. Facility teams were supported to take up improving data quality as improvement projects, and these were supported on a weekly basis to discuss, analyze performance, and implement improvement projects to address the identified gaps.
- **Conducted coaching session** (Quarter 4). Coaching sessions during the year were conducted in all six health facilities to support facility team members to improve the quality of TB data. There was a review of the data quality to ensure that patients' information is recorded in the TB unit registers at the end of each patient clinic visit.
- **Conducted learning session** (September 9-11, 2014). ASSIST conducted a second learning session and a harvest meeting for the six KCCA health facilities implementing TB QI activities. Twenty-five participants attended, including the facility-based health workers from the TB clinic, outpatient departments, HIV clinic laboratory, and the community supporters. During the meeting, health facilities put in place ways to improve TB data quality (completeness and accuracy of patients' information within the TB recording and reporting tools).

RESULTS

Improvement in Key Indicators

Activity	Indicator	Baseline	Last value	Magnitude of Improvement (percentage points)
Improve TB care	% of TB patients seen in the clinic whose information is complete and accurately filled	61.3% (Dec 2013) 3 sites	83% (Aug 2014) 6 sites	21.7
	% of TB suspects evaluated for active TB	62.7% (Dec 2013) 2 sites	76% (Aug 2014) 6 sites	13.3

- **Improvement in TB data quality.** Figure 9 shows progress the five KCCA clinics made in improving the completeness of TB patient information in TB recording and reporting tools.
- **Increase in the number of TB suspects identified.** A gradual increase in the number of TB suspects identified was reported from 47 in December 2013 to 364 in June 2014 to 555 in August 2014. Those evaluated for active TB rose from 51% as reported in February 2014 to 76% in August 2014 (Figure 10).
- **Increased TB/HIV co-infected clients on ART.** Figure 11 shows increases in getting co-infected patients on ART among the COR sites, from 48% in Dec 2013 to 80% in August 2014.

Figure 9: Percentage of TB patients seen at five KCCA TB clinics whose information is complete and accurately filled in the TB tools (June 2014 – Aug 2014)

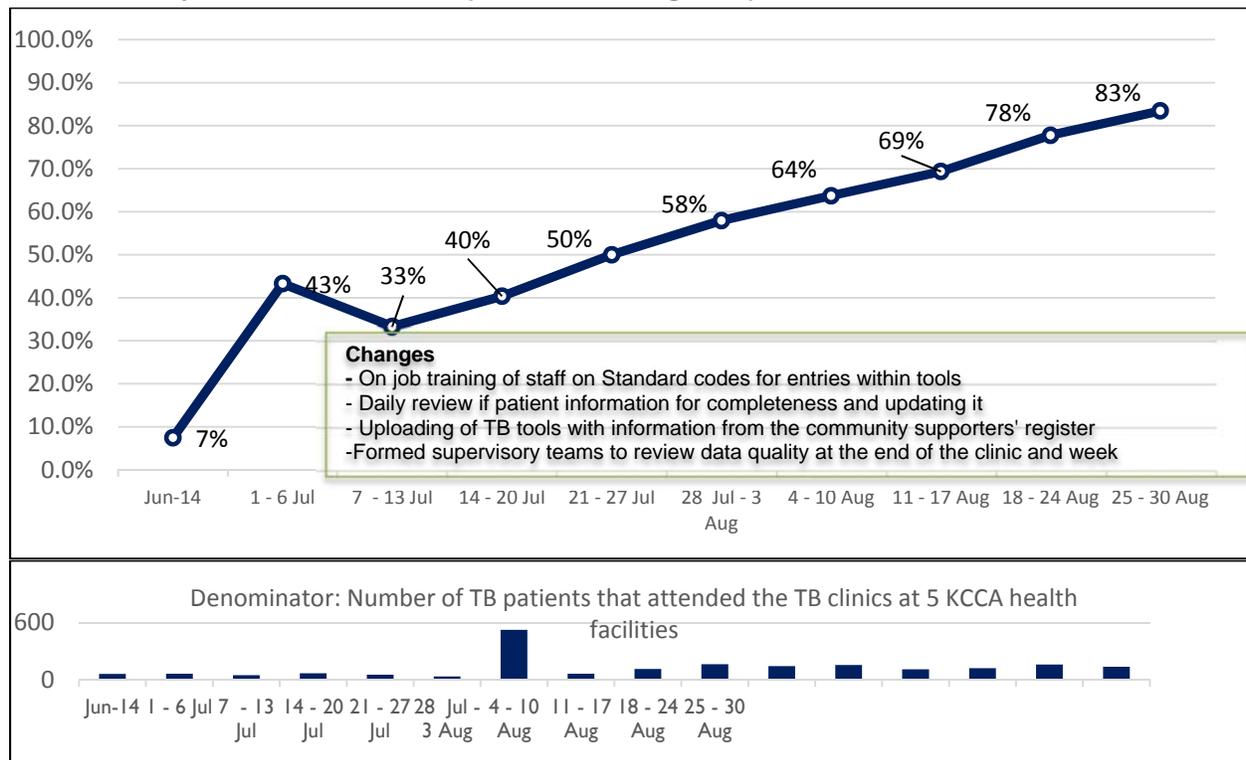


Figure 10: Percentage of suspects evaluated for TB, six KCCA health facilities (Oct 2013 – Aug 2014)

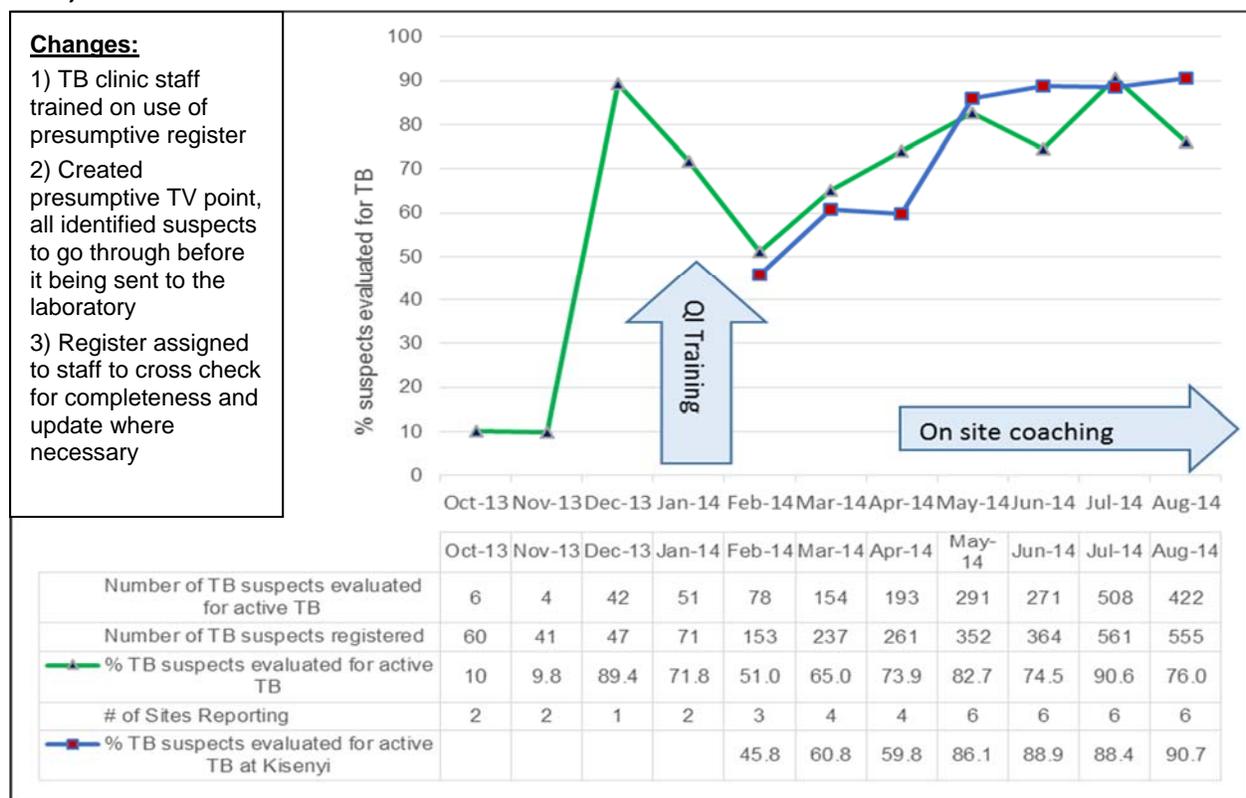
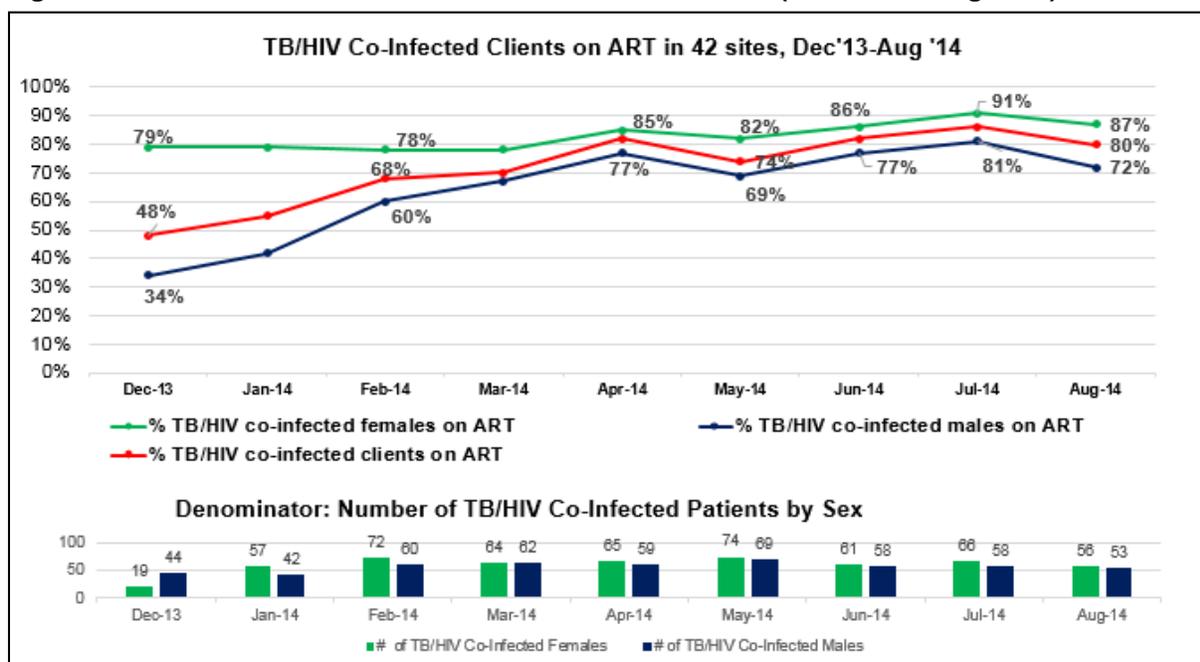


Figure 11: TB/HIV co-infected clients on ART in 42 COR sites (Dec 2013 – Aug 2014)



SPREAD OF IMPROVEMENT

A spread strategy was developed in September 2014 and shared in October 2014 with the stakeholders (i.e., with the KCCA authorities, TB TRACK, and the MOH NTLP), and action plans were developed to achieve the project objectives for the year. A phased approach to improving the quality of TB work and the spread plan to 10 new KCCA health facilities was discussed.

Activity 5. Improve MNCH

BACKGROUND

Uganda's maternal mortality ratio stands at 438/100,000 live births, which is substantially higher than the 162 which is needed to achieve the millennium development goal in 2015 (UDHS 2011). Most of the maternal deaths occur in the first 24 hours from the onset of labor, and high-impact, low-cost interventions do exist that can be employed to reduce this. Among these are: active monitoring of labor, active management of third stage of labor (AMTSL), and prompt management of complications that arise out of the labor process.

In addition, over half of the total newborn deaths occur during the first week of life, mainly in the first 24 hours of life. The common causes of neonatal deaths in Uganda include birth asphyxia, infections, and complications of preterm birth, accounting for 90% of all newborn deaths.

Since FY13, ASSIST has been one of the partners implementing the Saving Mothers Giving Life (SMGL) project in four districts of mid-western Uganda (Kyenjojo, Kamwenge, Kibale, and Kabarole districts) that is aimed at reducing maternal and perinatal mortality. The role of ASSIST is to supplement the efforts of other implementing partners to address gaps in processes and systems of care. In FY14, ASSIST convened a training of trainers for the newborn steering committee and newborn health partners in quality improvement; provided support to the steering committee in policy and guideline development; and addressed quality improvement gaps at the national level to institutionalize and build capacity of the Ministry of Health to provide quality newborn health care services.

ACCOMPLISHMENTS

- **Provided support to Ministry of Health – national level.**
 - As part of health systems strengthening, the MOH was supported to review the Health Management Information System (HMIS) tools to integrate data entry points to measure newborn

health quality indicators that will be used to monitor the quality of newborn health care services (Quarter 1).

- Technical support was also provided to the MOH to quantify national needs for newborn resuscitation and training equipment (Quarter 1). A quantification was conducted for all government health facilities and medical training institutions. The quantification needs were submitted to the World Bank Health Systems Strengthening Project for funding and subsequent procurement.
- National-level Born-Too-Soon Advocacy Campaign was conducted to commemorate World Prematurity Day (Quarter 1). The objective of the campaign was to raise more awareness of prematurity and its associated consequences if not addressed and to lobby and advocate for the use and scaling up of proven interventions that can help babies born prematurely survive.
- **Conducted three joint learning sessions of 10 pilot and 10 scale-up SMGL sites.** Conducted three learning sessions for 20 sites in the 4 SMGL districts implementing MNCH QI activities. Best practices were shared for each intervention area by the participants, and a mini-change package was shared at the end of the three-day meeting. In September 2014, ASSIST conducted a learning session for 20 sites from the 4 SMGL districts. The 10 spread sites were mixed with the 10 demonstration sites through group discussions in each of the improvement objectives facilitating learning across teams. Plenary sessions were organized for input from the rest of the group members.
- **Six of ten light-supported quality improvement teams in the phase II/scale-up districts started monitoring compliance with AMTSL, partograph use, and essential newborn care (ENC) provision.** Eight of ten facilities started holding regular quality improvement meetings and identified improvement projects. There was diffusion of the quality improvement MNCH interventions from the five ASSIST-supported facilities to Bigodi Health Center III in Kamwenge District which offers basic emergency obstetric care. The midwife at this health unit through interactions with other midwives from the quality improvement trained facilities started implementing the evidence-based interventions in January 2014. This midwife had never been trained in quality improvement nor received onsite coaching visits.
- **Conducted coaching sessions:** Conducted 9 coaching sessions; some were done independently by the regional and district coaching teams, and other jointly with the ASSIST team. During the joint coaching sessions, coaching skills of regional and district coaches were assessed during the site visits. Nine of 13 trained district/regional coaches have become competent and able to support teams to improve MNCH services.
- **Conducted an SMGL quality improvement technical working group (TWG) meeting of implementing partners who were involved in quality improvement activities in the SMGL initiative** (June 2014). The scope of work was developed and shared with the USAID SMGL coordination committee.
- **Conducted a harvest meeting (June 2014) for the SMGL-MNCH collaborative focusing on five improvement areas:** adherence to partograph use; compliance to the provision of the three components of AMTSL; provision of a complete package of ENC; screening for pregnancy-induced hypertension; and conducting maternal and perinatal death reviews. Changes included: photocopiers/printers at facilities are being used to avail the partographs; partographs have been included as part of the admission forms used in maternity wards; partograph supply has been included in the tendered out items for supply at the health facilities, thus reducing stock-outs of forms; and review of charts for use and completeness during the quality improvement review meetings.
- **Conducted monthly SMGL QI cluster meetings.** Coordinated four SMGL IPs implementing QI monthly meetings. QI tools have been shared with the TWG members, including documentation journals, reporting tools, and the MOH's QI Framework and Strategic Plan.

RESULTS

Improvement in Key Indicators

Activity	Indicator	Baseline	Last value	Magnitude of Improvement (percentage points)
Saving Mothers Giving Life	% application of AMTSL during delivery	5% (Jan 2012) 10 sites	99% (Aug 2014) 30 sites	94
	% use of a partograph for labor monitoring	4% (Jan 2012) 10 sites	72% (Aug 2014) 30 sites	68
	% delivery of a complete package of ENC	1% (Jan 2012) 10 sites	83% (Aug 2014) 30 sites	82
	% successful resuscitation of asphyxiated babies	90% (March 2013) 3 sites	93% (July 2014) 10 sites	3
	% blood pressure measurement of mothers during labor and delivery	94% (March 2013) 6 sites	86% (Aug 2014) 12 sites	-8
	% urine dipstick testing for mothers during labor and delivery	46% (Aug 2013) 1 site	76% (Aug 2014) 6 sites	30

- By August 2014, compliance to AMTSL use improved to 99% across both the 20 sites in the original SMGL districts plus the 10 light-support sites in the spread districts. Use of the partograph has also improved across all cohorts of sites (Figure 12), as has the proportion of newborns receiving the complete ENC package (Figure 13).

Figure 12: Percentage of clients for which partographs are used to monitor labor in 10 pilot, 10 scale-up, and 10 spread SMGL sites (Jan 2012 – Aug 2014)

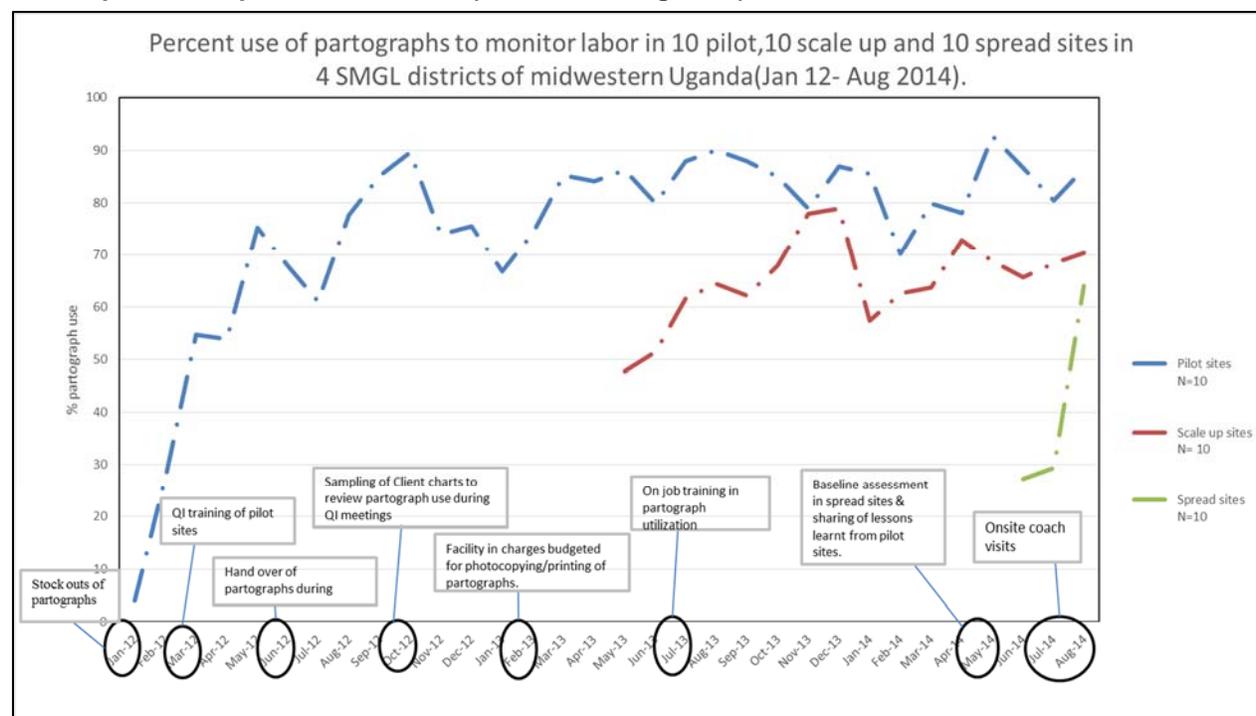
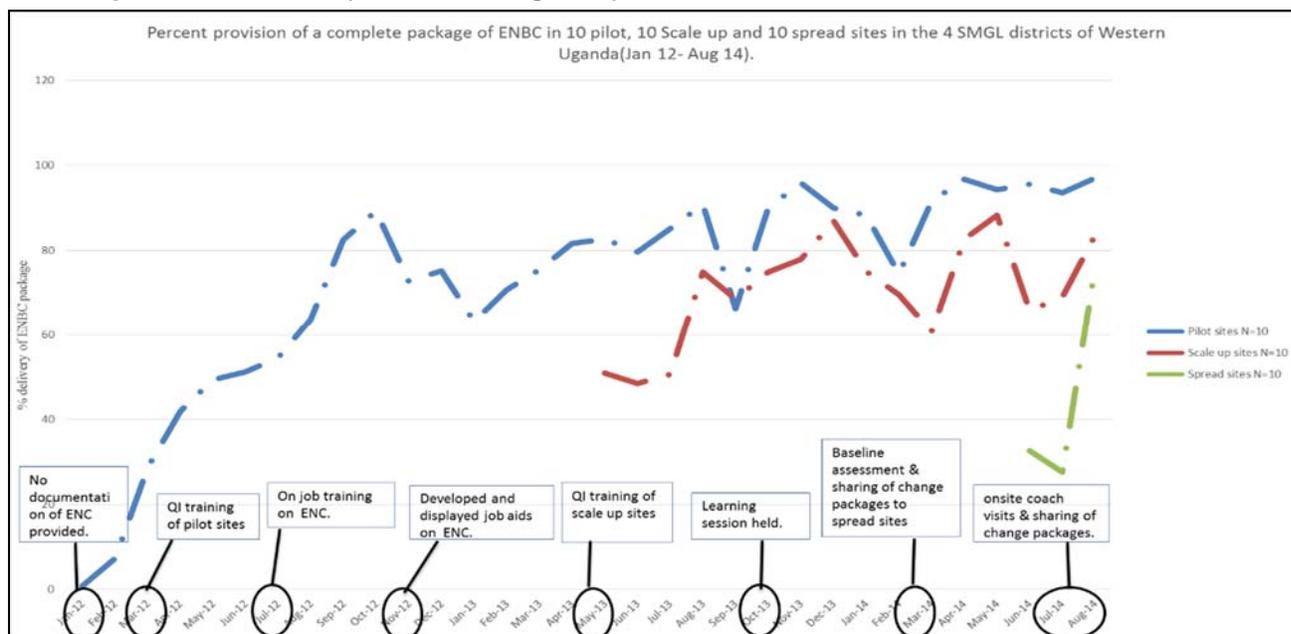


Figure 13: Percentage of newborns receiving a complete package of ENC in 10 pilot, 10 scale-up, and 10 spread SMGL sites (Jan 2012 – Aug 2014)



SPREAD OF IMPROVEMENT

Through the implementing partners and district structures in the four SMGL learning districts, ASSIST will scale up MNCH QI work to include all the health center IIIs offering MNCH services. ASSIST will work with the district-based coaches as spread agents and project staff of other SMGL implementing partners through sharing change packages, conducting joint quarterly coaching visits, and organizing semi-annual joint peer-to-peer learning meetings.

The project will build the capacity of district structures in the six new SMGL (phase II) districts to be able to support 10 new hospitals and health center IVs. This will be done through QI training of facility and district health team members, district based coaches will be identified, trained and used as spread agents to other non-ASSIST supported facilities. ASSIST will support the MOH in building QI structures at the district level during the scale-up activities in the six new SMGL districts. This will be done through QI training and establishing QI structures at the district, health sub-district, and facility levels in line with the national quality improvement and strategic plan. We hope that through the capacity built in the implementing partners and the district coaches by FY16, they will be able to spread the lessons learnt to all the remaining HC IIIs in the six new districts.

Activity 6. Integrate FP into maternal, newborn, and child health

BACKGROUND

Uganda's total fertility rate stands at 6.4 per woman, one of the highest in the world. Over 1.4 million women in Uganda report wanting to delay pregnancy, space their children, or stop child bearing altogether but are not using any contraceptive method (UDHS 2011). Only 26% of women of reproductive age report use of modern contraceptive methods, with an estimated unmet need for family planning of 34% (UDHS 2011). The current uncontrolled high fertility of women predisposes them to high-risk pregnancies and subsequently increases their chances of morbidity and mortality. Early sexual involvement of girls has sometimes led to unplanned and unwanted pregnancy, with evidence of high incidence of unsafe abortions and its related complications among teenage girls.

Integration of family planning into maternal, newborn, and child health ensures a safe and healthy pregnancy and birth for those who wish to have children. The goal of this ASSIST activity was to produce tools and knowledge that would enable more efficient and effective scale-up of integrated QI approaches into FP/MNCH service provision.

ACCOMPLISHMENTS

- **Conducted learning sessions** (Quarters 1-3). Site teams shared changes that have worked and not worked in improving the four focus areas of FP integration into MNCH care service. They discussed barriers to FP integration, solutions being tested, and other possible innovations. A list of changes tested to improve MNCH/FP integration in the 18 SMGL participating sites was generated, as well as action plans.
- **Conducted coaching visits with the District Health Teams to 18 SMGL sites** (Quarters 2-3). The coaching visits focused on supporting the sites to come up with possible interventions to improve documentation and monitor performance, address the myths and misconceptions that were affecting FP use, and address gaps in the processes of care in the integration of FP into MNCH services at maternity, postnatal care, and young child care clinics.
- **Conducted a baseline assessment** (Quarter 2).
- **Supported 18 FP-MNCH participating sites to address gaps in the processes of care in the integration of family planning into maternal, newborn, and child health care services at maternity, postnatal care, and the young child clinics through onsite QI coaching sessions** (Quarter 4). The major focus areas for improvement were: appropriate referral of clients in need of family planning contraceptives not available at a given time; documentation of the improvement work; and availability of FP contraceptives. Copies of order forms for reproductive health commodities not listed on the standard form for essential medicines were issued to all sites. Site teams were reminded of the submission dates, and health center IIIs who are under the push system were encouraged to send their orders through their respective health sub districts at the health center IVs.

RESULTS

Improvement in Key Indicators

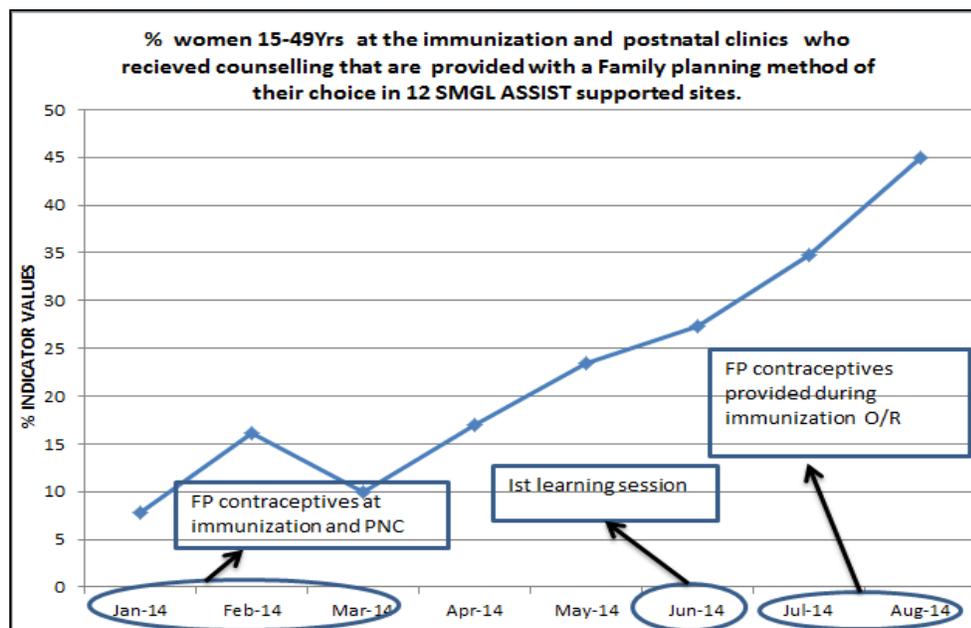
Activity	Indicator	Baseline	Last value	Magnitude of Improvement (percentage points)
Improve FP/MNCH integration	% of women 15-49 years attending young child care/immunization and PNC clinics who received FP counselling	38.2% (Jan 2014) 10 sites	91.3% (Aug 2014) 12 sites	53.1
	% of women 15-49 years attending young child care/immunization and PNC clinics who received counselling and are provided with a modern FP method of their choice.	7.8% (Jan 2014) 10 sites	45% (Aug 2014) 12 sites	37.2

- **Increase in percentage of women who received counselling and are provided with FP method of choice** (Figure 14).

SPREAD OF IMPROVEMENT

With the same approach as in FY14, in FY15 USAID ASSIST will use the lessons learned in the integration of family planning into maternal, newborn, and child health to support sites to improve the quality of family planning services at outpatient and HIV services in the 18 SMGL supported sites.

Figure 14: Percentage of women (15-49 years) at the immunization and postnatal clinics who received counselling and who were provided with a family planning method of their choice, 12 sites (Jan – Aug 2014)



Activity 7. Improve quality of OVC services

BACKGROUND

A situational analysis of vulnerable children conducted in 2010 by the MGLSD estimated that 8.1 million (about 51%) of Uganda’s children are moderately to critically vulnerable and require support to improve their livelihoods.

The high levels of vulnerability are attributed to poverty, HIV, internal conflicts, and other social economic factors. The report further explains that of the 8.1 million children, only 11% receive external support services. Even the small fractions of vulnerable children who receive support receive fragmented services that do not necessarily meet all their basic needs. This suggests that a large number of vulnerable children do not have their basic needs met, and therefore cannot compare to non-vulnerable children.

The line ministry in charge of orphans and vulnerable children in Uganda—MGLSD—provided guidance through policies and guidelines to support implementation of activities geared towards addressing the plight of the orphans and vulnerable children. National quality standards and service level standards were developed to guide implementers to provide quality services to vulnerable children. The current National Strategic Program Plan for OVC (NSPPI 2) stipulates the need for coordinated response to reduce vulnerability of the children and improve their wellbeing.

Whereas the Ministry and partners have done a remarkable job at the national level to ensure that services for vulnerable children are up to standards, there is a need to improve at the service delivery level to ensure that more children are provided support according to their needs. To this end, ASSIST is working with the MGLSD to support the application of modern quality improvement approaches to improve the delivery of OVC services at the community delivery level, and support the national level to coordinate and institutionalize these efforts. In FY13, USAID ASSIST established an OVC QI collaborative (a network of teams working to close the same gaps and regularly exchange successes and challenges) in four districts of Uganda supported by USAID OVC partners Sustainable Comprehensive Responses for Vulnerable Children and Families (SCORE), Inter-Religious Council of Uganda (IRCU), and Strengthening the Ugandan National Response for Implementation of Services for Orphans and Vulnerable Children to demonstrate the application of QI approaches to improve OVC services. The collaborative works with the national OVC structures, district and sub-county structures, and CSOs

supported by SCORE and IRCU projects.

In FY14, together with the MGLSD, USAID ASSIST utilized this network of partners, CSOs, villages and districts to ensure QI approaches are used to get the right OVC to receive the right services. This entailed setting up and supporting elaborate QI structures at CSO and village levels, which would inform the decisions made and activities supported by the national structure and supporting IPs.

ACCOMPLISHMENTS

- **Conducted learning sessions** (Quarters 2 and 3).
 - Teams were guided to select other areas for improvement work; for example, two teams (RUDFA and The Salvation Army) decided to work on improving sanitation among OVC households, and two other teams (Agape and Kakinga) selected increasing the proportion of vulnerable children who receive HIV counselling and testing.
 - The sub-county community development officers who had formed village child protection committees to improve community participation, ownership, and management of vulnerable children at the village level shared progress made and plans for scale-up.
- **Supported the improvement of regular school attendance.** The following change was tested: Engaged vulnerable households to monitor and report their children's school attendance. In Busia, The Salvation Army introduced a change of monitoring school attendance at the school through assigned teachers and community volunteers using specially designed school attendance sheets. In Rukungiri, RUDFA tested use of interest-free loans from the social welfare fund in the village savings and loan associations (VSLA) for purchase of materials for children to attend school.
- **Supported the improvement of birth registration.** The following changes were implemented: The Salvation Army introduced cost sharing so that vulnerable households would obtain birth registration certificates at 70% of the set fees. Community dialogues have been held to inform caregivers on the importance of birth registration and the process of obtaining the certificates. VSLA meetings have been used as an avenue to encourage member households to obtain birth registration certificates, with some groups offering to buy the certificates for the most vulnerable children and providing interest-free loans to members to pay for the registration certificates.
- **Supported the improvement of household economic strengthening.** To support vulnerable households to improve their social economic status, OVC service providers have supported the formation of household economic strengthening groups provided with skills to work together, save money, and generate capital for income-generating activities. The service provider teams improved follow-up and support for the groups through monthly support focused on improving members' monthly meeting attendance, savings, and other social challenges identified during their regular meetings.
- **Conducted eight coaching sessions** (Oct/Nov 2013, Dec 2013, Jan 2014, Feb/Mar 2014, April/May, June, July/Aug and Sept 2014) at 10 CSOs, 26 villages, and four child care institutions. The CSO teams were facilitated to collect baseline, identify gaps, and test changes for the newly introduced improvement aims.
- **Conducted three learning sessions** (Dec 2013, March and June 2014). The learning sessions involved CSOs, sub-counties representatives, MGLSD, and supported implementing partners Inter-Religious Council of Uganda and (IRCU and SCORE). Teams shared changes that had been implemented over the last action period and implementation challenges.
- **Two harvest meetings** were held to systematically document changes for improving saving among vulnerable households. Harvest meeting for CSOs was in June and for the village committees in September 2014. Documentation of the change package is currently underway, to compile the changes harvested by the implementing teams.
- **A one-day coaches' training was held in September 2014 after the harvest meeting to orient 10 community development officers on the roles of coaches** and prepare them to support scale-up of lessons learned so far in improving services for vulnerable children.
- **Facilitated MGLSD activities at the national level with a goal of sharing the progress of the improvement work and strengthening buy-in.** These activities included:

- Provided funds to hold the Kampala-based OVC service providers meeting (May 2014). The meeting brought together 50 participants from the major OVC implementing partners. ASSIST made a presentation on using a quality improvement approach to improve service delivery to share experiences and results.
- ASSIST facilitated the senior social welfare and probation officer of Rukungiri District to share results and experiences of the village child protection committees at the national review meeting for the National Strategic Program Plan of Intervention for OVC (NSPPI -2) (June 2014).
- ASSIST collaborated with the MGLSD to organize and conduct a field visit to Mukono District for the Permanent Secretary of the ministry (July 2014). The goal of the visit was to familiarize the Permanent Secretary with interventions to support OVC through the government structures and the community.
- Two ASSIST Uganda technical staff participated in the ASSIST OVC design content meeting held in Dar es Salaam at the end of June.

RESULTS

Improvement in Key Indicators

Activity	Indicator	Baseline	Last value	Magnitude of Improvement (percentage points)
Improve quality of OVC services	% of performance in all standards at 10 CSOs that are in green (>90%)	2% (April 2013) 10 CSOs	54% (June 2014) 10 CSOs	52
	% of OVC households saving regularly	56.5% (Apr 2013) 5 sites	88.7% (Aug 2014) 9 sites	32.2
	% of vulnerable children with birth registration	3% (July 2013) 2 sites	31% (Aug 2014) 6 sites	28
	% of OVC and their care givers with a known HIV status	20% (Feb 2014) 1 site	59.5% (Aug 2014) 1 site	39.5
	% of OVC households with proper sanitation	7% (Apr 2014) 1 CSO	52% (Aug 2014) 1 CSO	45
	% of vulnerable children identified and linked to services of need in the communities	4% (Aug 2013) 2 villages	49% (Sept 2014) 11 villages	45
	% of vulnerable children linked and received services of need in the communities	33% (Sep 2013) 7 sites	99% (Sept 2014) 10 sites	66
	% of children out of school re-enrolled back to school	3% (Aug 2013) 4 villages	69% (Sept 2014) 13 villages	66
	% of children with known families resettled	17% (Oct 2013) 1 site	66% (Sept 2014) 1 site	49

- **Increased percentage of vulnerable children with known HIV status:** In February 2014, Agape Nyakibale reported 20% of vulnerable children and care givers had a known HIV status; since then the team has tested several changes to increase access to HIV testing and counselling, reaching a level of 62% by September 2014 (Figure 15).
- **Increased number of vulnerable children registered, linked, and receiving needed services in 24 villages.** The village child protection committees have worked with the community development officers who have mobilized resources such as scholarships and bursaries to enable children who were out of school to return to school. In Amuru, the committees were used to enforce the education by-laws set by the sub-county to ensure that all caregivers commit to providing the basics for their

children to be in school. Those care givers who have been identified as critically vulnerable have been linked to community organizations and government community development funds to support them start income generation activities. This has contributed to improvement from seven individuals identified in August 2013 to 1,470 in August 2014 (Figure 16).

Figure 15: Percentage of vulnerable children with known HIV status, Agape Nyakibale site (Feb – Sept 2014)

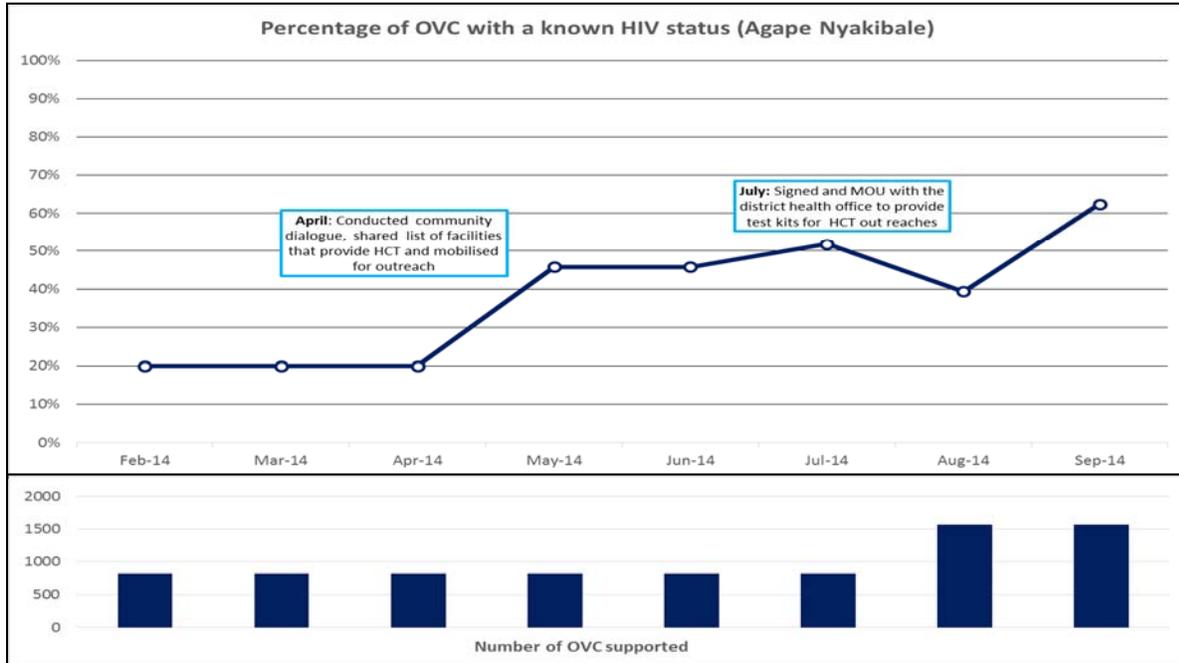


Figure 16: Number of vulnerable children registered, linked and received services of need, 24 villages (Aug 2013 – Aug 2014)

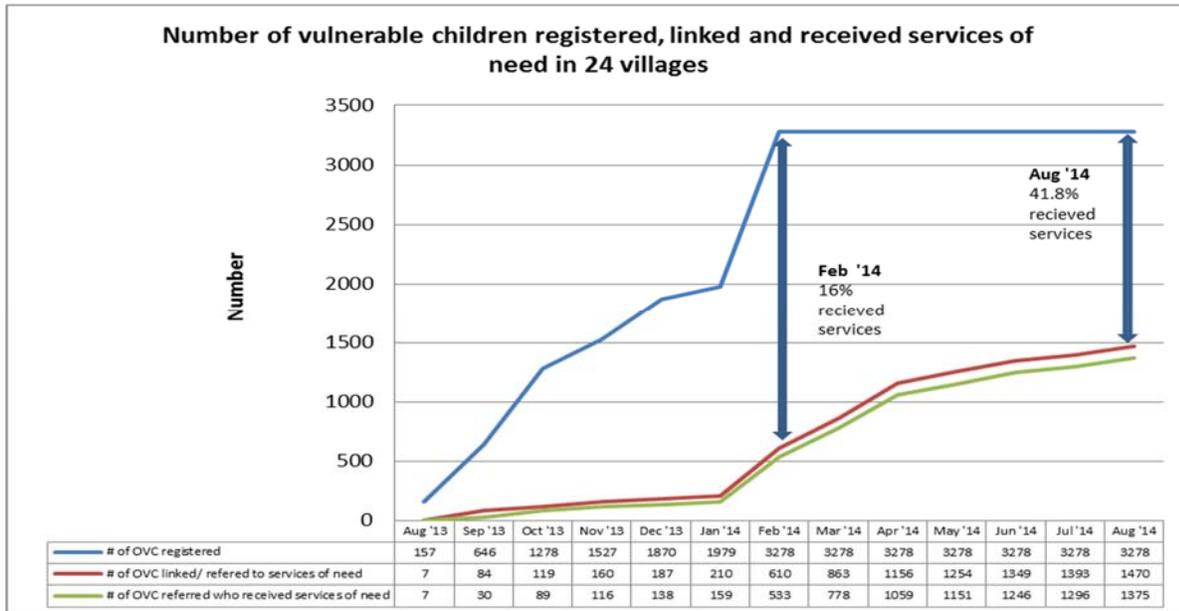
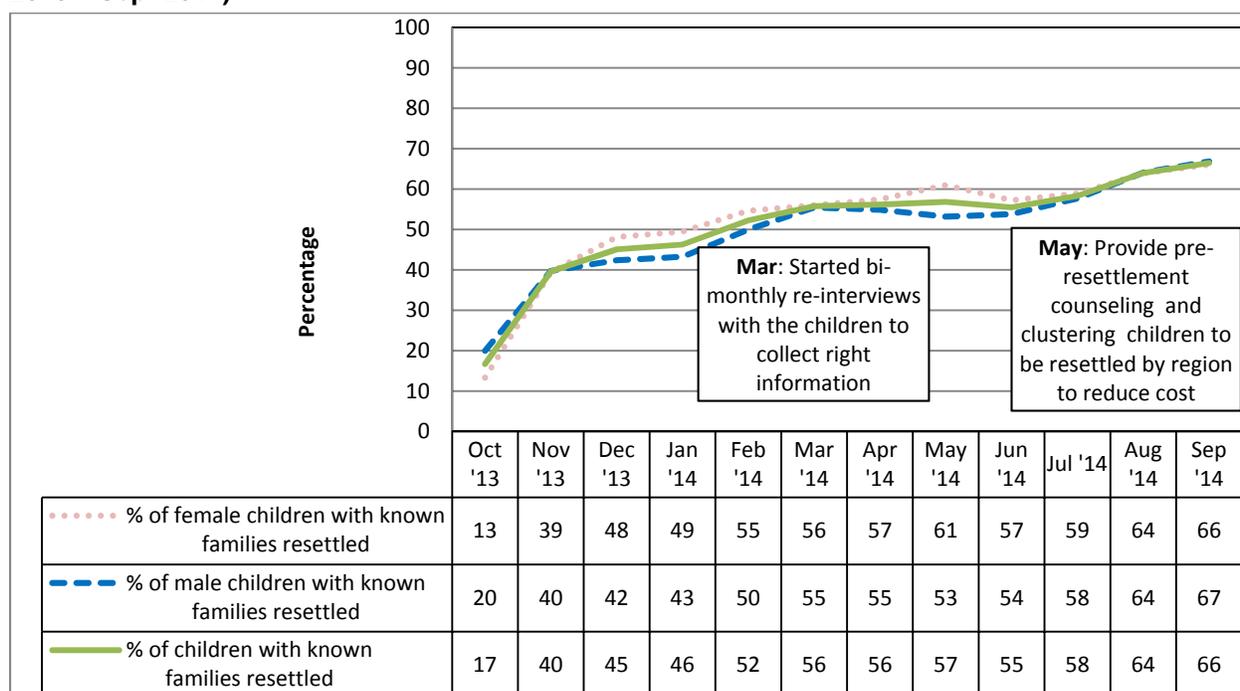


Figure 17 shows improvement at Naguru reception center. Guidance has been provided to the district probation and welfare officer to support Naguru reception center to use QI to improve services to children with aim of improving family re-unification. The children's home was assessed, quality gaps identified, and an improvement plan developed to increase resettlement of children back into their communities.

Figure 17: Percentage of children by sex who have been resettled by Naguru reception center (Oct 2013 – Sept 2014)



SPREAD OF IMPROVEMENT

In the FY15, USAID ASSIST will spread the QI interventions to 10 more districts. Discussions have been conducted with implementing partners SCORE and UPHS that took over IRCU sites and the Ministry of Gender, Labor, and Social Development to decide on the sites and districts. In the spread districts, USAID ASSIST will work with the local district and sub-county OVC structures in one sub-county supported by the implementing partners and build their capacity through joint QI activities. The district, sub-county, and implementing partners will be expected to use their resources to scale up the lessons learned beyond the selected sub-county with limited support in form of change packages and guides from USAID ASSIST.

4 Sustainability and Institutionalization

ASSIST's strategy in Uganda focused on capacitating Ministry of Health structures at national, regional, district, and facility levels to make measurable improvements in quality of care. While ASSIST has been directed to work through USG-funded implementing partners on a number of activities in Uganda, the project consistently engages MOH staff from regional and district levels in all its work to support improvement in facilities supported by implementing partners.

The project has also worked extensively to support the MOH in harmonizing all improvement activities with the Ministry QI Framework and Strategy and to spread the application of improvement methods beyond HIV. Jointly with the MOH Quality Assurance Department, ASSIST is support the establishment and functionality of the Rwenzori Region quality improvement framework and strategic plan structures at the regional, district, health sub district, and site levels to support improvement across all areas of care. This pilot activity will inform national-level roll-out of the QI Framework and Strategy.

5 Research and Evaluation

- Dr. Sarah Smith Lunsford, ASSIST Research and Evaluation Advisor, conducted virtual training on qualitative interviewing for the Uganda safe male circumcision data collection in August 2014.
- Dr. Edward Broughton, ASSIST Research and Evaluation Director, met with the Uganda monitoring and evaluation team to discuss how to go about the validation of improvement data for all of the

improvement activities in March 2014. The process was begun to define what the total number of indicators that are being reported for improvement activities are across all programs underway in the country. Dr. Broughton also presented on difference-in-difference analysis for program evaluation. The presentation was done for those involved in data collection, entry, and other aspects of the Safe Male Circumcision Knowledge Management (SMaCKM) study and chronic care program evaluation in Nakaseke and Mityana. Dr. Broughton also reviewed the statistical analysis that will be an important part of the evaluation of the chronic care study with Martin Muhire, the Improvement Advisor most responsible for managing the study on the ground. Dr. Broughton also met with the finance and administration staff to clarify what cost data are required for the economic analysis of the chronic care model.

- Submitted a concept note in September 2014 for a study “Assessing the cost-effectiveness of supporting savings groups to improve OVC access to services in Uganda” to the USAID Uganda Mission for approval.
- ASSIST is working in Uganda to spread the improvement of safe medical circumcision in Uganda using knowledge management methods. The SMaCKM study is currently being conducted in 15 sites, in partnership with Johns Hopkins Center for Communication Programs and is using a three-armed comparison, with sites randomly assigned to one of the following arms:
 - Provision of written materials
 - Provision of written materials with an in-person handover meeting
 - Provision of written materials with an in-person handover meeting and follow-up coaching from a District Health Office or IP

Using direct observation of circumcision provision, this study will seek to answer:

- What is change in the quality of male circumcision services delivered?
- Which dissemination method is more effective in improving care?
- What is the cost-effectiveness of different dissemination methods?
- How was KM implemented in the field?
- What KM methods do health care providers prefer?
- Baseline data collection began after URC received Institutional Review Board approval for this study from Makerere University and from URC. The development of the knowledge products used in the study along with the endline data collection will take place and conclude in the middle of FY15.
- In an effort to support country-wide learning in improvement initiatives, ASSIST conducted an information needs assessment with government and NGO staff working at the national and district levels of the Ugandan health system from March 2014 to June 2014. The 25 individuals interviewed included policy-makers, program managers, and health care providers; they were asked to share what quality improvement work they are currently undertaking, preferred communication tools, access to resources such as mobile phones and the Internet, and on what quality important topics they need more information for their work. The assessment findings point to the use of mobile networks, the development of synthesized print and electronic resources, and content development and management improvements to the existing MOH knowledge management web portal.

6 Knowledge Management Products and Activities

During FY14, a number of knowledge and communication products were developed by the Uganda team.

- With the launch of the ASSIST knowledge portal, the team published [11 blogs](#) chronicling success of programs and staff experience. During FY14, six case studies were been published by the Uganda ASSIST team covering SMC, SMGL, and OVC activities. The case studies are
 - Successfully Providing Essential Newborn Care for Term and Premature Babies: A Midwife’s Perspective (January 2014)
 - Organizing for obstetric emergencies: How Kabarole Hospital in Western Uganda is saving mothers’ lives (January 2014)
 - Improving income-generating activities for vulnerable children and families at Agape Nyakibare Civil Society Organization (January 2014)
 - A Fast Turn-around for Mengo Hospital: Improving the Quality of Safe Male Circumcision Services (February 2014)
 - Safe male circumcision: Improving client follow-up at Gulu Regional Referral Hospital, Uganda (June 2014)

- The role of improvement teams in managing male circumcision-related adverse events: The experience of the mobile van clinic in Uganda (June 2014)
- As a part of the PHFS activity, three change packages were developed and finalized on data quality, routine visits, and retention of mother-baby pairs. The PHFS team tailored these packages as the best way to compile and share knowledge on the changes resulting in improvement in addition to guide spread sites.
- A technical report entitled "[Applying the Chronic Care Model to Health System Design in Low-resource Settings: Lessons from HIV Improvement Interventions](#)" was published in July 2014.
- An abstract was accepted for oral presentation to the Third Global Symposium on Health Systems Research in South Africa titled: "[Experiences of how patients are involved in tracking fellow patients back to HIV chronic care at a health centre III in Uganda](#)"
- Developed a poster presentation titled: "[Sustaining HIV care and treatment outcomes in resource limited settings; Lessons from a quality improvement Intervention in Buikwe district, Uganda](#)". This was presented at the International AIDS conference 2014, Melbourne, Australia on July 22nd 2014.
- The OVC team developed an OVC QI brochure and a short technical report. Two change packages are in development.

7 Gender Integration Activities

Continuum of Response: ASSIST worked to integrate gender into the COR and identified several gender-related gaps and challenges that the team has worked to address. Challenges identified include: More women than men were being initiated on ART among TB/HIV co-infected clients; stronger health-seeking behavior among women; more women than men were contacted with follow-up care/check-ins; and a greater number of male clients were being tested, linked and enrolled in care HIV care. The ASSIST team also identified gender-issues related alcohol use among men, health providers' attitude towards men in the facility. The percentage of male and female PLHIV linked to the community improved from an average of 86% to 90%, due in part to the use of community-based "mentor mothers" who linked HIV-infected mothers to the community. The numbers of males and females PLHIV that were followed up with after initial care improved, now both sexes are followed up on in nearly equal proportions.

SMC: ASSIST identified that the lack of female partner involvement negatively impacted SMC outcomes, including follow-up, post-operative care, and adherence to sexual abstinence requirements. The team found it effective to engage female partners in SMC counselling so they could learn about the health benefits and care requirements, address stigma, and ask questions about the procedure and postoperative care. The creation of female-friendly SMC clinics that offered services for both males and females helped engage female partners, although couples sometimes have a hard time attending SMC clinic visits together because of the female partner's unavailability due to household chores. It has also been challenging trying to integrate gender considerations at all facilities due to time and resource constraints. To combat this, the team decided to scale back on the number of health facilities they are tracking gender-related SMC data so that higher quality data can be collected and the methodology can be improved before scaling up.

PHFS: ASSIST integrated gender into PHFS to improve retention rates of HIV-positive mother-baby pairs, by identifying gender-related barriers and working to overcome them. Twenty rural clinics began utilizing the following gender-specific interventions: Encouraging male partner involvement, involving male community leaders/volunteer health workers, utilizing family support groups, and offering male-focused services at clinics. The interventions appear to have increased retention rates of HIV-positive mothers and their babies in ART; the Ivukula facility achieved and has maintained for several months 100% retention of mother-baby pairs as a result of gender integration and other changes. Facilities that continue to face challenges are working to test the following changes: Calling husbands and involving community and religious leaders to encourage men to support their female partners maintain appointments and providing financial support to enable male partners to come to the facility. Across all clinics, the overall retention rate of mother-baby pairs has increased from 2.2% at baseline, to 60.8% in April 2014.

MNCH: Based on the field visit of Dr. Taroub Faramand, President of WI-HER, to Uganda in July 2014, the following gender-related issues were identified that may be contributing to high maternal and perinatal deaths: Late referral to facilities, lack of financial resources for delivery at a facility, lack of transportation, and decision making power to access and utilize care. ASSIST recognized that the engagement of male

partners/fathers in couples counselling and the involvement of partners/fathers at their female partner's visits to maternity clinics has been effective. Sites are tracking male involvement through improved couple counselling and male involvement at maternity and young child/postnatal care clinics. Kyenjojo Hospital and Ntara HC IV have revised their required care strategy so that men are counselled with their female partners upon her admission into care, before the male partner returns home. If feasible and desired by the female partner, male partners are also encouraged to accompany their wives during the delivery and attend a health education class and group counselling. For women admitted early into care, health care providers now postpone counselling sessions until the couple can attend together.

OVC: ASSIST identified gender gaps in school reintegration for male and female vulnerable children. Teams worked to address the following challenges in the economic empowerment program: The potential increase of gender-based violence against women who live in households with a male partner and are participating in income-generating programs, and the potential lack of spending on vulnerable children by men who participate in income-generating programs and earn money, but choose not to spend money on their children. The team identified that fathers need to be sensitized to the needs of their children.

At the CSO level: In three CSOs, focus group discussions were conducted with members of the saving groups to identify the prevalence of violence in the households. One CSO, Agape, reported cases of gender-based violence. Three women had dropped out of the saving groups due to experiencing gender-based violence. In further discussions the women indicated that they did not want to report their partners for fear of imprisonment that would affect relationships in their families. They suggested the use of social structures in the community such as the religious leaders and community elders to help with the family problems as opposed to using the legal channels such as the police. Agape has since set up counselling services with a contact person as the social worker to whom cases of violence are reported and support services provided to the family. Most recently there was no reported case of gender-based violence, and the CSO plans to expand the counselling services and provide an opportunity for all saving group members to meet a social worker.

At the village level: In Busia, an assessment was conducted of the saving groups for vulnerable households formed by the village child protection committees to identify if participation of both women and men had equal effects on the wellbeing of their children. The assessment found that before the saving groups, children of male members were much less likely to attend school, but after the intervention, they were equally likely to attend school. Before the formation of the saving group in November 2013, 20/34 (58.8%) of children of the future male savings group members were regularly attending school compared to 59/71 (83.1%) children of the future women savings group members. The households cited lack of scholastic materials and food packed for school as the main reasons for low school attendance. After formation of the saving group, households that did not have a source of income were introduced to opportunities through other members' experiences to create income-generating activities. By July 2014 33/34 (97%) children of the male members were regularly attending school; only one child with epilepsy who was receiving treatment from Masafu hospital was not in school, while 75/75 (100%) children of female members were regularly attending school, including four children who were out-of-school and had returned to school. Enrollment in savings groups appeared to have the same positive impact on child's school attendance for both men and women.

Gender integration trainings: Dr. Faramand conducted three visits to Uganda during FY14 (in March, July, and September 2014), to support the Uganda team to integrate gender across all technical areas. She conducted gender integration trainings for staff and travelled to the field to support teams to integrate gender, including the PHFS, SMC, OVC, and COR programs.

The ASSIST Uganda team collected the following sex-disaggregated and gender-sensitive indicators during FY14:

- Percentage of newly tested positive for HIV linked & enrolled into HIV care at the facility
- Percentage of TV/HIV co-infected clients that are on the ART
- Percentage of TB/HIV co-infected clients on/completing TB treatment
- Percentage of pre-ART clients retained in care 12 months after enrollment
- Re-enrolling children in school by sex
- % of SMC clients what attend with their partners at 18 sites at Buyinja HC IV
- Number of SMC clients who attended group education with their partners
- % of female patients who attend ANC or PMTCT clinic with male partner

8 Directions for FY15

HIV COR	<ul style="list-style-type: none"> • Conduct the 3rd HIV COR learning session and 2nd harvest meeting with a focus on improvement of retention in each of the four regions of East / East Central, South Western, Northern, and Central Uganda • Attend District Management Committee meetings in supported districts • Conduct gender analysis by doing data analysis on some HIV COR indicators which have shown some notable disparities between sexes in terms of service access and continuity in care • Disaggregate data by age to capture services targeting the youth. This will determine a baseline for the youth in care and services offered to provide more youth-friendly services in the HIV COR • Conduct coaching sessions to support team performance in 18 villages and 3 health facilities • Conduct 2 learning sessions for the 18 villages to promote sharing knowledge and learning • Hold a meeting with community service providers for HIV patients
SMC	<ul style="list-style-type: none"> • Conduct monthly onsite coaching • Conduct orientation of new coaches • Conduct handover meeting • Conduct learning session • Support MOH to convene National Task Force meeting
PHFS	<ul style="list-style-type: none"> • Conduct 5th learning session for the demonstration sites • Conduct harvest meeting for the special visits • Conduct coaches' meeting to plan for spread and orient new coaches • Share and make a presentation to the MOH Senior Management Committee on the PHFS change package so that it can be endorsed and used nationally • Work with MOH to plan for the scale-up phase • Get 3 additional sites to test changes around male involvement in EMTCT care
SMGL	<ul style="list-style-type: none"> • Conduct a baseline MNCH QI Assessment in 10 new SMGL scale-up facilities and QI training to 10 new SMGL scale-up facilities • Conduct monthly QI coaching visits in 10 new SMGL scale-up facilities and bimonthly coaching in 30 facilities of the SMGL learning districts • Conduct a coaches' review meeting to orient them on the newborn care indicators, modified improvement strategy and objectives for FY15 • Conduct an SMGL QI stakeholders meeting involving implementing partners, SMGL district health leaders, and facility in-charges to discuss QI implementation and spread strategy among the SMGL implementing facilities
OVC	<ul style="list-style-type: none"> • Hold a stakeholders meeting with the local government officials and OVC partners to discuss their roles in the implementation of quality improvement activities • Conduct QI training for the new scaled up CSOs and new coaches • Conduct joint coaching with district coaches • Research protocols: Suggested research questions will be submitted to USAID for approval, and research protocols developed and submitted to the Institutional Review Boards • Conduct gender analysis for two communities in Busia and develop an improvement aim focused on reducing gender-based violence in the community

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

Tel: (301) 654-8338

Fax: (301) 941-8427

www.usaidassist.org