USAID ASSIST Project

Applying Science to Strengthen and Improve Systems

USAID ASSIST Project

Uganda Country Report FY13

Cooperative Agreement Number:

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Performance Period:

October 1, 2012 – September 30, 2013

DECEMBER 2013

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DISCLAIMER

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

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Abbreviations

AIMGAPS	Assuring Infants and Mothers Get All PMTCT Services
AMTSL	Active Management of the Third Stage of Labor
ART	Antiretroviral Therapy
ASSIST	Applying Science to Strengthen and Improve Systems
CDC	Center for Disease Control
CDO	Community Development officers
CME	Continuous Medical Education
CSA	Community Support Agents
CSO	Civil Society Organizations
DOD	Department of Defense
EID	Exposed Infant Diagnosis
ENBC	Essential Newborn Care
ENC	Essential Newborn Care
EQA	External Quality Assessment
FP	Family Planning
HBB	Helping Babies Breathe
HCI	Health Care Improvement Project
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HSSIP	Health Sector Strategic and Investment Plan
IRB	Institutional Review Board
IRCU	Inter-Religious Council of Uganda
IYCF	Infant and Young Child Feeding
MGLSD	Ministry of Gender, Labor and Social Development
MMR	Maternal Mortality Ratio
MNCH	Maternal Neonatal Child Health
MUWRP	Makerere University Walter Reed Project
NACS	Nutrition Assessment, Counseling and Support
NSPPI-2	National strategic program plan for interventions
NTF	National Task Force
NUHITES	Northern Uganda Health Integration for Enhanced Services
OVC	Orphan and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PHA	People with HIV/AIDS
PHFS	Partnership for HIV-Free Survival
PPH	Post-Partum Hemorrhage
QAP	Quality Assurance Project
QI	Quality Improvement
QI	Quality Improvement
RH	Reproductive Health
SCORE	Sustainable, COmprehensive REsponses for Vulnerable Children and their Families
SMC	Safe Male Circumcision
SMGL	Saving Mother and Giving Life
SPEAR	Supporting Public Sector Workplaces to Expand Action and Responses Against HIV/AIDS
STAR-E	Strengthening TB and HIV&AIDS Response in Eastern Uganda
STAR-EC	Strengthening TB and HIV&AIDS Response in East Central Uganda
STAR-SW	Strengthening TB and HIV&AIDS Response in South Western Uganda
SUNRISE	Strengthening the Ugandan National Response for Implementation of Services for Orphans and Vulnerable Children
TB	Tuberculosis
UPHS	University of Pennsylvania Health System
URC	University Research Co., LLC
USG	US Government
VHT	Village Health Teams

1 Introduction

University Research Company, LLC (URC) started working in Uganda in 2005 through the USAID Quality Assurance Project (QAP). The success of QAP allowed URC to lead the USAID Health Care Improvement Project (HCI) in 2008, the next generation of continuous quality improvement in Uganda. As the project life cycle of HCI has run its course, URC has been asked to continue its support for quality improvement in the Ugandan health sector through HCI's successor project, the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project.

During FY13, ASSIST provided technical assistance in quality improvement (QI) to the Ministry of Health (MOH), the Ministry of Gender, Labor and Social Development (MGLSD) and to implementing partners (IPs) supported by USAID, the Department of Defense (DOD), Walter Reed, and the CDC. The overall goal of the work was to provide quality health care and orphans and vulnerable children (OVC) services to clients and to build a system through which these services can be delivered in a sustainable way. The project objectives included:

- Build the capacity of US government (USG) partners to improve quality of HIV/AIDS, tuberculosis (TB), maternal neonatal child health (MNCH), reproductive health (RH), family planning (FP), nutrition, and OVC services in Uganda.
- Build the capacity of the MOH and MGLSD to coordinate and oversee implementation of national QI plans and strategies.

During FY13 the project supported the following technical areas:

- HIV care and treatment, including TB-HIV integration
- Safe male circumcision as part of the national comprehensive HIV prevention strategy
- Partnership for free HIV survival
- Prevention of mother-to-child transmission of HIV
- Maternal and newborn health as part of the Saving Mothers Giving Life (SMGL) initiative
- Family planning integration into HIV and MNCH care
- OVC quality improvement

To ensure government ownership, ASSIST worked with the responsible ministries and government structures for each technical area and with the leaders at the district and facility levels to ensure that services are coordinated and resources are used in the most optimal way. In addition – and relating to both of these objectives – the project worked in FY13 to generate new knowledge and evidence-based best practices in QI as part of a continuous learning and adapting agenda. Throughout the year, ASSIST staff documented what they learned and continuously shared information with the ministries and other partners.

2 Program Overview

What are we trying to accomplish?	How will we know?	At what scale?
1. Improve HIV Care and Treatment through the Continuum of Response (COR) • HIV counseling and testing • Prevention messages for the HIV negative • Antiretroviral therapy (ART) initiation for the eligible HIV positive • Retention in care, clinical outcomes • Early infant diagnosis and	• Proportion counseled and tested who get their results • Percentage of eligible ART clients started on ART • Percentage of ART clients retained in care • Percentage of infants initiated into care • Percentage of ART clients clinically well • Percentage of HIV patients screened for TB • Percentage of HIV/TB co-infected patients started on TB treatment	51 sites in 39 districts Engaging leaders: 12 sites in three districts

What are we trying to accomplish?	How will we know?	At what scale?
treatment • Engage facility leaders to participate in QI activities • Improve management of patients with TB/HIV co-infection • Community linkages and follow up	• HIV/TB completion • Proportion of sites with improvement aims • Percentage of clients retained in care • Percentage of clients with a good clinical outcome	
2. Safe Male Circumcision (SMC) services • Work with MOH and partners to follow the MOH standard operating procedures to guide clinical practice in line with WHO recommended guidelines. • Improve quality of SMC services	• Proportion of sites adhering to standards • Proportion of clients counseled before the operation • Proportion of adverse events following SMC services • Proportion of clients that are followed up after SMC	30 sites in 26 districts
3. Partnership for HIV-Free Survival • Increase coverage, retention and outcomes of mothers and infants accessing Mother-to-Child Transmission of HIV (eMTCT) and NACS services.	• Proportion of infants born to HIV-positive women in eMTCT programs that are alive at 12 months of age and HIV negative • Number and proportion of infants and mothers who are found to be malnourished at any point during the reporting period	22 sites in six PFHS supported districts
4. Improve Maternal and Newborn Health • Contribute to the collective efforts of partners to reduce maternal and perinatal mortality in the four SMGL districts	• Proportion of mothers whose pregnancy is monitored using a partogram • Proportion of mothers in labor who receive AMTSL • Percent of newborn babies receiving essential newborn care • Proportion of maternal deaths • Proportion of perinatal deaths	Facilities in four districts
5. Family Planning • Integrate FP into HIV and maternal health	• Proportion of clients attending HIV and MNCH clinics that are counseled on FP services • % HIV positive clients of reproductive age and leaving the facility with a modern FP method of their choice, post obstetric event	17 SMGL sites in four districts
6. Improving and Institutionalizing QI in the health sector • Form QI committees in accordance with the MOH national QI framework and strategy	• Number of partners supporting the QI framework and site/districts with functional QI teams will serve as a measure towards institutionalization • Number of IPs supported and joint plans made will be an indicator of the support we are providing to the other USG partners	National (112 districts)
7. Develop an OVC national QI framework and institutionalize QI	• Proportion of Civil Society Organizations (CSOs) correctly and consistently using national standard tools for identification,	10 CSOs in four districts

What are we trying to accomplish?	How will we know?	At what scale?
in OVC • Support the MGLSD, SCORE and other OVC partners to incorporate QI into OVC assessment, care, referral, follow up, and measurement of social status outcomes. • Improve access to essential services for orphans and other vulnerable children and their caregivers	selection, care and follow-up of vulnerable children • Proportion of CSOs continuously testing changes to improve service delivery to vulnerable children • Proportion of CSOs improving in adherence to OVC standards • Proportion of CSOs with appropriate referral and linkages to ensure provision of at least three core program areas plus psychosocial support to vulnerable children	

3 Key Activities, Accomplishments, and Results

Activity 1. Continuum of Response: Improving HIV care, treatment, and support

Background

The Republic of Uganda has an estimated population of 34 million people (Government of Uganda, 2011-2012), with an HIV prevalence rate of 7.3%. Approximately 2.5 million people are infected with HIV. In the last decade the Government of Uganda has rapidly scaled up HIV care services to lower health facilities (levels IV and III), in collaboration with health development partners.

The objectives of this activity were to improve HIV care and treatment through improved coverage, retention, and clinical outcomes. The activities built on the successes that were achieved under the HCI project. Technical areas that were supported included ART follow-up, TB screening and care, HIV counselling and testing, care for people with HIV attending private for-profit clinics, and integration of QI into community health activities to improve linkages to facility health services, adherence and long-term retention.

In addition, in FY13 ASSIST focused on increasing leadership involvement in QI. This work was started under HCI where the project worked with leaders in 13 health facilities in three districts in Uganda and developed eight core functions for leaders to focus on: coordination, results-oriented accountability, prioritization, capacity building, patient-centered care, motivation, participation in improvement work, and leveraging available resources. Under ASSIST, the project continues to work with these facilities and districts to learn more about the role of leaders in supporting improvement work.

Accomplishments and Results

Activity 1(a). HIV Continuum of Response (facility component)

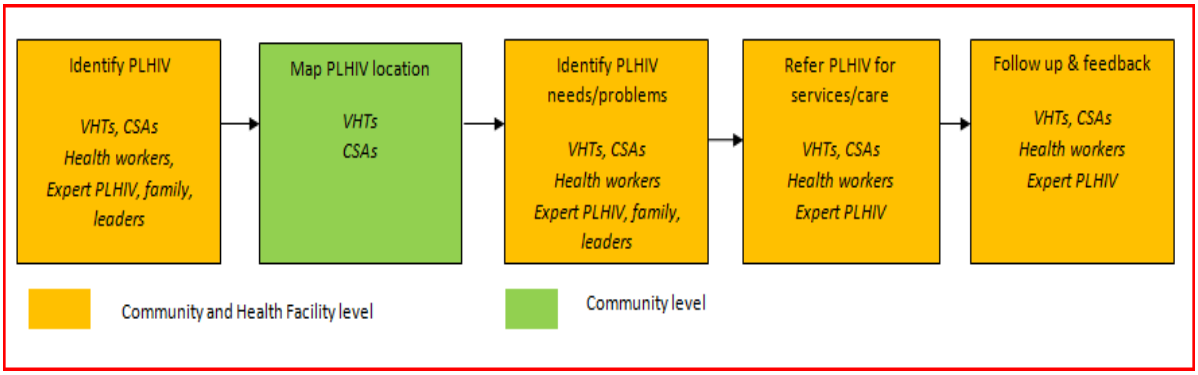
- **Developed joint work plans with partners:** Developed joint work plans with nine IPs (STAR-EC, STAR-E, STAR-SW, NUHITES, Mildmay, IRCU, MUWRP, UPHS and SPEAR) and identified and agreed upon 51 sites for intensive support (roughly 10 sites in each of the four regions of Uganda). The selection of the sites was done in collaboration with the USAID partner working in that region. The criteria for selection included high patient load, existing gaps in coverage, retention and clinical wellness. Memorandums of Understanding (MOUs) were developed for review by the partners and are awaiting signature.
- **Identified performance and service provision gaps in 51 health facilities through a baseline assessment of HIV/TB care services**: Conducted baseline assessments in the 51 health facilities in the 39 districts supported by nine IPs. Carried out analyses of the results of the baseline assessment and identified site specific gaps in HIV/TB care that needed to be addressed. Gaps in service provision included: low HCT uptake at 48 facilities; poor linkages of HIV positive clients, including HIV positive babies into HIV care; poor linkages of HIV/TB co-infected patients to ART; poor TB treatment completion and cure rates.

- **Supported facilities to identify improvement projects for implementation:** Shared the baseline assessment results with the 47 facilities where data had been collected. Included an additional four private health facilities**.** Supported facilities to identify change ideas that have worked elsewhere through sharing the ART care and treatment and the chronic care change packages generated from the QI work under HCI with the facility QI teams. Forty-eight (48) facilities out of 51 have active QI teams with improvement projects going on and changes are being tracked (apart from Kiswa where it has been challenging to establish an MOU with a partner). Facilities were supported in two coaching sessions each for continuous implementation of the QI projects.
- **Built the capacity of implementing partners to implement HIV/COR in the facilities they support:** Involved the nine IPs in the coaching visits at varying levels and sharing of the dash boards for the HIV/COR indicators. Shared USAID ASSIST work plan and trip plans with the IPs to synchronize activities.

Activity 1(b). HIV Continuum of Response (community component)

- **Conducted a situation analysis on client retention and adherence in three USG partner sites:** In June 2013, data was collected from 1,406 People Living with HIV/AIDS (PLHIV) who attended HIV clinics in Kamuli Hospital, Bugiri Hospital and Kabwohe Health Center IV. In Bugiri and Kamuli Hospitals (STAR EC region) over 90% of the patients adhered to their medications. Appointment keeping in Bugiri and Kamuli Hospitals was 64% and 73% respectively, which was below the national target of 85%.
- **Selected villages for QI intervention:** Following the situation analysis, a total of 14 villages were selected in the STAR EC region. The villages selected were those that contributed to 80% of the retention gap. The villages in STAR SW villages will be selected when data analysis for one health facility is complete or a new site to replace Kabwohe Health Center IV - where retention/adherence gaps don't exist - is done. Analysis of data from the selected STAR SW sites showed no apparent QI gaps in the retention/adherence of HIV clients. Plans are on-going to have partners suggest other areas with QI gaps in HIV for support.
- **Conducted baseline assessment on QI indicators:** A baseline assessment on improvement indicators was conducted in seven villages in Bugiri Hospital's catchment area. The indicators include complete PLHIV referrals, follow ups, adherence support and appointment keeping. There was no documentation on referrals made and follow-up of patients, partly due to lack of a structured community-health facility linkage system and data systems
- **Conducted QI training for community actors:** Conducted two community trainings in Bugiri and Kamuli districts in QI, HIV/AIDS care, and gender. A total of 70 participants comprised of Village Health Teams (VHTs), Community Support Agents (CSAs), Community Development Officers (CDOs), and PLHIV network representatives were trained. In the training we defined a community-health facility linkage process and facilitators for each step. The facilitators in the linkage process guided the community QI team formation as illustrated in Figure 1.

Figure 1: Community-health facility linkage process



- **Formed Community QI teams:** Seven community QI teams were formed in Bugiri district based on the community-health facility linkage steps shown in Figure 1 above. Team roles, leadership, and norms were defined. Action plans were made and some of the changes being tested are listed in Table 1.

Table 1: Changes tested for community-facility linkages

Improvement area	Changes tested
Referral of PLHIV for community follow up	Health facility based expert PLHIV aggregate list of PLHIV scheduled on ART appointment and link them to the district PLHIV coach who distributes to VHTs and CSAs
Complete community-health facility follow up	VHTs, CSAs sign in the PLHIV hand-held care book which is reviewed at the health facility level and recorded as a complete referral.

- **Implementation review meetings held with USG partners:** Three review meetings were held with partners (two meetings with STAR-EC and one with STAR-SW) to share progress reports, joint work plans, budgets, reporting and improvement indicators. As a result improvement indicators were adopted and reporting systems established.

Continuum of Response (community component)

Improvement Strategy

Community QI teams in seven villages in Bugiri District were grouped into an improvement collaborative. An improvement collaborative enables QI teams to work collectively towards a common aim to improved ART retention or adherence.

Spread Strategy

ASSIST included a member of the Bugiri District Health Team on the community coaching team as a step towards sustaining results. Joint work planning, QI training and review meetings were conducted with USG partners to develop their capacity to scale up interventions to other villages.

Activity 1(c). The effectiveness and efficiency of applying the chronic care model (CCM)

- **Conducted coaching visits:** Supported three intervention sites to review the action plans developed in June. Facilitated sites to implement targeted changes to address gaps in provision of HIV chronic care while focusing on selected improvement aims; improvements in records and adherence, helping sites improve clinic efficiency by introducing changes to reduce client waiting time. Facilitated sites to prepare for the first learning session in Q1 FY14. Some of the changes being tested at the facilities are listed in Table 2.

Applying the Chronic Care Model

Improvement Strategy

The collaborative strategy is being used and involves 12 health facilities from three districts (Busia, Kisoro and Manafwa in Kabale and Mbale regions). This collaborative learning network provides an environment for generating and sharing of new knowledge about engaging system leaders in implementing core leadership functions. This strategy is implemented through monthly onsite support to the system leaders and their QI teams; one such support visit was carried out during the fourth quarter.

Activity 1(d). Leadership collaborative

- **Measured the role of leaders in improving QI:** Carried out baseline assessment of leadership involvement in QI, internal and external clients' satisfaction at the new leadership districts and facilities and analysis is ongoing. The baseline assessment showed inadequate support/involvement of leaders and employee engagement in QI. This was the basis for the leadership collaborative and facilities were chosen on the basis that they all participated in the ART framework collaborative, under the same leadership.
- **Established a leadership collaborative:** Established a leadership collaborative in the three districts of Arua, Lwengo and Lyantonde involving 10 facilities to engage the leaders both at site and district levels to improve HIV care (close gaps in coverage, retention and clinical outcome) and at the same time sustain QI results.
- **Organized a harvest meeting for QI leadership collaborative districts/facilities:** Handed knowledge harvested to a set of new districts and facilities.
- **Organized and carried the first joint coaching of leadership districts and facility leaders to support current projects the QI team is implementing**.

Results across the four COR sub-activities are shown in Table 3 from April – August 2013.

Table 2: CCM changes being tested at the facilities

Improvement area	Changes being tested
Increase the proportion of individual clients with complete and correct medical records at the facility	Held a continuous medical education (CME) to teach fellow staff on how to properly update records (two sites). Assigned staff to review a sample of records to ensure they are well filled in (one site). Cards with incomplete records are returned to a respective staff that attended to the patient (one site). All staff asked to fill in care cards if not sure about what to fill in, should ask fellow staff (three sites). Fill all patient records while patient is still at the clinic (two sites). Selected a staff in charge of medical records (one site). Labels are put on the filling cabins (two sites).
Complete community-health facility follow up	VHTs, CSAs sign in the PLHIV hand-held care book which is reviewed at the health facility level and recorded as a complete referral.
Increase the proportion of clients on ART seen at the facility in adhering to their ARVs	Teach patients on how to swallow ARVs (one site). Health education about need to swallow all medicines, when and reminder systems such as asking children to reminder parents to swallow their medicines (three sites). Expert patient record pill balances in the patient treatment book at the triage area as they measure the patient weight (one site). Health workers review treatment books for pill balances recorded and determine patients' adherence level, then document on care card (1 site). Ask patient to come back with pill balances (three sites).
Increase the proportion of clients on ART who seek services at a health facility that wait for less than 30 minutes between each service point in the clinic	Introduced nurse visit (two sites). Assigned staff to do drug refills for stable patients (one site).
Increase the proportion of clients on ART who show stable or improving CD4 counts	Set days when patient CD4 samples will be taken off for testing (three sites). Carry out CD4 tests on non clinic days (one site). Assigned a staff to ensure CD4 tests are done on designated days (one site). Ensure CD4 results are recorded onto patients' charts (two sites).

Table 3: Activity 1: Improvement in key HIV COR indicators in FY13

Activity	Indicators	Baseline (April 2013)	Last value in FY13 (Aug 2013)
HIV Continuum of Response	Percentage of HIV positive eligible clients started on ART	80.1%, 30 sites	71%, 41 sites
	Percentage of HIV positive on ART that are retained in care	87%, 32 sites	79%, 35 sites
	Percentage of TB/HIV co infected clients ever started on ART that are seen in a month	57%, 35 sites	58%, 42 sites
	TB completion rate	42%, 34 sites	40%, 39 sites
	Percentage of HIV positive on ART that are clinically well (working functional status, no weight loss of >2kgs, and no new opportunistic infections)	64%, 36 sites	61%, 41 sites

What Are We Learning?

- How can we identify communities affected by poor retention or adherence?
  - Documentation of PLHIV physical locations on their ART clinic records helps to identify communities with retention or adherence gaps.
- How can we identify participants in community quality improvement teams?
  - It is important to involve partners in the coaching visits; capacity is built for spread to other facilities.
  - Integrating all QI activities under ASSIST on the same day is very difficult and unproductive.
  - There is need to engage the District Health Offices more in the QI activities.
  - Successful implementation of the chronic care model fosters integration of services. This is supported by the fact that staff from other departments come to take part in the coaching meetings.
  - Demonstrating improvements in chronic care requires involvement of patients in self care. Improving records first leads to improvement of other indicators.

Activity 2. Safe Male Circumcision (SMC) Services

Background

SMC is an effective and proven procedure which in clinical trials reduces female-to-male transmission of HIV by 60% (WHO, 2012). In 2010, the MOH developed a policy on safe male circumcision, and in 2011issued minimum standards of procedures to guide the 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 WHO male circumcision services quality assessment toolkit. Several gaps were identified including: lack of a process for regular monitoring of SMC service quality; lack of comprehensive documentation; lack of standardized provider competency 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 counselling; SMC-related data capture; consent process; post-operative follow-up; adverse events monitoring and reporting; emergency preparedness and use of methods of sedation and general anaesthesia that are not recommended.

To expand and improve the quality of SMC services, USAID asked ASSIST to directly support partners and facility-based QI teams in 30 sites in 26 districts.

Safe Male Circumcision

Improvement Strategy

ASSIST is working with the MOH to improve the delivery of SMC services through: Intense support to 30 sites, light support, building MOH QI structures (setting up QI teams at the district and facility levels based on the MOH QI framework and strategic plan) and supporting the MOH SMC task force to meet quarterly to review and provide guidance to the partners carrying out SMC activities.

Spread Strategy

ASSIST has shared tools for QI with the IPs and the change package both at the partner and site levels. During the quarter, ASSIST worked jointly with all stakeholders especially the district health offices in order to promote ownership and sustainability of results.

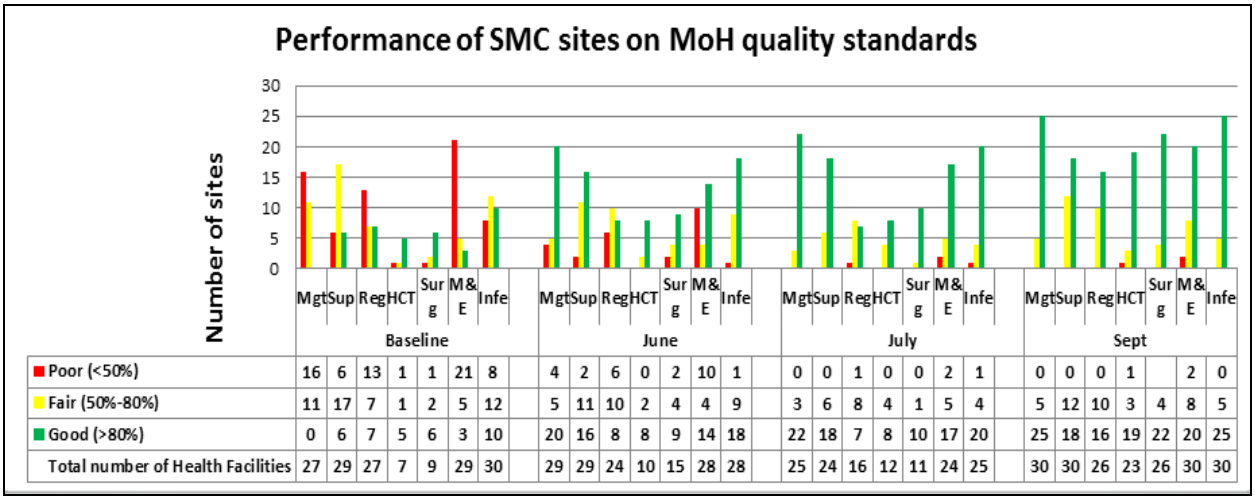
Accomplishments and Results

- **Built consensus for QI activities among MOH and SMC stakeholders:** Conducted a series of meetings with the Ministry and SMC stakeholders to build consensus on how QI can enhance the national SMC strategy. Supported the National Task Force (NTF) for SMC to convene and review progress of SMC services in Uganda and adapt a self-assessment tool developed by WHO/PEPFAR to align it to the MOH SMC policy, minimum standards of procedure, and SMC strategic plan.
- **Worked with IPs and districts to carry out baseline and follow-up of quality standards in SMC:** Worked with implementing partners and district health office staff to conduct site self-assessments

aimed at identifying gaps that impede implementation of SMC services according to the MOH/WHO standards.

- **Assessed health facilities providing SMC to determine their baseline status**. Based on the findings from using the assessment tool, supported facility teams to improve adherence to MOH quality standards. This was done through supporting the formation of functional health unit QI teams and supporting the training of new regional coaches through joint coaching. These will join a pool of existing national coaches who provide support to district teams on ad hoc basis.
- **Performance of SMC sites performing "good" on different MOH quality standards increased from considerably from baseline to September 2013.** Figure 2 shows the performance of the SMC sites on the MOH quality standards, showing significant site improvement over the last four months. At the baseline assessment many sites scored below 50% on the standards and in September 2013 of the 30 sites assessed, 23 sites were scoring above 80% on the standards. The two standards with performance below 50% include: individual counselling and testing for HIV and monitoring and evaluation (M&E). This was due to one site not offering pre-operative and post-operative counselling for HIV to the SMC clients and lack of standardized SMC data tools respectively.
- **Addressed gender considerations in SMC:** At the national level, ASSIST successfully proposed to the MOH SMC National Task Force to integrate gender into the national SMC quality standards. At all available opportunities (i.e., trainings), a session on gender integration is included which has generated a lot of interest among the participants. At the health unit level, ASSIST has empowered health workers to develop innovative ways of encouraging partners to participate in SMC activities. Teams were supported to test changes to help promote partners involvement in SMC. Indicators to measure partner involvement were developed.

Figure 2: Performance of SMC sites on MOH quality standards (May-Sept. 2013)



	Baseline							June							July							Sept						
	Mgt	Sup	Reg	HCT	Surg	M&E	Infe	Mgt	Sup	Reg	HCT	Surg	M&E	Infe	Mgt	Sup	Reg	HCT	Surg	M&E	Infe	Mgt	Sup	Reg	HCT	Surg	M&E	Infe
Poor (<50%)	16	6	13	1	1	21	8	4	2	6	0	2	10	1	0	0	1	0	0	2	1	0	0	0	1		2	0
Fair (50%-80%)	11	17	7	1	2	5	12	5	11	10	2	4	4	9	3	6	8	4	1	5	4	5	12	10	3	4	8	5
Good (>80%)	0	6	7	5	6	3	10	20	16	8	8	9	14	18	22	18	7	8	10	17	20	25	18	16	19	22	20	25
Total number of Health Facilities	27	29	27	7	9	29	30	29	29	24	10	15	28	28	25	24	16	12	11	24	25	30	30	26	23	26	30	30

- **HIV counseling and testing:** There was an increase in the percentage of clients that were counseled and tested and received results from 91% in October 2012 to 96% in September 2013. The number of sites reporting adverse events increased from only eight sites in October 2012 to 21 in September 2013. The improvement was due to the orientation of the site teams on the importance of documentation and provision of adverse events, grading scales to aid identification of adverse events, establishment of systems of investigating adverse events at the sites, institution of CME sessions, and having the guardians of the minors attend post-operative health education. For post-operative follow-up at 48 hours, at baseline, only five of the 30 sites that were carrying out this follow-up. Most health workers told clients to come back if they had a problem. A root cause analysis showed that most health workers had a knowledge gap on the usefulness of the follow-up visit. Further, there were many data gaps in the registers. ASSIST started by mentoring sites on the importance of the follow-up visit, trained them in QI, and assisted them to form QI teams. With this, sites started testing changes like repackaging of health education information to include need to return for follow up, improving documentation, and telling clients to return for bandage removal. Currently, 48-hour follow-

up is at 68%, and the number of sites offering it has risen from five in October 2012 to 25 in August 2013.

- **Increased reporting by sites:** Figure 3 summarizes details of how the number of sites engaged in the various SMC indicators has been increasing since baseline in October 2012 to August 2013. It can be observed that for all indicators, there has been a demonstrable increase in the number of sites involved. Work on seven-day follow-up increased from seven sites at baseline (October 2012) to 22 sites in August 2013. Facility staff repackaged their health education messages to include the importance of day seven follow-up. Currently, seven-day follow-up stands at 33% with the peak being 47% for 25 sites in July. A decline in August was observed due to sites conducting outreach SMC activities which still pose a challenge to follow-up at seven days.
- In addition, the percentage of clients who experienced severe adverse events due to SMC decreased from 0.5% in October 2012 to 0.4% in August 2013 and the percentages of clients who returned within 48 hours post operation increased during this period (Table 4).

Figure 3: Number of facilities reporting various SMC indicators (Oct. 2012-Aug. 2013)

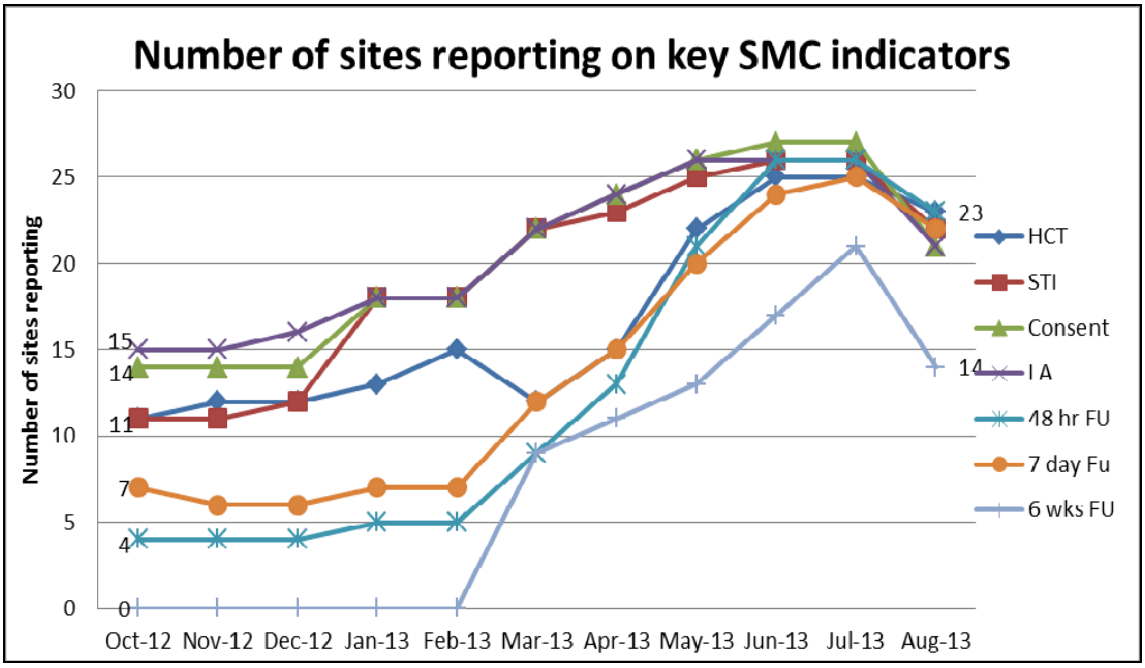


Table 4: Activity 2: Improvement in key indicators

SMC	Percentage that experience moderate to severe adverse events	0.5%, 8 sites	0.4%, 21 sites
	Percentage that return within 48 hours post operation	58%, 4 sites	68%, 23 sites
	Percentage that return after 1 week follow-up	54%, 7 sites	33%, 22 sites
	Percentage that return after 6 weeks	0%, 2 sites	7%, 14 sites

What Are We Learning?

- What are the gaps that impede sites from meeting the MOH/WHO quality standards?
  - Major gaps in meeting quality standards have been identified as summarized in the compilation of changes tested to improve quality of SMC service, and they are being addressed. Majority of sites are showing dashboard values of green, which indicates compliance with standards at a

level of 80% of higher. See Appendix 1 for the October 2013 values of the SMC quality dashboard for the 30 "intense support" sites.

- What causes poor follow up of clients post-surgery and what interventions can be put in place to address the poor follow-up?
  - A research study to address this question has been approved by the URC IRB and submitted to the Uganda National Council for Science and Technology for regulatory approval. The study is set to start in 2014.

Activity 3. Partnership for HIV-Free Survival (PHFS)

Background

Malnutrition is a major public health problem in Uganda. Over 49% of women of reproductive age and 64% of pregnant women are anemic. Twelve percent (12%) of women of reproductive age suffer from chronic malnutrition. Malnutrition remains a problem in children with stunting rates of 33%, underweight at 14%, and wasting at 5% (Uganda DHS, 2011). Over 50% of children are anemic, and 20% have Vitamin A deficiency. The burden of malnutrition is complicated by HIV/AIDS. Recent data indicate that 40-50% of malnourished children are HIV-infected, which is higher than the prevalence among children in the general population (Source: National Nutrition rehabilitation unit in Mulago (MwanaMugimu). The prevalence of adult malnutrition in pre-ART HIV-infected clients attending care and treatment services was found to be 20% in 54 health units supported under the NuLife project.

In an effort to address the burden of malnutrition, the Government of Uganda has prioritized nutrition as a key factor in enhancing human development and economic productivity as reflected in the National Development Plan (2010-2014); the Health Sector Strategic and Investment Plan (HSSIP) (2010-2014); the Uganda Nutrition Action plan (2011 -2016); the National HIV/AIDS Health Sector Strategic Plan (2010/11-2014/15); the Nutrition and HIV/TB Strategic Plan (2009-2014). With the advent of the 2010 WHO PMTCT Guidelines, it is important to focus on prenatal and postnatal provision of ARVs to HIV-infected mothers and support optimal feeding practices in the first 12-24 months of infancy.

The Partnership for HIV-Free Survival (PHFS) is an initiative that aims to accelerate the adoption and implementation of the 2010 WHO Guidelines on PMTCT and infant feeding in six countries, including Uganda. The PHFS initiative was officially launched in March 2013 in a partners meeting in Pretoria, with technical assistance in QI provided by ASSIST. The scale-up of improvement work for ASSIST is mainly conducted by implementing partners – TASO and SPRING. ASSIST is building on the capacity of these implementing partners to improve the nutrition and PMTCT services through implementation of known strategies and development of their QI competencies.

Partnership of HIV-Free Survival

Improvement Strategy

ASSIST conducted three monthly joint coaching visits with the partners SPRING and TASO to all 22 health facilities during the quarter. The coaching visits focused on supporting the sites to improve one area of focus at a time and progressively move site teams onto the next area of focus.

To better understand the reasons for the low retention rates of mother-baby pairs in care, a study was conducted in nine health facilities in Eastern Uganda. HIV-positive mothers attending the clinic were asked about the barriers and facilitators of retention and Pareto charts were developed. This information will be used to guide the sites to test changes aimed at solving the barriers.

Spread Strategy

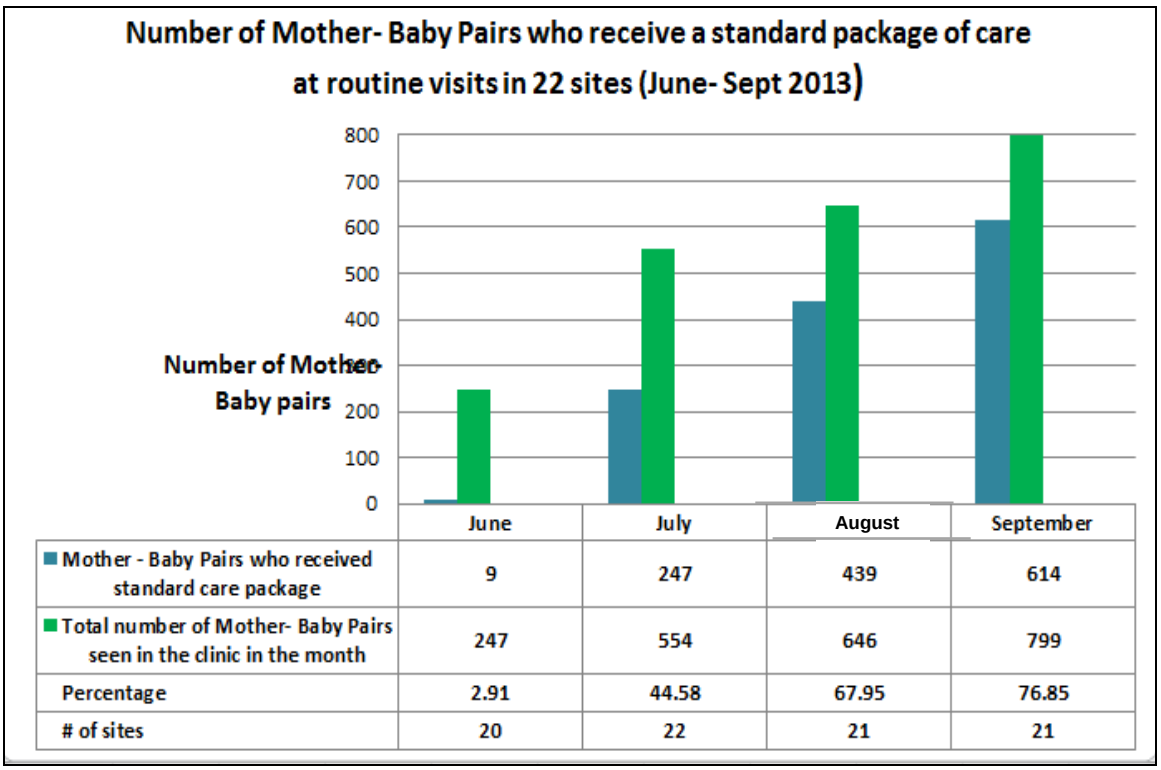
At each coaching visit with the site teams, coaches discussed with the team an inventory of changes which might improve some of the focus areas.

Through the leadership collaborative, the core functions of leaders were shared with two district coaching teams (Kisoro and Manafwa) and the team members identified which of the core functions could be used to support site improvement teams. Members of the coaching teams have been allocated health facilities for which they will be responsible. It is anticipated that the district coaches will spread results from the initial sites to other health facilities in the course of their support supervision visits and in the next phase.

Accomplishments and Results

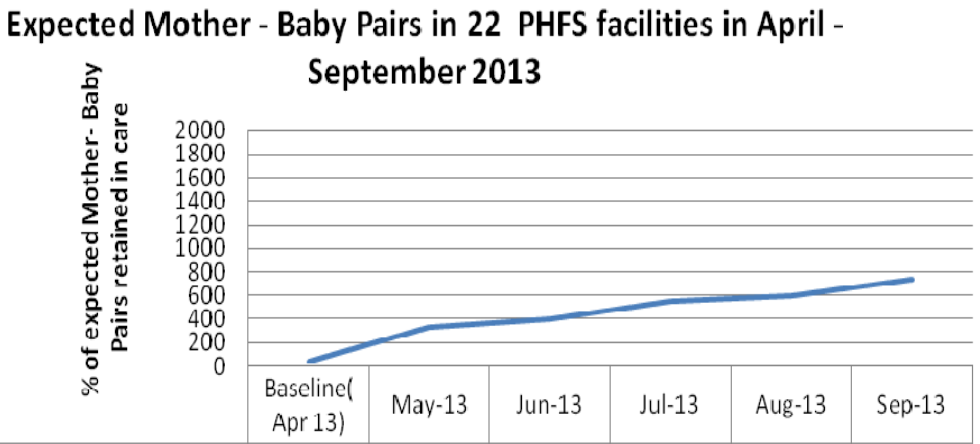
- **Defined role of ASSIST in PHFS through a series of consultative meetings with partners:** Partners included FANTA, SPRING, TASO, and MOH.
- **Developed a set of indicators for monitoring the PHFS** initiative through consultative meetings.
- **Conducted a baseline assessment** in seven out of 22 health facilities.
- **Tested change ideas and rolled out action plans in 22 health facilities**: ASSIST developed change ideas in one of the IP's sites where ideas were discussed on how to improve retention of mother-baby pairs in care and improvement in data quality of infant diagnosis (EID) registers that had been identified at the site would also be achieved. From this prototype visit we were able to develop the first coaching tool to use for similar coaching visits in the other 21 health facilities. The same approach that was used in the prototype visit was rolled out in all 22 health facilities with the support of the regional and district coaches and IPs (TASO and SPRING). Coaching teams were assigned two to three sites to support and coaching was done in all the sites in the same week. Coaching visits were carried out among all the 22 health facilities.
- **Increase in sites delivery of standard package of care:** The standard package of care for mother-baby pairs includes ART for the mother, Cotrimoxazole or Nevirapine for her baby, Infant and Young Child Feeding (IYCF) counselling, nutrition assessment, and an appointment for the next visit. Twenty (20) health facilities worked to provide every mother-baby pair who was seen in the month with this standard package of care, and the percentage of mother-baby pairs who received all components of care increased from 2.9% in June to 76.8% in September 2013 in 21 sites as shown in Figure 4. The specific changes which the sites tested to improve the quality of care provided at routine visits include:
    - Dispensing drugs (ARVs and Cotrimoxazole) in the clinic instead of the pharmacy (nine sites)
    - Assigning a nurse or peer educator the responsibility of taking mother and baby's anthropometric measurements for nutrition assessment (eight sites)
    - Increase the clinic days from one to two days a week so that mothers and their babies can get all the services (one site)

Figure 4: Number of mothers-baby pairs who received standard package of care at routine visits, 22 sites (June-Sept. 2013)



- **Retention of mother-baby pairs in care:** Overall the data on retention is becoming more available, and the site teams have tested changes to improve retention as shown in Figure 5. By the end of September 2013, 36% of mother-baby pairs in 17 PHFS sites were retained in care, compared to only 2.2% in April 2013. The number of sites which tested specific changes which were identified in the last quarter to improve retention of mother baby pairs increased as follows:
  - Giving mothers and babies the same appointment dates (21 sites)
  - Keeping the mother and baby's clinical charts together (22 sites)
  - Merging ART and EID clinic services so that both mother and baby are seen together (17 sites)
  - Increasing the number of days in the week that the clinic runs for mothers and their babies to access care and spread workload for the staff (7 sites)
  - Following up mothers who were lost to follow up by making phone calls and using peers to trace these mothers and return them to care (7 sites)

Figure 5: Percentage of expected mother-baby pairs, 22 PHFS facilities (April-Sept 2013)



	Baseline(Apr 13)	May-13	Jun-13	Jul-13	Aug-13	Sep-13
# of Mother - Baby pairs that returned	39	326	394	554	597	732
Total Number who should be accession care	1800	1800	1800	1800	1800	1800
% of Mother- Baby pairs	2.2	18.1	21.9	30.8	33.2	40.7
# of sites	22	22	22	22	22	20

- **Barriers and facilitators of retention of mother-baby pairs in care:** To understand the barriers and facilitators of retention of mother-baby pairs in care, mothers attending nine HIV clinics were asked about the reasons why they missed appointments and why they sought care. Responses were: 71.6 % of mothers said that they forgot their appointment dates, had other engagements on the same date, lacked transport and the lack of privacy during counselling sessions as the barriers to retention in care. To improve retention in care, 74.3% of mothers suggested continued counselling, creating reminders, reducing waiting time, and involving male partners in care as strategies that might work. This information was shared in the learning session in October 2013 to enable the sites generate possible changes to address these barriers.
- **Improvements in key indicators:** Table 5 shows improvements in PHFS indicators from April to September 2013.

What Are We Learning?

- How best can we track mother-baby pairs and retain them in care?
  - During FY13, ASSIST field tested an indicator for retention and continued to work on this. We also developed a case study on the retention of mother-baby pairs in Kisoro Hospital and shared this with global PHFS community (see Appendix 2).
- What are the barriers and facilitators to the retention of mother-baby pairs in care?

- We asked 41 mother-baby pairs in 9 health facilities why their missed their last appointments, and what can be done to help them keep appointments. We shared this information with other site teams and supported them to do something similar so that they can test changes will directly address the barriers raised by the mothers.

Table 5: Activity 3: Improvement in key PHFS indicators in FY13

PHFS	Percentage of HIV-negative women retested for HIV as per national guidelines	12%, 5 sites	26%, 9 sites
	Percentage of HIV-exposed infants whose mothers were put on ART	92%, 15 sites	92.4%, 17 sites
	Percentage of HIV-positive mothers who receive IYCF counseling at each visit	24%, 15 sites	76%, 13 sites
	Percentage of HIV-positive mothers who receive maternal nutrition counseling at each visit	23%, 15 sites	81%, 14 sites
	Percentage of exposed infants reporting to be adhering to recommended IYCF practices	73%, 20 sites	71%, 17 sites
	Proportion of HIV-positive pregnant and lactating mothers who receive nutrition assessment every month	20%, 19 sites	72%, 17 sites
	Proportion of exposed infants who receive nutrition assessment every month	32%, 16 sites	81%, 16 sites
	Proportion of HIV-positive mothers who are found to be malnourished during the reporting period	0.88%, 11 sites	3%, 12 sites
	Proportion of exposed infants found to be undernourished and receive therapeutic or supplementary feeding support at any point during the reporting period	100%, 3 sites	0%, 6 sites
	Proportion of HIV-positive mothers found to be undernourished and receive therapeutic or supplementary feeding support at any point during the reporting period	0%, 2 sites	48.4%, 3 sites
	Proportion of exposed infants who are found to be malnourished at any point during the reporting period	5%, 1 sites	0%, 8 sites
	Proportion of mother-baby pairs retained in care each month	8%, 15 sites	41%, 22 sites
	Percentage of HIV-positive lactating women initiated on ART	41%, 8 sites	92%, 16 sites

Activity 4. Improve Maternal and Newborn Health

Background

Uganda has a maternal mortality ratio (MMR) of 440 deaths per/100,000 live births (UNICEF, 2011) which is substantially higher than the 2015 Millennium Development goal of 162. Most of the maternal deaths occur in the first 24 hours from the onset of labor.

Postpartum hemorrhage, obstructed labor, and ruptured uterus account for about three-quarters of maternal deaths in Ugandan facilities (Countdown 2015: Uganda). Under the HCI project, URC worked with staff at 10 high-volume health facilities in two districts to ensure that all women receive high-impact interventions such as AMTSL to prevent post-partum hemorrhage (PPH) and that partograms are used to monitor the progress of labor. Significant progress was made under HCI, which is being expanded upon through ASSIST.

Through ASSIST, URC is working with 20 high-volume sites in four districts to improve maternal and newborn health and reduce maternal mortality through use of high-impact, low-cost, and evidence-based interventions. In addition we work with the MOH and other implementing partners to build their capacity to

deliver quality maternal and newborn care.

Improving Maternal and Newborn Health

Improvement Strategy

ASSIST used three approaches to improve care: Facility-based quality improvement through monthly onsite coach visits with the districts and partners; maternal and perinatal death reviews by the facility QI teams; and quarterly peer-to-peer learning meetings involving 20 high-volume facilities of the four SMGL districts.

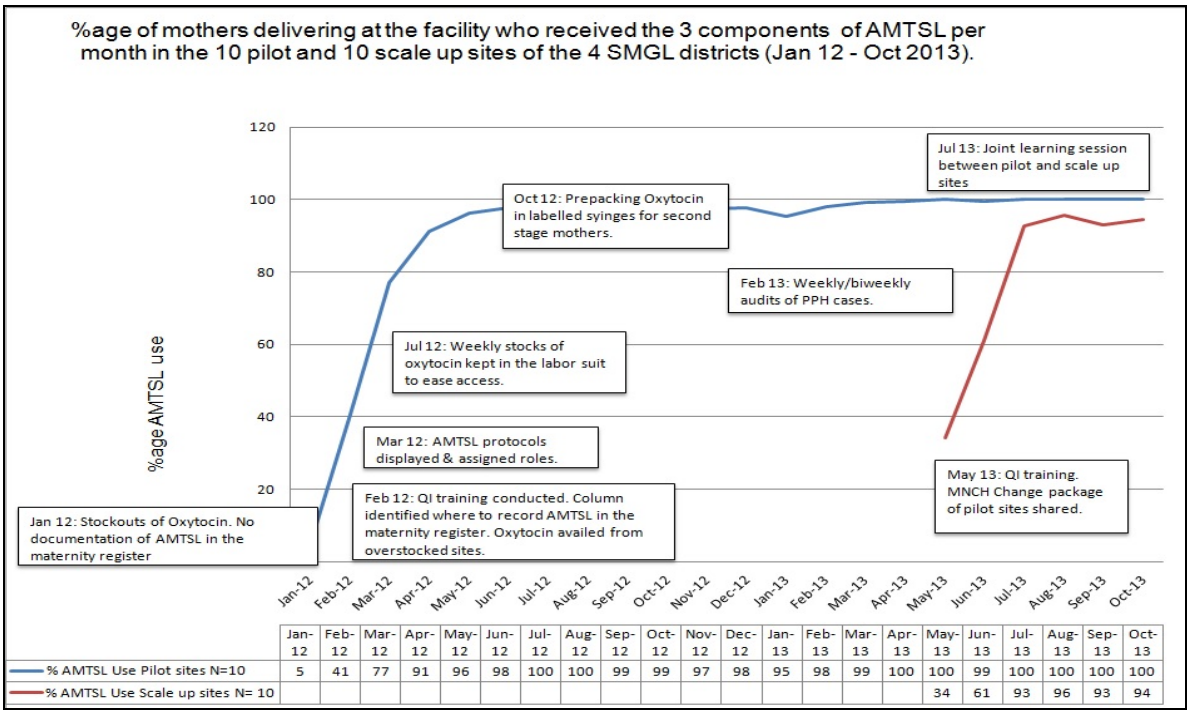
Spread Strategy

ASSIST has engaged the leaders at district and facility levels during quarterly review meetings to create ownership. The facility teams have been supported to understand and own the outcome of their improvement work through use of data and including QI activities in the facility work plans. Through the capacity built in the partners and the district health team members, they are using a similar QI approach to scale up MNCH QI activities to other non-ASSIST supported districts and facilities during support supervision visits.

Accomplishments and Results

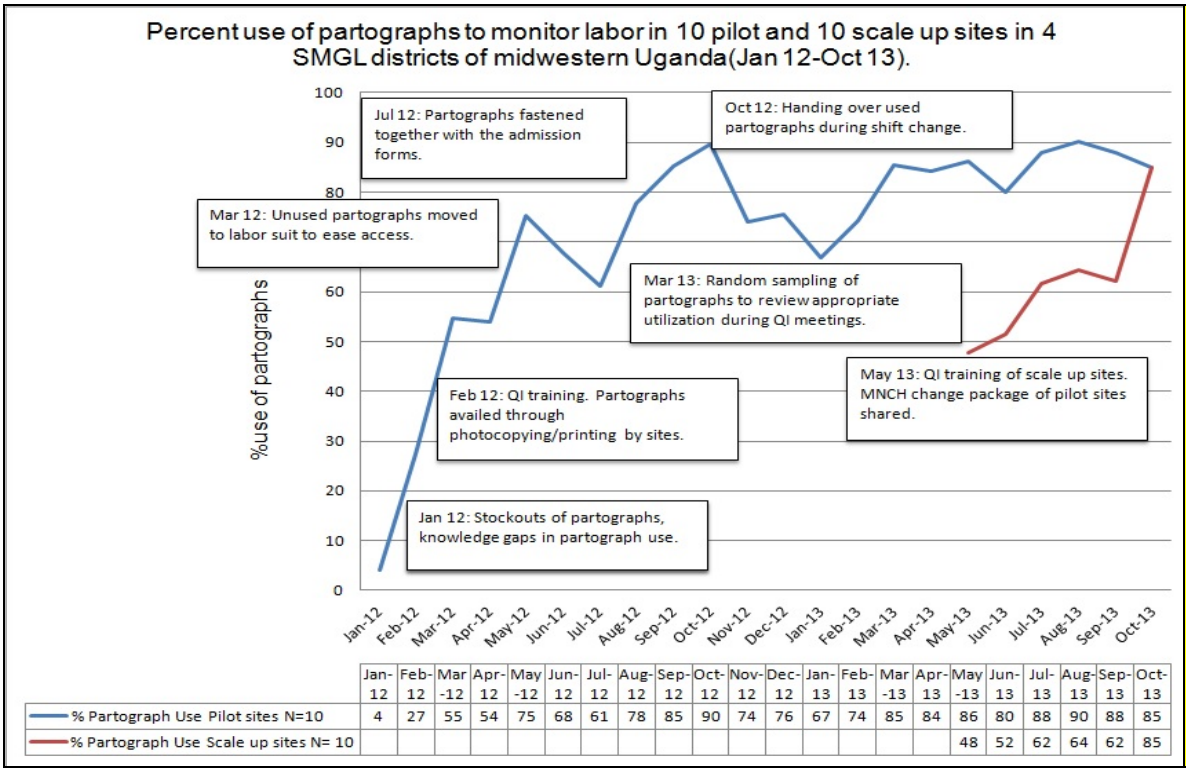
- **Piloted and scaled up application of the three components of AMTSL in 10 pilot sites.** Application of the three components of AMTSL improved to 100% across the initial pilot 10 sites in two districts in a period of six months. Scale-up of a package of changes was done in May 2013 in 10 other high-volume sites of two districts of Kibaale and Kabarole. It took only three months to attain a high performance in the scale-up facilities compared to the initial 10 facilities where it took six months (see Figure 6). The change package included: reallocation of uterotonic drugs from overstocked to sites with stock-outs; prepacking oxytocin in labeled syringes for mothers approaching second stage of labor; individual on-the job training; display of reminders and job aids on AMTSL use and PPH management; assignment of a focal person to oversee AMTSL use and PPH management; audit of mothers who develop PPH during the morning ward meetings; and preparation of all items necessary in PPH management as a PPH emergency pack in the maternity unit.
- **Increased use of the partograph:** Partograph usage was 4% at baseline and improved to 88% in September 2013 in the pilot sites. With the scale-up to the 10 sites in the two other districts, the MNCH change package was shared and a high performance has been attained in a three-month period compared to the six-month period that was required in the pilot sites to attain improvement (48% in May to 62% in September 2013) (Figure 7). The package of changes tested included: involvement of facility in charges in availing partographs through printing/photocopying; including partographs supply in the facility work plan and budget; assigning a focal person to oversee partograph use; handing over of mothers, their files and partographs during change of shifts; actively involving senior cadres in reviewing partographs during ward rounds and during reviews of mothers in labor; random sampling of partographs to review for completeness and appropriate use during QI team meetings; display of reminders and job aids on partograph use; review of patient files with partographs during morning ward meetings/handover report; and individual mentoring/on-the-job training.
- **Increase in coverage of newborns with complete ENC package:** Provision of a complete essential newborn care (ENC) package for every live newborn before discharge improved in a period of three months in the scale-up facilities compared to the pilot facilities that took six months to attain a higher performance (Figure 8). The package includes: immediate skin-to-skin contact; immediate and exclusive breastfeeding; cord care; eye care with tetracycline ointment; administration of vitamin K one mg intramuscular injection (0.5 mg for preterm babies); immunization with oral polio vaccine and BCG and thermal protection (drying baby, cap and socks, blanket, room temperature, delaying bathing baby until after 24 hours). A package of changes tested include: developing job aids and displaying protocols for each element of ENC and displaying them in the labor suit; staff charity project for warm clothes for newborns whose mothers come without them, assignment of a focal person to oversee provision of the Essential Newborn Care (ENC) package, individual mentoring/on the job training and schedule health education talks for each element of the ENC package.

Figure 6: Percentage of mothers who received the 3 components of AMTSL, 10 pilot and 10 scale-up sites in 4 SMGL districts, Western Uganda (Jan. 2012-Oct. 2013)



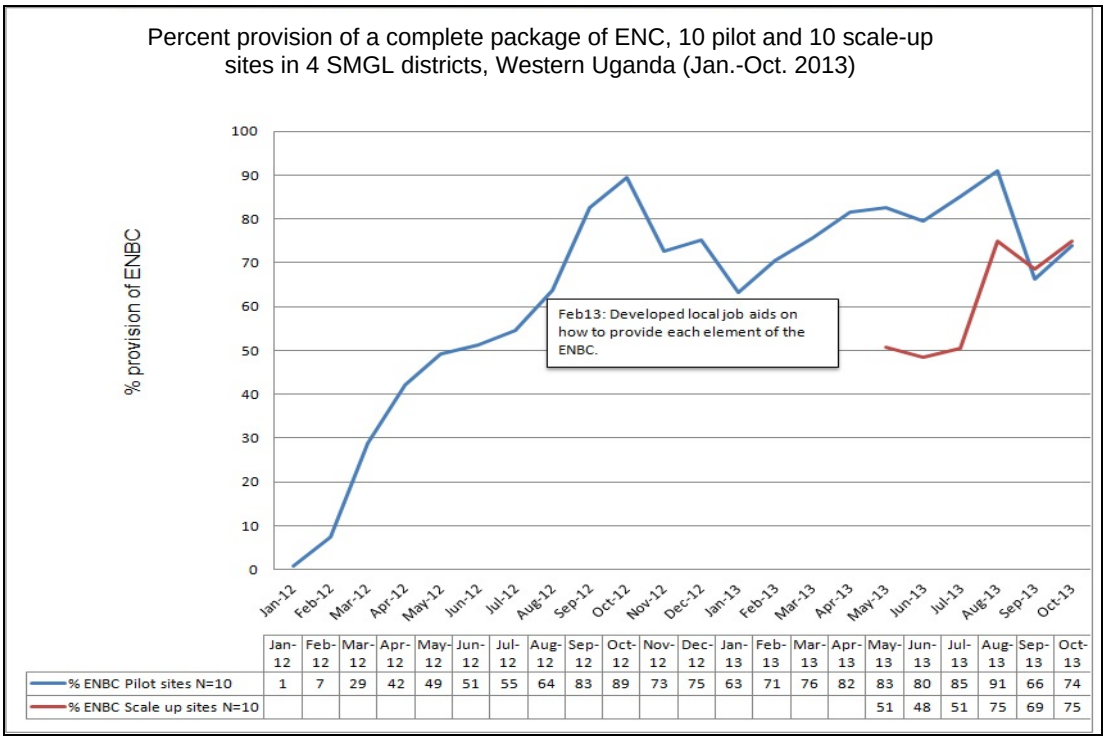
	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13
% AMTSL Use Pilot sites N=10	5	41	77	91	96	98	100	100	99	99	97	98	95	98	99	100	100	99	100	100	100	100
% AMTSL Use Scale up sites N= 10																	34	61	93	96	93	94

Figure 7: Percent use of partograph to monitor labor, 10 pilot and 10 scale-up sites in 4 SMGL districts, Midwestern Uganda (Jan. 2012-Oct. 2013)



	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13
% Partograph Use Pilot sites N=10	4	27	55	54	75	68	61	78	85	90	74	76	67	74	85	84	86	80	88	90	88	85
% Partograph Use Scale up sites N= 10																	48	52	62	64	62	85

Figure 8: Percent provision of a complete package of ENC, 10 pilot and 10 scale-up sites in 4 SMGL districts, Western Uganda (Jan.-Oct. 2013)



	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13
% ENBC Pilot sites N=10	1	7	29	42	49	51	55	64	83	89	73	75	63	71	76	82	83	80	85	91	66	74
% ENBC Scale up sites N=10																	51	48	51	75	69	75

Activity 5. Family Planning

Background

Despite the overwhelming evidence of the potential benefit of family planning (FP) in reducing maternal mortality, unfortunately, most women presenting in these 18 high-volume maternity units in the four SMGL districts of western Uganda leave without receiving family planning services. This constitutes a huge missed opportunity to address the fertility needs of women of reproductive age.

To contribute to reducing maternal mortality by achieving better spacing of pregnancies and avoid unwanted pregnancies, USAID ASSIST is implementing an improvement collaborative in 18 selected SMGL facilities in four districts of western Uganda.

Post-partum Family Planning

Improvement Strategy

Worked with the MOH and the district health teams to support 18 MNCH QI teams of the four SMGL districts of Western Uganda integrate FP into immediate post obstetric event care services, using QI approaches. This will be achieved by ensuring that all women post-obstetric event in the 18 SMGL selected health facilities receive effective FP services before discharge.

This improvement collaborative is considered to be a demonstration effort to be adapted and scaled up to other health facilities and to the community level. The demonstration improvement collaborative will permit the testing of a package of interventions/changes to arrive at a set of “best practices” to be scaled up.

Supported Marie Stopes Uganda in integrating QI in the provision of family planning services in six FP SMGL private health facilities of western Uganda.

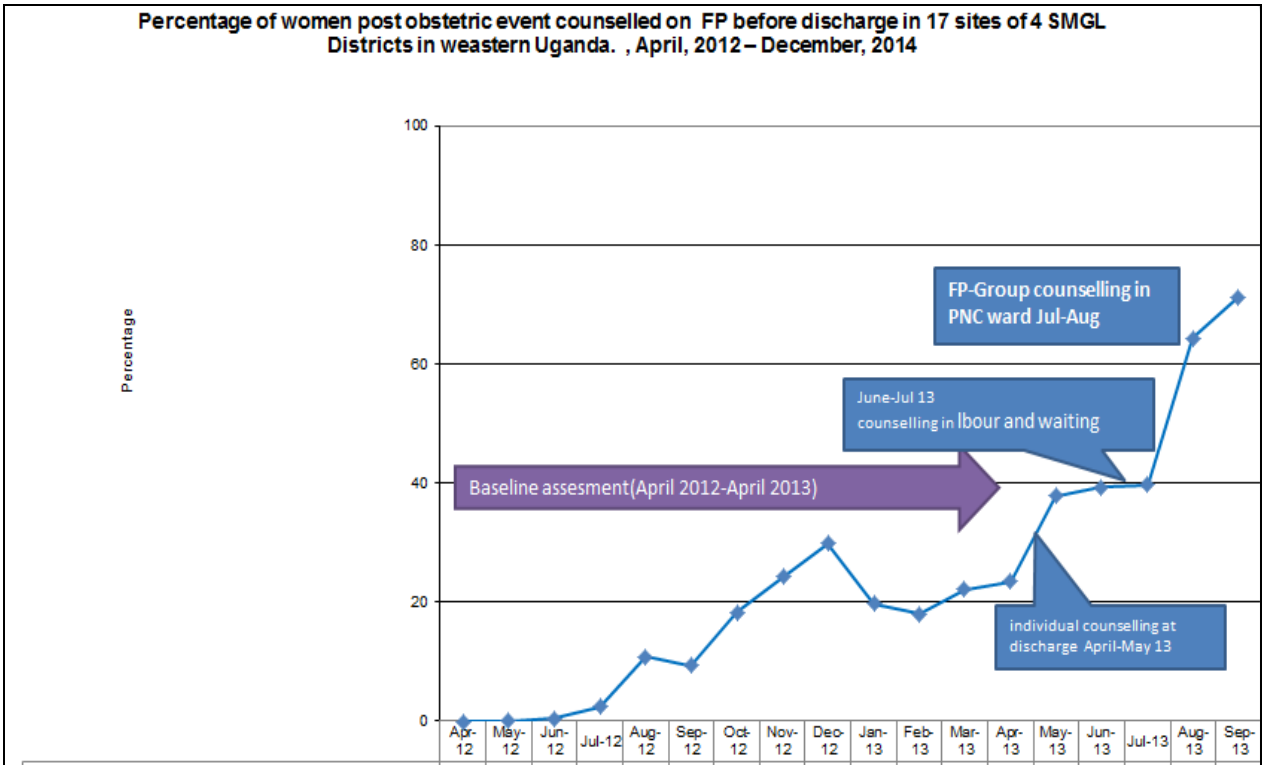
Spread Strategy

USAID ASSIST will involve national policy makers from the onset of the collaborative improvement intervention to ensure their participation in the process and endorsement of the results and to engage them in planning for spread.

Accomplishments and Results

- Conducted a baseline assessment in 17 high-volume health facilities in four SMGL districts to review the integration of family planning into MNCH: Baseline assessment in showed that only 27.56% of post obstetric women are counseled on FP before discharge and none counseled with a partner. None was provided with the FP method of choice at discharge. Mothers were being told to come back at six weeks for FP services and immunization.
- **Increased individual FP counseling:** FP individual counseling increased to 71% by September 2013 compared to 38% in May 2013 as seen in Figure 9. Couples counseling increased to 20% by September 2013, compared to 3.9% in May 2013. FP uptake at discharge is beginning to pick up and results were 4% by September 2013 compared to 0% in April 2013 (Table 6).

Figure 9: Percentage of women post obstetric event counseled on FP before discharge in 17 sets of four SMGL districts in Western Uganda (April 2012-Sept. 2013)



	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13
Number of of women post obstetric event who received FP counseling prior to discharge	0	2	8	45	198	196	373	478	556	382	320	426	496	677	840	838	1013	795
Total women discharged post obstetric event	1664	1988	1875	1821	1813	2112	2047	1980	1863	1930	1783	1927	2121	1789	2131	2107	1575	1116
Percentage of women post obstetric event who received FP counseling prior to discharge	0.00	0.10	0.43	2.47	10.92	9.28	18.22	24.14	29.84	19.79	17.95	22.11	23.39	37.84	39.42	39.77	64.32	71.24
# of Sites Reporting	17	17	17	18	18	18	18	18	17	18	18	18	18	16	18	18	14	10

- **Conducted site coaching sessions:** Conducted two joint (with the district health teams and the regional and the district QI coaches) site coaching support visits to 17 public facilities working on improving integration of FP into the SMGL program in the four SMGL districts of western Uganda.
- **Conducted learning session/stakeholders meeting:** Conducted one learning session to enhance spread of best practices among the SMGL and the FP integration participating sites. Held a stakeholders meeting with the district health team regional coaches and Marie Stopes Uganda to share the baseline assessment results and plan for implementation to improve FP service delivery. See the improvement in Key indicators in Table 6.

Table 6: Activity 5: Improvement in key FP indicators in FY13

Activity	Indicators	Baseline	Last value in FY13 (Sept 2013)
FP	Proportion of women post-obstetric event that are counseled on FP before discharge	23%, 18 sites (April '13)	71%, 10 sites
	Proportion of women post-obstetric event that are counseled of FP with partner before discharge	0%, 18 sites (April '13)	20%, 15 sites
	Proportion of women post-obstetric event that are provided with a FP method of choice at discharge	0%, 17 sites (April '13)	4%, 15 sites
	% of mothers delivering at the facility who receive AMTSL per week.	5%,10 sites (Jan '12)	96%, 20 sites
	% of mothers delivering at the facility who were correctly monitored by a partograph per week.	4%,10 sites (Jan '12)	73%, 20 sites
SMGL	% of live births who received ENC per week	1%,10 sites (Jan '12)	68%, 20 sites

Activity 6. Improving and institutionalizing QI in the health sector

Background

The overall goal of the health sector during HSSIP 2010/11 – 2014/15 is *"To attain a good standard of health for all people in Uganda in order to promote a healthy and productive life."*

To achieve this goal, the health sector intends to accelerate quality and safety improvements for health services through implementation of identified interventions as one of the strategic objectives. The Health Sector Quality Improvement Framework (QIF) and Strategic Plan are aligned to this strategic objective. The QIF and Strategic Plan have been developed in recognition that the health sector needs to institutionalize, harmonize and coordinate quality management interventions in Uganda. USAID ASSIST will support the implementation of this framework as a way of contributing to the institutionalization of QI in the Ugandan health sector.

Accomplishments and Results

- **Supported the MOH in QI training:** Supported the MOH to build the capacity for district QI committee members from 11 districts and the NUHITES project staff.
- **Supported the first QI stakeholders meeting to develop a joint work plan:** Supported the MOH to hold the first stakeholder meeting with QI partners to develop a joint work plan for October 2013 to September 2014.
- **Participated in the annual health sector review:** Supported the MOH to compile the Annual Health Sector Report for FY2012/13 and the Midterm Review for the Health Sector Strategic and Investment Plan (HSSIP 2010/11 – 14/15).
- **Supported the MOH to conduct the Second National QI Conference.** This conference among other objectives was aimed at taking stock of the national QI efforts (June 2013).

Activity 7. Develop a national QI framework for services for orphans and vulnerable children and institutionalize QI in vulnerable children care

Background

In Uganda, over half (57%) of the total population are children (Uganda National Health Survey 2009/2010). Of these approximately 2.43 million have been orphaned mainly due to HIV/AIDS, and over 100,000 under 14 years are HIV-positive. The Government of Uganda, through the MGLSD and partners, has worked on policies, guidelines and standards to guide the delivery of a comprehensive and

equitable package of OVC services. The policies and operational plans are to enable provision of sustainable quality services to children so that they realize their full potential and have their rights and aspirations fulfilled.

The second National Strategic Program Plan for Interventions (NSPPI-2) for OVC services outlines seven core program areas of care and support for vulnerable children. Delivery of services to vulnerable children and their households in the different care areas has been spearheaded by the government and OVC partners reaching an estimated 11% of the eight million vulnerable children in need of external support. Thus many vulnerable children are not being served.

To address these gaps in OVC care, the USAID ASSIST Project works in four districts to strengthen the capacity of families, caregivers and other service providers to protect and care for the orphans and other vulnerable children; and improve access to essential health, education, psychosocial, and water and sanitation services for orphans and other vulnerable children and their caregivers. The project also works to support the MGLSD, SCORE and other OVC partners to incorporate QI into OVC assessment, care, referral, follow-up, and measurement of social status outcomes. In addition, ASSIST supports the MGLSD and SUNRISE to ensure that OVC national structures are using QI as an approach to roll out the vulnerability index, child status index and other quality tools. ASSIST supports the use of self-assessment and continuous quality improvement for community OVC and institutional care programs.

Services for Orphans and Vulnerable Children

Improvement Strategy

In the four selected districts ASSIST worked with the different OVC service delivery levels namely; national, district, sub-county and village to build their capacity to improve services for the vulnerable children. At the national level, ASSIST engaged the ministry in monthly update meetings to discuss progress and challenges. At the district and sub-county level, the probation and community development officers participated in all activities as coaches, in effort to build their skills to support and train the OVC structures at their respective levels to improve service delivery. At the village level OVC village committees were formed to support the identification and follow-up of vulnerable children and to report through the established government structures. At the CSO level, joint activities were held with the respective partner QI focal persons.

Spread Strategy

Six sub-counties formed 13 village committees. During a learning session, teams from two sub-counties shared their experience of using village committees to identify vulnerable children or link children to services. In "*Rushoyo village in Rukungiri district, children couldn't go to school because of an impassable road. The community repaired the road. In the same village some parents were reluctant to take their children to school so the community engaged the parents so as to encourage them to send them to school.*" In FY14 all 11 sub counties will have at least two active village committees and an improvement aim to improve school attendance and linkage to services.

Accomplishments and Results

- **Together with MGLSD, OVC partners SCORE, SUNRISE and ASSIST developed a QI framework** to guide the implementation and institutionalization of QI in national OVC structure with a goal of promoting the provision of quality comprehensive services for vulnerable children and their households. Together with MGLSD and the OVC partners, agreed on indicators to measure the OVC QI framework.
- In collaboration with the MGLSD and other OVC partner,s developed a self-assessment tool for measuring and monitoring adherence to OVC standards: Supported the MGLSD to organize an OVC stakeholders' meeting to introduce and share the OVC QI framework, OVC QI collaborative and the self-assessment tool.
- **Conducted a baseline assessment for QI:** In collaboration with MGLSD, conducted a baseline assessment in the districts of Rukungiri, Amuru, Busia and Mukono with aim of identifying gaps at the CSO, sub-county and district level so as to design appropriate QI interventions based on need. The results obtained were shared with the partners and the OVC structures at sub-county, district and national levels.
- **Collaborated with the MGLSD to organize and conduct QI training for selected district, sub-county and CSOs representatives:** District coaches were trained so that they can orient the District

OVC Coordination Committee and Sub-Count OVC Coordinating Committee members to a use QI approach to manage and improve OVC services in their respective districts and sub-counties. The CSOs were oriented to QI approaches so that they can apply them in their work to measure and improve the services provided to vulnerable children. At the CSO training, each CSO used a prioritization matrix and the baseline data to identify two areas to start the improvement work. Most teams (six) selected "economic strengthening," three chose "food and nutrition security," two chose "PSS," two chose "education" and one chose "health" as areas for improvement and developed improvement aims and indicators.

- **Conducted QI training:** By the end of the year all 10 CSOs had been trained in QI and were working on at least two focus areas for improvement.
- **Conducted coaching session:** Three joint coaching visits by ASSIST, MGLSD, partners and district- based coaches were conducted to support QI team formation and ensure they are functional. Teams were supported to use their data to identify gaps in the process of care for the selected areas of improvement; however there was a general problem with availability and completeness of data given that the teams do not use standardized data tools and compiled data on individual vulnerable children or households on quarterly basis. All CSOs have existing group structures at community level where households meet regularly to participate in communal activity, for example, saving, learning new skills in farming or business. The QI teams were asked to use the existing structures of groups to collect monthly data on the wellbeing of the vulnerable children and their households. By the end of the year at least seven CSOs were able to get data from over fifty percent of the vulnerable households supported. This data was used to identify the gaps in the process of care for the selected areas and monitor improvements.

4 Sustainability and Institutionalization

To institutionalize and ensure sustainability, our mode of work revolved around:

- Working with the established QI structures (e.g., central MOH staff, regional referral hospitals, district health management teams and their quality improvement focal persons) for program ownership but also capacity building in QI.
- During FY13 we also worked with the MOH to support 16 district quality improvement committees to develop quality improvement work plans. These are comprehensive work plans with funded and unfunded areas, which will facilitate new partners in the district to buy in. This should facilitate the coordination and sustainability of QI efforts.

5 Knowledge Management Products and Activities

In the context of the USAID ASSIST Project, knowledge management (KM) is a key strategy for fostering "evidence-based quality improvement" by putting in practice efficient processes for making available learning about what does and does not work to make care better and by connecting sites participating in improvement efforts to generate and efficiently spread that learning within the improvement effort and beyond it to the larger system.

Knowledge management activities this year have included:

- *Knowledge transfer session in the National QI Conference***:** During the June 2013 conference, ASSIST and its partners organized two knowledge transfer sessions as an approach to engage the participants in in-depth sharing of new knowledge and experiences of implementing QI activities. This enabled all participants, even those who couldn't ask questions and give their views in a large group of over 400 participants, to actively take part in the discussions. The sessions were on: 1) Transferring existing QI knowledge on setting up QI initiatives, spreading QI, national QI programming, and measuring QI; and 2). Quality Management Programs: Keys to sustainability (Organizational assessment of quality management). An overview flyer on the ASSIST program in Uganda was distributed at the conference (see Appendix 3).
- *Knowledge harvest and transfer for our work in leadership:* Through July 30 – August 1, 2013 leaders from the four districts who had been implementing the leadership collaborative, were brought together with leaders from the three districts that are going to start implementing the collaborative to:

- Harvest what has been learned about the role of leaders in QI in the districts of Arua, Lwengo and Lyantonde
- Review the core functions of leaders in QI
- Come up with change ideas for the leaders of Busia, Kisoro and Manafwa to carry out their roles as leaders in QI

- *Knowledge sharing during learning sessions:* ASSIST used the learning sessions to begin documenting and collecting evidence of tested changes that have shown some improvement. This will allow for the project to continually inform stakeholders of what is working in QI at the facilities. The teams have used different knowledge management techniques to allow the teams to share and learn from each other, which include knowledge cafes which allow for small group discussions.
- *Meetings and conferences to showcase our work:* This has been done through distributing case studies, success stories, flyers on our work, and compilation of changes/change packages. An example of these meetings includes the PHFS Regional Meeting in Kampala in October 2013.

Knowledge products developed and shared with partners during FY13 include:

- *PHFS case study:* The PHFS component has generated a case study documenting the successes experienced in specific sites that we are working in. The PHFS case study is entitled: "Implementing the PHFS Initiative in Uganda: Retention of Mother-Baby Pairs in Kisoro District Hospital." It has been shared with the partners both within Uganda and internationally, who are implementing PHFS for their learning, it has also been uploaded to the ASSIST web portal. The case study was also shared with stakeholders who attended the PHFS regional meeting in Kampala in October 2013. (See Appendix 2.)
- *SMGL case studies*: Two SMGL case studies were drafted and are currently in review: 1) Organizing for obstetric emergencies: How Kabarole Hospital in Western Uganda; and 2) Successfully Providing Essential Newborn Care for Term and Premature Babies: A Midwife's Perspective.
- *OVC case study:* "Improving income-generating activities for vulnerable children and families at Agape Nyakibare Civil Society Organisation". This case study was drafted and shared with the USAID mission in Uganda for review.
- The Implementation of the National QI Framework, being piloted in Rwenzori region has started developing an *implementation guide* that is highlighting the experience of institutionalizing QI through the MOH systems.
- *Knowledge Nuggets:* A statement or explanation, based on experience, from which others can learn and improve their working practices. The PHFS component has developed and distributed two knowledge nuggets providing information to partners. They have been shared on the PHFS listserv: Prototyping interventions at one site and having detailed guidance for coaches helps to kick start improvement work in other sites; and avoid comprehensive baseline data collection up front and start up the improvement work with a small number of indicators.
- *Blogs:* SMC and the Health workforce component of the project have started writing blogs to inform on their experience in implementing QI.
  - *SMC blog has been uploaded on:* Bringing women on board in SMC in Uganda: http://assist.k4hdev.org/blog/bringing-women-board-safe-male-circumcision-uganda-0
  - *Health workforce blog on:* http://www.k4health.org/blog/post/strengthening-human-resources-health-uganda

6 Directions for FY14

- ASSIST will continue the same lines of work with the MOH and IPs and work to improve the quality of TB care. Overall, we will aim to ensure that all TB patients receive good quality care (i.e., they access appropriate care, comple*te treatment and attain* treatment success).
- ASSIST will spread lessons learned among the IP projects and test new innovations to further improve care and spread improvements to new sites.

7 Appendices

1. SMC Quality Performance Dashboard for 30 Sites Receiving Intensive Support from ASSIST

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PERFORMANCE OF 30 USAID ASSIST SUPPORTED SAFE MALE CIRCUMCISION SITES ON QUALITY STANDARDS

>80% -Good	50 - <80%-	<50% - Poor	Not assessed

Baseline (February - May 2013)

Health Unit IP Supporting Site, District	Management systems	Supplies, equipment & environment	Registration group education and IEC	Individual counselling & HIV testing	Male circumcision surgical procedure	Monitoring & evaluation	Infection prevention
1, Masindi	30	50	0			33	92
2, Kyenjojo,	20	33	0			7	67
3, Bulkwe	40	83	0			14	77
4, Kitgum	30	50	0			18	82
5, Apac	20	33	0			14	80
6, Nwoya	10	50				7	70
7, Arua	40	50	50			75	40
8, Bushenyi	60	50	25			14	77
9, Kampala	60	50	83	33	64	29	69
10, Gulu	20	50	50			0	33
11, SUSTAIN	33	25	0			0	64
12, Fortportal	25	33	0				70
13, Namutumba	60	67	75	83	81	14	35
14, Namayingo	70	50	25			50	40
15, Bugiri	60	33	25			50	46
16, Kibuli	30	67	100			14	58
17, SPEAR	40	83	75	100	100	14	58
18, Masaka	70	67	100	67	100	69	75
19, Rakai Agri	40	50	0			21	46
20, Isingiro	60	50	0			21	92
21, Kiboro	70	50	0			21	46
22, Kayunga	80	83	100			93	100
23, MUBWP	70	100	100	100	100	93	100
24, Mukono	70	100	100	100	100	93	100
25, Bidaka	60	50	100			46	100
26, Butaleja	60	33	50			15	62
27, Kibaale	40	83	75	100	100	75	92
28, 2nd Division	20	50			78	15	35
29, RTI	20	67	67		47	29	80
30, 4th Division	40	67				36	62

June 2013

Health Unit District IP Supporting	Management systems	Supplies, equipment & environment	Registration group education and IEC	Individual counselling & HIV testing	Male circumcision surgical procedure	Monitoring & evaluation	Infection prevention
1, Masindi							
2, Kyenjojo,	40	67	0			86	92
3, Bulkwe	70	83.3				85.7	84.6
4, Kitgum	80	66.7	0			78.6	82
5, Apac	40	66.7	0		56	28.6	80
6, Nwoya	70	50				28.6	70
7, Arua	90	83.3	50			100	60
8, Bushenyi	90	67	25			28	77
9, Kampala	80	83	100	100	100	50	92
10, Gulu	60	50	67	67	55	100	33
11, SUSTAIN	25	33	0				
12, Fortportal	100	100	67			100	70
13, Namutumba	100	90	100	100	100	80	80
14, Namayingo	80	90				80	80
15, Bugiri	100	90	100			80	90
16, Kibuli	30	66.7	100			14.3	58.3
17, SPEAR	100	100	75	100	100	28.6	84.6
18, Masaka	80	67	100	67	100	77	75
19, Rakai Agri	100	50	67		70	86	100
20, Isingiro	80	50	0			21	92
21, Kiboro	100	83	75		50	86	77
22, Kayunga	100	100	100	100	100	100	100
23, MUBWP	100	100	100	100	100	90	100
24, Mukono	100	100	100	100	100	90	100
25, Bidaka	80	90				46	100
26, Butaleja	80	33.33	50			15.39	76.92
27, Kibaale	80	83.3	75	100	100	75	100
28, 2nd Division	50	50			89	85	50
29, RTI	60	83.3	67			29	86
30, 4th Division	80	83	67	83	40	46.2	84.6

23rd October 2013

Health Unit District IP Supporting	Management systems	Supplies, equipment & environment	Registration group education and IEC	Individual counselling & HIV testing	Male circumcision surgical procedure	Monitoring & evaluation	Infection prevention
1, Masindi	60	50	67	83	82	79	82
2, Kyenjojo,	80	67	75			87	92
3, Bulkwe	90	67				86	100
4, Kitgum	80	83	83	83	80	79	54
5, Apac	60	83	67	100	70	93	92
6, Nwoya	80	83	83	100	100	71	80
7, Arua	80	67	67	83	73	50	67
8, Bushenyi	90	100	83	100	90	86	85
9, Kampala	90	100	100	82	100	100	100
10, Gulu	80	83	100	83	82	86	83
11, SUSTAIN	80	50	67	67	80	77	75
12, Fortportal	100	83	100	40	83	100	92
13, Namutumba	80	83	67	83	93	71	100
14, Namayingo	90	83	83	89	90	79	91
15, Bugiri	90	83	100	94	90	79	92
16, Kibuli	90	100	83	83	80	86	92
17, SPEAR	100	100	100	100	100	86	83
18, Masaka	100	67	100	100	100	100	75
19, Rakai Agri	100	83	83	78	97	100	100
20, Isingiro	100	83	83	83	85	93	85
21, Kiboro	90	67	83	94	77	50	76
22, Kayunga	90	100	100	100	100	100	100
23, MUBWP	90	100	100	100	100	100	100
24, Mukono	90	100	100	100	100	100	100
25, Bidaka	100	100	75	83	80	72	100
26, Butaleja	90	83	83	100	79	79	92
27, Kibaale	100	83	100	100	91	93	100
28, 2nd Division	90	75	50	94	87	93	70
29, RTI	80	67	67	83	80	93	82
30, 4th Division	90	67	83	100	91	93	82

2. Implementing the Partnership for HIV-Free Survival (PHFS) Initiative in Uganda: Retention of Mother-Baby Pairs in Kisoro District Hospital*, Case Study,*

   [http://www.urc-chs.com/resource?ResourceID=786]

MINISTRY OF HEALTH

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Applying Science to Strengthen and Improve Systems

CASE STUDY

Implementing the Partnership for HIV-Free Survival (PHFS) Initiative in Uganda: Retention of Mother-Baby Pairs in Kisoro District Hospital

With support from the United States Agency for International Development (USAID) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), Kisoro District Hospital in Uganda is finding ways to increase the retention of HIV-positive mothers and their newborns in care. In only one month, the Kisoro PHFS improvement team raised the coverage of mother-baby pairs from under 1% of expected client load to 26%. The team also has made great strides in the quality of its records—a critical requirement for providing quality care for chronic conditions like HIV—improving the completion of all information on client ART cards from 2% of cards to 51% in the same period. This case study emphasizes the simple steps that Kisoro Hospital's quality improvement (QI) team took to make these changes without additional resources and in a short time period.

Introduction

Kisoro Hospital, located in South Western Uganda, is one of the 22 health facilities implementing the PHFS initiative. PHFS is a six-country partnership geared towards the elimination of mother-to-child transmission of HIV by strengthening and accelerating uptake of Option B+, nutrition counseling, and support for mothers and their babies. Kisoro Hospital was chosen by the Ministry of Health of Uganda to participate in PHFS because it is a high-volume facility providing care to approximately 250 patients a day in the HIV clinic; it is also one of the only three ART centers in Kisoro District. It has been providing Option B+ since the end of March 2013. The site is being supported by the Strengthening Partnerships, Results, and Innovations in Nutrition Globally (SPRING) Project to support health workers to strengthen nutrition assessment, counseling, and support (NACS).

Problem Analysis

Retention of mother and baby pairs in care at health facilities is a major challenge in the provision of quality HIV services. To understand the magnitude of the problem in Kisoro, we carried out a baseline assessment in May 2013. The review team, composed of the site QI team leader, government district coaches, regional coach, and a USAID ASSIST Project coach, checked the accuracy and completeness of the exposed infants' clinical charts and the early infant diagnosis (EID) register and calculated the retention gap.

The assessment revealed two main gaps; first, retention in care was poor. Only 1 of 226 mother-baby pairs who should have come to the clinic in April 2013 actually came. It was also clear that the clinic was not putting in place simple systems to make it easier for mothers and babies to remain in care. For example, mothers and babies were often given different appointment dates in the same month.

JULY 2013

This case study was authored by Tamara Nyombi, Angella Kigonya, Esther Karamagi Nkolo, Nigel Livesley, and Humphrey Megere of University Research Co., LLC (URC). We would like to acknowledge the contribution by Birungi Anshilla and Joseph Nturo of Kisoro Hospital. It was produced by the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, funded by the American people through USAID's Bureau for Global Health, Office of Health Systems. The project is managed by URC under the terms of Cooperative Agreement Number AID-OAA-A-12-00101. URC's global partners for USAID ASSIST include: Broad Branch Associates; EnCompass LLC; FHI 360; Harvard University School of Public Health; Health Research, Inc.; Institute for Healthcare Improvement; Initiatives Inc.; Johns Hopkins University Center for Communication Programs; Women Influencing Health Education and Rule of Law, LLC; and the World Health Organization Patient Safety Programme. For more information on the work of the USAID ASSIST Project, please visit www.usaidassist.org or write assist-info@urc-chs.com.

Second, data about retention was very weak. For example, only 3 (2.5%) of 118 exposed infant clinical charts were filled in correctly. Data from different tools were not consistent. These problems meant that the clinic had no clear way of measuring retention.

Data tools for recording retention in Kisoro:

Exposed Infant Clinical Chart: contains the infant's bio-data, information on the mother, testing, linkage to care and treatment and all services provided to the infant at each clinical visit.

Early Infant Diagnosis register: The EID register contains all information on care provided to an exposed infant from enrolment to discharge.

Clinic appointment book: This book is used to record all the clients who have been given appointments.

The Approach

In May 2013, the QI coaches held a meeting with the facility QI team to discuss the findings of the assessment and to share the data with the team. The facility QI team then carried out a problem analysis to determine the root causes of low retention rates and poor data quality. The QI team proposed some changes that they would test to improve the two focus areas. Some of the changes included: giving all services to the mother-baby pair in the Post Natal Care (PNC) clinic for women who have delivered to return for review and family planning services. Another change proposed was finding exposed infants in the Young Child Clinic (YCC), a clinic where children receive immunisation, growth monitoring, and promotion services, and in the Anti-Retroviral Therapy (ART) clinic and physically escorting them to the PNC. The QI coaches also shared some change ideas that we thought might work, including: giving same appointment dates and services for the mother and the baby and keeping the mother and baby's care cards in the same file to enable easy retrieval and recording.

The Results: June 2013

A subsequent coaching visit was carried out to Kisoro hospital in June 2013. The purpose of the visit was to follow up on the site's action plan and provide additional support in improving care. During this visit, the facility QI team shared some of the changes they had tested as well as their data on retention. Between May 14th and June 10th, the team had managed to locate a large number of mother-baby pairs in care, bringing their number from 1 (0.4%) to 59 (26%). Of these 59, 30 were mothers who were still on Option A (AZT at pregnancy and babies on Nevirapine). These 30 were transitioned to Option B+ and their babies, if eligible, were put on Co-trimoxazole. Another 24 mother-baby pairs were in care at the hospital, but seen in different clinics, and because the mothers' ART number was not recorded on the babies' EID card, health workers couldn't tell what type of care they had received. These 24 mother-baby pairs can be attributed to an improvement in documentation. Five mother-baby pairs were still within the 18 month timeframe, but had stopped breastfeeding; they were enrolled into the program so the baby would receive the final PCR test and for the mother to continue on ART.

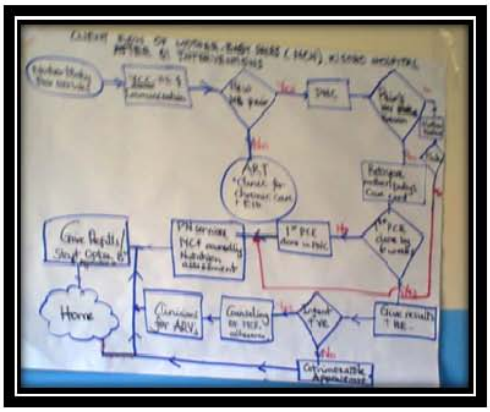
Data quality has also improved. In just one month, the percentage of infants' clinical cards having all parameters completely and correctly filled out increased from 2.5% to 50.8%.

What the Kisoro team did to achieve these results

Improving retention of mother-baby pairs:

- Because the ART clinic was congested, the Kisoro team decided that from now on, any newly diagnosed or identified mothers and babies will be seen in the PNC clinic (mother-baby pairs who were on ART prior to introduction of Option B+ will continue to access their care in the ART clinic).
- The PNC clinic routinely provides care to 20-30 clients a day. With these new changes, the clinic is currently seeing two to three additional new clients a day and has been able to absorb these numbers into their daily routine and structure. The four full-time staff available at the clinic are working on how they will handle the extra workload when the numbers increase.
- The team started giving same appointment dates for the mother and baby; and they are seen by the same person in one area (ART clinic for old clients and the PNC clinic for newly identified and enrolled clients).

- The hospital team informed mothers through health education sessions and Family Support Group (FSG) days that they would be receiving care together with their babies in the same clinic on the same day.
- To find clients lost in care and newly exposed babies, all staff who work in these clinics have been sensitised and are aware that exposed infants and their mothers must be physically escorted to PNC.
- To make clinic visits more convenient for the clients, ART is dispensed in the PNC instead of sending mothers to the pharmacy.



New flow of mother-baby pairs in the postnatal clinic

Improving data on retention:

- The team assigned a team member the role of filling out the mother and baby cards and registers as soon as the service is provided.
- The baby's card is now being kept in the mother's clinic file.
- PNC and ART departments keep the same registers and dispensing logs and, at the end of the week, the in-charges from both Maternal and Child Health (MCH) and ART departments come together to tally and review their registers to ensure that they have matching data.

Improving early infant diagnosis and HIV testing after mothers have stopped breastfeeding:

- To increase the number of exposed babies who get their first DNA-PCR test, staff in the PNC clinic are doing the test in the clinic rather than sending the babies to the laboratory. Staff received on-the-job training from the laboratory technician on how to do this.
- When mothers come for immunisation services in YCC, the staff member who does health education makes an announcement for all the mothers who have stopped breastfeeding to see her; the baby's card is checked for the mother's PMTCT code and if they are eligible, the second or final rapid test is done that very day.

The changes made to date have helped standardise post-natal care in the clinic. They ensure that babies and mothers coming to the clinic receive care in one place and that this care is as efficient and convenient as possible at delivering the services required.

Kisoro's recommendations for starting to work on retention:

- Measurement of work: The Kisoro hospital improvement team recommends that facilities should measure the number of mother-baby pairs they have in care to ensure that they understand their performance in relation to HIV free survival. In Kisoro, measurement of retention was achieved by using the EID register to find out how many infants are in care and checking the ART card to see whether the mothers of these infants are receiving ART. The mother-baby pair is considered "retained in care" if the baby is in EID care and the mother is in ART.
- The hospital recommends giving the mother and baby pair all services they need to receive that month on the same day. Kisoro hospital received five mothers on one day for the babies' first PCR test, and during the health education session, the health worker informed these mothers that they would receive drug refills, nutrition assessment, immunisation, and post natal review of the mother,

> *"The following week, we received about 19 mothers who came with their babies, expecting to receive care for themselves and their babies on the same day."*
>
> -- Joseph, QI Team Leader, Kisoro Hospital

TB screening, and any other service that the mother or baby required for that month. These mothers expressed their appreciation because this meant that they did not have to come back to the clinic several times for different services in the same month.

Next steps for Kisoro Hospital

The first phase of improvement work was targeted to addressing clients who were within the facility, but were not being seen in a coordinated way; the hospital has put in place all the changes mentioned above to address this.

The next phase of improvement work is to find mother-baby pairs who are not coming to the facility for any services.

The hospital plans to start implementing the following changes to find these clients:

- Making phone calls to mothers who have not yet transferred to option B+ and asking them to return to the hospital. Another USAID-funded project, STAR SW, managed by the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), will provide cell phone airtime for this activity.
- Having staff assigned to look for specific mother-baby pairs in the community either through phone calls or home visits

ABOUT THE PARTNERSHIP FOR HIV-FREE SURVIVAL

The Ministry of Health, with support from the United States Agency for International Development partners -- USAID Applying Science to Strengthen and Improve Systems (ASSIST), Food and Nutrition Technical Assistance (FANTA), Strengthening Partnerships, Results and Innovations in Nutrition (SPRING), and U.S. Centers for Disease Control partner (The AIDS Support Organisation, TASO) -- is implementing the Partnership for HIV-Free Survival (PHFS) Initiative in 22 phase 1 health facilities in six districts in Uganda.

Using quality improvement (QI) methods, the PHFS supports existing country-specific elimination of mother-to-child transmission protocols and the ongoing nutrition assessment counseling and support activities to achieve four essential steps of postnatal mother-infant care that result in excellent nutritional and HIV care for both the HIV-exposed and non-exposed infants over the first 24 months of life. The partnership is being implemented in Kenya, Lesotho, Mozambique, South Africa, Tanzania, and Uganda.

3. USAID ASSIST Project: Uganda Technical Assistance, *Flyer*
[http://www.urc-chs.com/resource?ResourceID=767]

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USAID ASSIST PROJECT: UGANDA TECHNICAL ASSISTANCE

Background

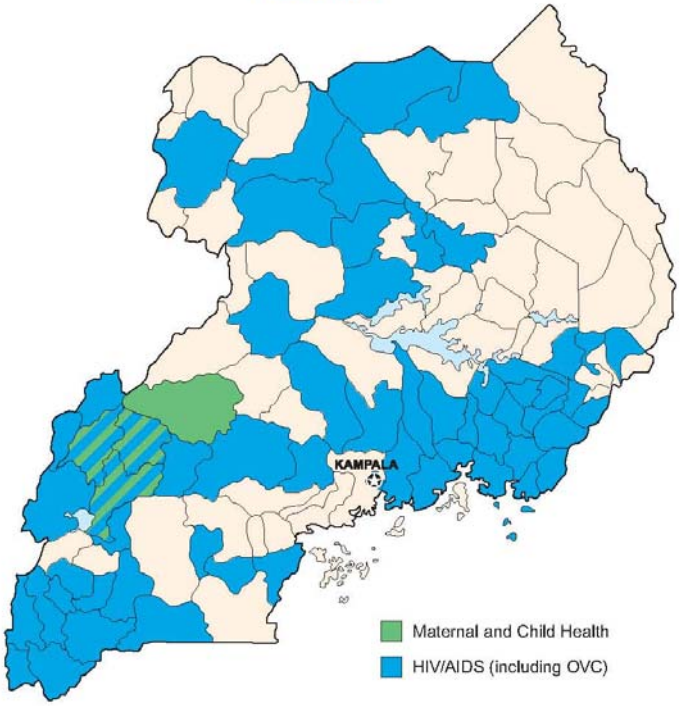
With funding from the United States Agency for International Development (USAID) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project is supporting the Ministry of Health and the Ministry of Gender, Labor and Social Development of Uganda to provide high quality, integrated care at the community, primary care, and referral levels. ASSIST activities in Uganda build on previous technical assistance to the Ministry of Health's HIV and maternal health care improvement initiatives through the USAID Health Care Improvement and Quality Assurance projects.

Project Objectives

In 2013, ASSIST support to the Government of Uganda and to implementing partners is focused on building their capacity to deliver quality services for men, women, youth, children, and newborns. Specific areas of technical assistance are:

- Build the quality improvement capacity of the Ministry of Health and selected districts and health facilities in the areas of integrated HIV prevention, treatment, care and support
- Work with the Ministry of Gender, Labor and Social Development and implementing partners to increase the wellbeing of orphans and vulnerable children

UGANDA



The USAID ASSIST Project supports improvement efforts in 61 out of Uganda's 112 districts.

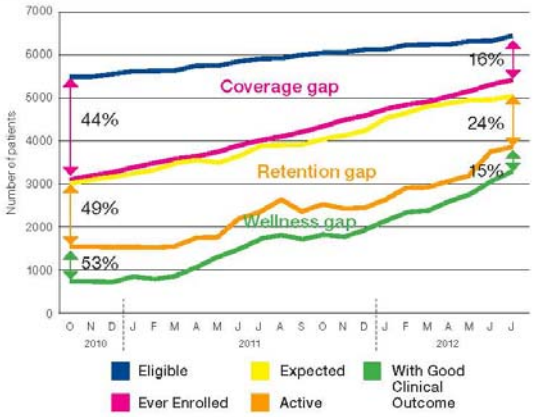
ASSIST support to the Government of Uganda and to implementing partners is focused on building their capacity to deliver quality services for men, women, youth, children, and newborns.

JUNE 2013

The USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project is funded by the American people through USAID's Bureau for Global Health, Office of Health Systems. The project is managed by University Research Co., LLC (URC) under the terms of Cooperative Agreement Number AID-OAA-A-12-00101. URC's global partners for USAID ASSIST include: Broad Branch Associates; EnCompass LLC; FHI 360; Harvard University School of Public Health; Health Research, Inc.; Institute for Healthcare Improvement; Initiatives Inc.; Johns Hopkins University Center for Communication Programs; Women Influencing Health Education and Rule of Law, LLC; and the World Health Organization Patient Safety Programme. For more information on the work of the USAID ASSIST Project, please visit www.usaidassist.org or contact assist-info@urc-chs.com.

Health provider in Buikwe District, Uganda and URC staff discuss how to overcome barriers to providing comprehensive care for patients with chronic conditions like HIV. ASSIST is supporting the Ministry of Health to implement the chronic care model tested and refined in Buikwe District in new sites. *Photo by Suzanne Gaudreault,URC.*

Applying the Framework for improving care for patients on ARV's to improve coverage, retention, and clinical outcomes in Buikwe District



- Apply improvement methods to expand the availability of essential maternal, newborn and child health services (including use of the partogram to monitor labor for early detection of obstruction, active management of third stage of labor to prevent bleeding, provision of essential newborn care, resuscitation of the asphyxiated newborn, and strengthening of the referral system) in primary and referral health facilities
- Increase community ownership and participation in decision making at the local level, patient involvement in care, and leadership and management engagement in improving quality of health care
- Disseminate the Ministry of Health's Quality Improvement Framework and institutionalize the use of improvement methods in all departments of the Ministry of Health and all districts

The USAID ASSIST Project also works to strengthen the performance of the health workforce as well as community-based services and community linkages with facility-based care.

Focus Areas

Improving HIV and Tuberculosis Care and Treatment

ASSIST is working intensively in 47 sites (roughly 10 sites in each of the four regions of Uganda) to improve the quality of HIV care, including working with communities served by the sites to strengthen community-facility linkages to increase retention in care and improve care outcomes. Sites are also being supported to improve the management of patients with tuberculosis (TB)-HIV co-infection by intensified screening of HIV patients for TB and support for TB treatment adherence. ASSIST is supporting implementing partners to introduce quality improvement activities in line with the Ministry of Health's quality improvement framework, providing training and mentoring as well as joint coaching visits. In 10 sites in three districts, the work also includes active engagement of the health facility leadership in directing improvement activities to strengthen their capacity to lead improvement activities.

ASSIST is implementing a refined chronic care model in a new district and undertaking a robust impact evaluation to quantify the effects of the chronic care intervention on HIV care and treatment process and outcome measures.

Chronic Care of HIV

Drawing on the HCI experience of piloting a chronic care model in one district of Uganda, ASSIST is implementing a refined chronic care model in a new district and undertaking a robust impact evaluation to quantify the effects of the chronic care intervention on HIV care and treatment process and outcome measures. The impact evaluation also includes an economic analysis to show the costs inputs needed to implement changes necessary to achieve improved clinical outcomes for HIV and other ancillary chronic disease such as hypertension or diabetes. As patient self-management is an important component of this activity, this will also help provide more information on the costs and benefits of community involvement in the continuum of care to improve chronic disease programs (like HIV treatment).

Safe Male Circumcision

ASSIST is working with the Ministry of Health and stakeholders to apply improvement methods to enhance the roll-out of the national Safe Male Circumcision strategy. ASSIST is providing intensive support to 30 sites and technical assistance to USAID implementing partners to improve the safety and quality of medical male circumcision in Uganda. To date, sites have been supported to conduct self-assessments of facilities' adherence to the Ministry of Health

This short film highlights how quality improvement methodology positively impacted essential newborn care in Luwero and Masaka districts. It features health workers and community members sharing their accounts of how improvement methods empowered them to support mothers and newborns in their communities with essential care. View the video at: https://vimeo.com/63860143.

Safe Male Circumcision policy and minimum standards and to put in place strategies to address gaps in care. ASSIST is also supporting the Ministry to address gender considerations in the promotion of male circumcision.

Prevention of Mother-to-Child Transmission of HIV

As part of the Partnership for HIV Free Survival, ASSIST is working with the Ministry of Health and other implementing partners to support 22 health facilities in improving prenatal and postnatal provision of antiretroviral therapy to HIV-infected mothers and in integrating nutrition assessment, counseling, and support into PMTCT services.

Maternal and Newborn Health: Saving Mothers Giving Life

Building on the Saving Mothers Giving Life (SMGL) work with 10 high-volume delivery facilities in Kyenjojo and Kamwenge districts under HCI, ASSIST is working with partners and 20 facilities in four districts to reduce maternal and perinatal mortality. ASSIST is also supporting the Ministry of Health to expand training and coaching in Helping Babies Breathe-plus.

Family Planning Integration

In the same four districts that ASSIST is supporting under Saving Mothers Giving Life initiative, the project is supporting facility teams and implementing partners to integrate post-partum family planning services into maternal health services. Sites are being supported to offer the full range of modern contraceptive methods, including long-acting methods.

Building on the Saving Mothers Giving Life (SMGL) work with 10 high-volume delivery facilities in Kyenjojo and Kamwenge districts under HCI, ASSIST is working with partners and 20 facilities in four districts to reduce maternal and perinatal mortality.

Care for Orphans and Vulnerable Children

A new activity for ASSIST in Uganda in 2013 is to support the Ministry of Gender, Labor and Social Development and orphans and vulnerable children (OVC) partners to incorporate improvement methods into OVC needs assessments, care, referral, follow-up and measurement of wellbeing. ASSIST's focus is on building the capacity of civil society organizations to apply national OVC standards and tools for identification, selection, care, and follow-up of vulnerable children.

USAID ASSIST Project

The USAID ASSIST Project is a five-year initiative of the Office of Health Systems of the USAID Global Health Bureau designed to address this challenge by improving health care in USAID-assisted countries, strengthening their health systems, and advancing the frontier of improvement science. Currently working in 15 countries, USAID ASSIST builds on the work of the USAID Health Care Improvement Project (HCI) and addresses weaknesses in the delivery of the following services:

- Care and support for vulnerable children and families
- HIV and AIDS
- Maternal, newborn, and child health
- Non-communicable diseases and chronic conditions care
- Nutrition assessment, counseling and support
- Reproductive health and family planning
- Tuberculosis, malaria, and other infectious diseases

The USAID ASSIST Project also works to strengthen the performance of the health workforce as well as community-based services and community linkages with facility-based care.

Community Health

ASSIST is supporting a demonstration project to improve the performance of Village Health Teams (VHTs) in locating HIV patients in the village, determining if patients on ART comply with treatment regimens, identifying physical functionality and medical complaints, and strengthening the existing network of community organizations to support VHTs. Health facility teams are supporting community teams by linking patients to the community and developing a schedule to engage encourage VHT visits at the facility.

A team of community volunteers and health workers visit a patient at home to provide palliative care. URC supported the Ministry of Health to integrate palliative care for patients with HIV in Mayuge and Namutumba districts. *Photo by Juliana Nabwire, URC.*

Strengthening Pharmaceutical Human Resources

This activity seeks to improve the quality of drug dispensing for patients with HIV and TB, working in three districts of Uganda. ASSIST is building the capacity of districts coaches to support sites in analyzing their process for dispensing drugs to HIV clients and improve drug ordering and stock management as well as adherence counseling.

Institutionalizing Quality Improvement in the Health Sector

ASSIST is supporting the Quality Assurance Department of the Ministry of Health to roll out the national quality improvement framework and strategic plan. In 2012, with HCI assistance, the Ministry of Health formed regional, district and facility quality improvement committees in all seven districts of Rwenzori Region. During 2013, ASSIST is continuing to support the Ministry to learn how best to operationalize the framework and the strategy in these seven districts, involving at least one facility from every health sub-district in the region.

Knowledge Management

In all activities, ASSIST is applying knowledge management principles and techniques to gather learning from improvement work and develop knowledge products that enable government ministries, implementing partners and health care providers to apply successful changes in new sites. In this way, the project contributes to both national and global learning about how to improve HIV, care for vulnerable children and families, maternal, newborn, and child health, non-communicable diseases and chronic conditions care, and family planning services.

USAID Applying Science to Strengthen and Improve Systems Project

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