THE REPUBLIC OF UGANDA
MINISTRY OF HEALTH

The 6th National Quality Improvement Conference Report

Theme: *Integrating Quality Improvement Approaches in all service delivery areas to Improve Accountability for Health Outcomes.*

(3rd to 5th December 2019)

Speke Resort Munyonyo - Uganda

LIST OF ACRONYMS

ACP	AIDS Control Program
ANC	Antenatal Care
APN	Assisted Partner Notification
ART	Antiretroviral Therapy
ARVs	Anti-retro viral drugs
CDC	Centers for Disease Control and Prevention
COP	Chief of Party
CSO	Civil Society Organization
DHO	District Health Officer
eMTCT	Elimination of mother to child transmission.
FP	Family Planning
GIT	Gastro-Intestinal Tract.
GoU	Government of Uganda
HMIS	Health Management Information System
HRH	Human Resources for Health
HRIS	Human Resource Information System
IP	Implementing Partners
IPT	Isoniazid Preventive therapy
JICA	Japan International Cooperation and Agency
KMC	Kangaroo Mother Care
MOH	Ministry of Health
NCDs	Non-Communicable diseases
NGT	Nasal Gastric Tubes
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of mother to child transmission
PNC	Post Natal Care
QI	Quality Improvement
QIF	Quality Improvement Framework
SCAPP	Standards Compliance Accreditation & Patient Protection
TB	Tuberculosis
TQM	Total Quality Management
UHC	Universal Health Coverage
UHDS	Uganda Health Demographic Survey
VLS	Viral Load Suppression
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

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1.0 Introduction

The Ministry of health (MOH) has been supporting the implementation of the Health Sector Quality Improvement Framework and Strategic Plan (QIF & SP) 2015/16-2019/20 which includes "strengthen the framework for documentation, reporting and sharing quality improvement knowledge" as an objective. MOH has carried out this objective through National Annual QI conferences. The Annual Health Care Quality Improvement Conference promotes the sharing of best practices, successes, and challenges across Uganda. The event is organized by the Ministry of Health -Standard Compliance Accreditation and Patient Protection (SCAPP) Department. This forum brings together international experts and key stakeholders from all levels of the health system to discuss best practices, lessons learned, and way forward in strengthening and improving the health system through the health system building blocks. This year, the conference was held at Speke Resort Munyonyo based on the theme "*Integrating Quality Improvement Approaches in all service delivery areas to Improve Accountability for Health Outcomes".* The theme guided the conference sessions to focus on integration of Quality Improvement (QI) in all the WHO health system building blocks.

The Health system building blocks include:

- Leadership and governance
- Human resources for health
- Health information system
- Access to essential, medicines and supplies
- Health financing.
- Service delivery
- Client centred care and patient

The Objectives of the conference were to:

- Share experiences, challenges and opportunities, and tested solutions in implementation of QI in health care in Uganda and other countries
- Provide an opportunity for peer learning on QI among health workers and other stakeholders
- Mobilize support, resources and attention from leaders and financing actors towards quality of care improvement
- Launch Patient Rights and Responsibilities Charter, 5S-continuous Quality Improvement, and total Quality Management implementation Guidelines for Uganda this will be used to cause quality in service delivery.

The Conference was attended by 510 participants including representatives from the Parliament of Uganda, World Health Organization, development partners (USAID, World Bank, JICA, CDC), implementing partners, MOH officials, District Health Officers, medical bureaus, KCCA, prisons, National & Joint Medical Stores, officials from the Office of the Prime Minister (OPM), professional councils, and foreign delegates from Malawi, Kenya, Namibia, United States, Haiti and Zimbabwe.. This report highlights the discussions, key talking points, and key recommendations that emerged from the conference.

2.0 Opening Remarks

The modulator Dr Henry Mwebesa, the Acting Director General Health services MOH led this session

Figure 2: The MOH Acting Director General Dr Henry Mwebesa giving his remarks at the National QI conference

Opening remarks were given by the Honorable Minister of Health, Dr. Jane Ruth Aceng, and the USAID Mission Director, represented by Ms. Jackie Calnan. This section provides a detailed account of their remarks and visions for the QI sector in Uganda.

2.1 Remarks by USAID Mission Director.

Ms. Jackie Calnan, (Deputy HIV/AIDS Team Leader-USAID) provided the following remarks on behalf of the USAID Mission Director.

Calnan stated that USA government is proud to be associated with Government of Uganda to promote quality and safety for better health outcomes in the Ugandan health sector. She emphasized that the conference was an opportunity to help the Government of Uganda and USAID take stock of their progress to date, discuss and share experiences and provide guidance on implementing QI approaches within the health sector going forward. Calnan reported that the US government has been working with MOH-SCAPP (formerly Quality Assurance Department) department since 2005 and has undertaken several activities to strengthen the system and improve quality of care across all program areas.

During her remarks, Calnan highlighted the work that has been done in the spirit of collaboration. She stated that "together we have achieved a lot in improving the quality of MNCH, reproductive health, comprehensive HIV and TB services. The ongoing implementation of national QI initiatives, where we have over 1300 health facilities, has focused on some of the ministry's priority areas and this has demonstrated our ability to pilot implementation and taking the effective evidence in the best intervention to scale. PEPFAR has supported the identification of 330,000 new HIV positive individuals and has provided lifelong treatment for about 1.1 million HIV+ individuals. In all these, QI approaches have ensured quality of life of people living with HIV".

PEPFAR has supported the ministry to reduce the burden of TB by identifying almost 42000 new cases and starting them on TB treatment, as well as completion of TB preventive treatment of over 1000 HIV+ individual. She mentioned that QI has been an integral component of all the programmatic services and that the experience and lessons shared in this conference will provide MOH with opportunity to learn what we can do differently at every level for better health outcomes.

Calnan mentioned that, "We need to learn from each other and adopt approaches so as to meet the changing needs of our clients". She expressed gratitude to GOU, commented that the US government (USG) remains committed to work with the Ugandan local systems through continuous partnership with its people and institutions.

In her conclusion; She pledged that the USG shall continue supporting MOH to find and retain TB infected patients in care especially in high burden districts. Even though donor funding keeps reducing, there's need to prioritize where we invest our resources, how we can improve efficiencies and accountability and build the entire health system to respond to the health needs of our people.

2.2 Remarks by Honorable Minister of Health of Uganda.

The Honorable Minister of Health, Dr Jane Ruth Aceng who was the guest of honour, focused on commitment to working with partners and appreciating their support to the recently concluded child health activities; and raising advocacy for the new challenge of rising NCDs; and support by the donor partners towards implementation of the National QI framework and strategies. She concluded by launching the 5S-CQI and TQM Guidelines.

The Hon. Minister of Health stated that, ***"A QI conference like this one provides a platform for health workers, researchers, scientists and policy makers to share their cutting edge on research and fruits of improvement science plus best practices".*** She commented that this provides opportunity for progressive improvement by showcasing innovations, products and technologies through exhibition. The Hon. Minister specified that MoH will continue working with all partners and stakeholders in addressing the issue of access to health care, promoting quality service delivery, and addressing the challenge of financial hardships while accessing health services by the citizens in order to achieve universal health coverage (UHC).

Afterwards, the Hon. Minister of Health turned her attention to the issues of maternal and child health, malaria, and noncommunicable diseases (NCDs). She cited the Uganda Health Demographic Survey (UHDS) 2016 highlights (total fertility rate reduced from 6.2% (2011) to 5.4% (2016)), Infant mortality rates and the under-five mortality rates were also discussed. she noted that 78% of the households possess at least one insect treated mosquito net and malaria prevalence is currently at 9%. She wrapped up her remarks by commenting on the rising prevalence of NCDs and a need to enhance the quality of service provided to patients in Uganda.

The Hon. Minister of Health concluded by stating that if we continue embracing the implementing QI strategies, we shall be able to improve quality of health care. She appreciated JICA for championing implementation of 5S Philosophy particularly in all Regional Referral Hospitals in the country. And recognized Kabale and Entebbe hospitals for their good performance. Completed by launching the 5S guidelines and declined launching the Patient Rights and Responsibilities Charter until the Health Workers Charter is completed so that both documents can be implemented together.

The minister Launched the **'5S-Continous Quality Improvement and Total Quality Management Implementation Guidelines for Uganda"** supported by JICA**,** she however did not launch the Patient Rights and Responsibilities Charter. She requested the responsible persons to bring it back next year for launching after "the health workers rights and responsibilities charter" is produced and launched first. She concluded by informing the audience that change begins with "me and you".

Figure 4: The Hon. Minister of health Dr Jane Ruth Aceng launching the 5S-CQI and TQM Guidelines.

3.0 Keynote speakers:

This year's keynote speakers were: Dr. M. Rashad Massoud (Vice President, University Research Co., LLC (URC), Professor Handa. Advisor to JICA (5S-KAIZEN-TQM framework), and Dr Bruce Agins MD, MPH, Professor of Infectious Disease Epidemiology in the Institute for Global Health Sciences at the University of California, San Francisco. The co-keynote speaker was Dr. Sophie Namasopo, Hospital Director of Kabale Regional Referral Hospital's (RRH)
The speakers presented on a wide range of topics from sustainability and transition, to best practices at regional referral hospitals, and mechanisms to bridge gaps in the QI sector. This section provides brief summaries of the keynote addresses.

3.1 Keynote speaker 1; *Dr. M. Rashad Massoud (Vice President, URC)*

In his keynote address, entitled "***Sustainability and Transition***", Dr. M. Rashad Massoud (Vice President, URC) focused on the following key concepts; integration, sustainability, transition, and country ownership.

Key concepts are:
-Integration,
-Sustainability: Continuous benefits
-Transition: Continuous Improvement of service &
-Country ownership: effective leadership.

The following provides a brief overview of the key points from the discussion:

- As we, in the field of quality improvement, work towards independence and self-reliance; it is important to keep four major categories into consideration- human institutionalization, financial governance, guidelines; and policies, rules, and regulations to ensure sustainability.
- The building blocks for sustainability and transition include community and stakeholder engagement, measuring transition in real time, learning, on-site support, and effective program management.

- Important lessons for all to remember included: 1) timing of sustainability and transition should starts from day one; 2) sustainability and transition plans should include a 'what, who, and how'; 3) simplify and engage key stakeholders for success- to the extent possible, make it simple and much more usable.

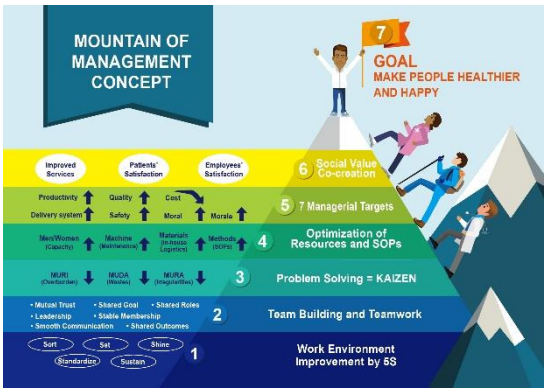
Dr. Massoud concluded by commending Uganda's "journey to self-reliance". He noted that Uganda has been making strides towards improving quality improvement (QI) work that is guided by the QI framework and these efforts have been implemented at different levels.

3.2 Keynote speaker 2: *Prof Handa Yujiro (Advisor to JICA)*

Professor Handa Yujiro's keynote speech was focused on bridging the gaps in the integration of 5S implementation to improve health services of all levels of care. Key points from his keynote included the following:

- Think beyond 5S implementation and consider questions like; what can we learn as a country? what best practices were mentioned? is there a global trend we need to be aware of?
- Work on strengthening teamwork and support team members to understand the process of problem identification, analysis, and implementation of solutions.
- Kabale Regional Referral Hospital has reached total quality management (TQM), by practicing improvement in waste management, patient management, medical equipment management, and data management. This Kabale model should be adopted with local focus and global vision to support all of us in achieving a culture of safety in healthcare facilities.
- Teams must work on eliminating the negative perception that is currently associated with incident reporting. Furthermore, health workers should be trained to provide consistent feedback to appropriate stakeholders.

Professor Yujiro concluded his speech by sharing the following take home message with the audience:



1) Changing the mindset of people is difficult, we feel that experiencing success is the only way to change the attitudes of staff

2) Strong leadership from the top management to the core management team of the health facilities is needed

3) Each health facility should be independent and autonomous in a sense- to improve its own performance.

3.2:1 **Best practices from Kabale RRH** presented *by the Hospital Director. Dr Sophie Namasopo*

Dr. Sophie Namasopo, presented highlights of the 5S Continuous Quality Improvement (CQI), Total Quality Management (TQM) performance journey the hospital underwent. She narrated that prior to the implementation of 5S, the hospital's QI structures were "non-functional", which resulted in poor 5S performance results. The 1st assessment took place in August 2017 and was conducted by MoH/JICA. Kabale RRH's performance scored 45% which prompted work towards the functionalization of the hospital's QI structures. However, the reassessment in March 2019 the hospital score was 98% showing an im 53% improvement.

She concluded by recommending that, "KAIZEN is a problem-solving process which should be used within existing resources. It can help a hospital to create CQI culture to meet internal and external client expectations and make things better step by step".

Improvement Objective	Problem identified /Gaps	Intervention/changes tested	Results
Improving functionalization of QI structures in Kabale RRH	-QI structures were non-functional. -There was no appointed committee. -No clear roles hence leading to poor	-Appointed QI team conducted monthly QIT meetings and assessments, -Established 5S/QI coordination office with a focal person.	-Improvement from 45% (Aug,2017) to 98% Mar,2019 -33 WITs were formed and implemented the 5S. -Monthly

	performance of 5S and negatively affecting the quality of care.	-Supervision checklists were adapted, -Trained QIT, -Assigned each facilitator 4 units, with setting targets	assessment indicated progressive improvement of 5S performance for the period October 2017 to June 2018

Table 1: summarizing the interventions and results from Kabale RRH.

3.3 Keynote speaker 3: *Dr Bruce Agins MD, MPH-professor.*

This discussion was modulated by Dr Bruce Agins MD, MPH- Professor of infectious Disease Epidemiology in the institute for Global Health sciences at the University of California, San Francisco.

Fig:12 Dr Agins introducing the session.

Dr. Agins introduced the session by highlighting the importance of working towards sustainable national QI structures and activities, supporting the integration of QI activities and approaches in all health care services, and ensuring that performance measurement takes place when engaging in quality improvement implementation. Following his brief introduction, panelists from Namibia, Kenya, Haiti, and Zimbabwe shared the following perspectives.

3.3.1 Experience from Namibia: by Dr Apollo Basenero.

Dr Apollo stated that creating a culture of QI improvement and sustainability requires holding the Ministry of Health accountable for provision of quality services at all levels of health care.

Dr Apollo stated that health care workers in Uganda must understand the role of quality improvement in their everyday work. He also highlighted the fact that QI coaches should not be the ones to collect the data in facilities, but rather give guidance and build capacity of the facility's staff. Dr Apollo shared that within Namibia's Ministry of Health, the QI department has been

elevated to Quality management directorate; with QI focal persons at regional and national levels to ensure sustainability.

Namibia has developed quality standards for hospitals for accreditation that match international standards and ensures accountability at all levels of health care.

Figure 13: Panel 1 Discussion team (Right to Left: Dr Bruce, with representatives from Kenya, Zimbabwe, Haiti and Namibia respectively)

3.3.2 Experience from Kenya; by Mr. Mburu Muiyuro

Mr. Mburu specified that in Kenya, the building of sustainable National QI collaborative structures has been through national sharing of experiences from all health facilities. Kenya's HIV quality framework was revised and now incorporates QI approaches, involvement of leaders and top management at all levels, as well as the formation of a National steering committee.

3.3.3. Experience from Haiti: by Ms. Margareth Celestin Jasmin

Ms. Margareth described that in Haiti, the National QI collaborative structures have been set up by increasing coaching teams in each of the provinces. This structure focuses on both technical and managerial competencies. MOH representatives, representatives from implementing partners, and a representative from the funding agency are part of the coaching team. They identify the need for capacity building on a regular basis. Continuous capacity building of the coaches and annual coaching refresher trainings are provided to ensure that everybody has the right knowledge of QI

at all levels. The coaching teams participate in international and national QI meetings, as well as support the standardization of all the QI tools and guidelines.

3.3.4 Experience from Zimbabwe: by Mr. Joseph Murungu

Mr. Joseph reported that sustaining national QI structures requires stakeholder engagement to ensure sustainability. There is a need for concept development, design meetings, indicators, an implementation plan, and a series of learning sessions. The learning sessions should include facility teams and other stakeholders who all understand their roles. The overall role of this team during learning sessions is to address challenges and barriers to improvement as they arise and build expertise across stakeholders to ensure their understanding of quality improvement.

Mr. Joseph also noted that consumer involvement is very important and should happen right from the design stage from the facility level up to the national level. Countries should build local networks of clients up to village level so they can share experiences and involve the opinion leaders and communities. In Zimbabwe's case, they have supported community involvement in the QI process through:

- Development of consumer training curriculum by the MOH
- Bottom- up planning
- Peer–led community groups
- Formed community working groups for health; creating platforms for learning.

4.0 Plenary Presentation

4.1: National QI initiatives *by Dr Herbert Kadama.*

In his address to conference participants, Dr. Kadama shared updates that focused on the progress of the implementation of National QI initiatives to improve viral load suppression (VLS), early retention in care, the elimination of mother to child transmission (eMTCT) services, and IPT scale up. He highlighted the underperforming areas across the 90,90,90 UNAIDS cascade, especially the 3rd 90, which was first raised by the 2018 Joint AIDS review mission. As a result of the 2018

joint review, four priority areas were selected; 1) viral load suppression for HIV; 2) eMTCT; 3) early retention; and 4) IPT initiation.

The national QI initiative was set up to fast track the 3rd 90, as well as guide and manage improvement at scale within Uganda. The aproach focused on supporting the teams to carry out their root cause analysis, to guide in identification of the problems and design appropriate intervention. The best practice for improving retention in care was by focusing on improving early retention in care and bring back to care" Using the "**Early Retemtion Care Bundle.**

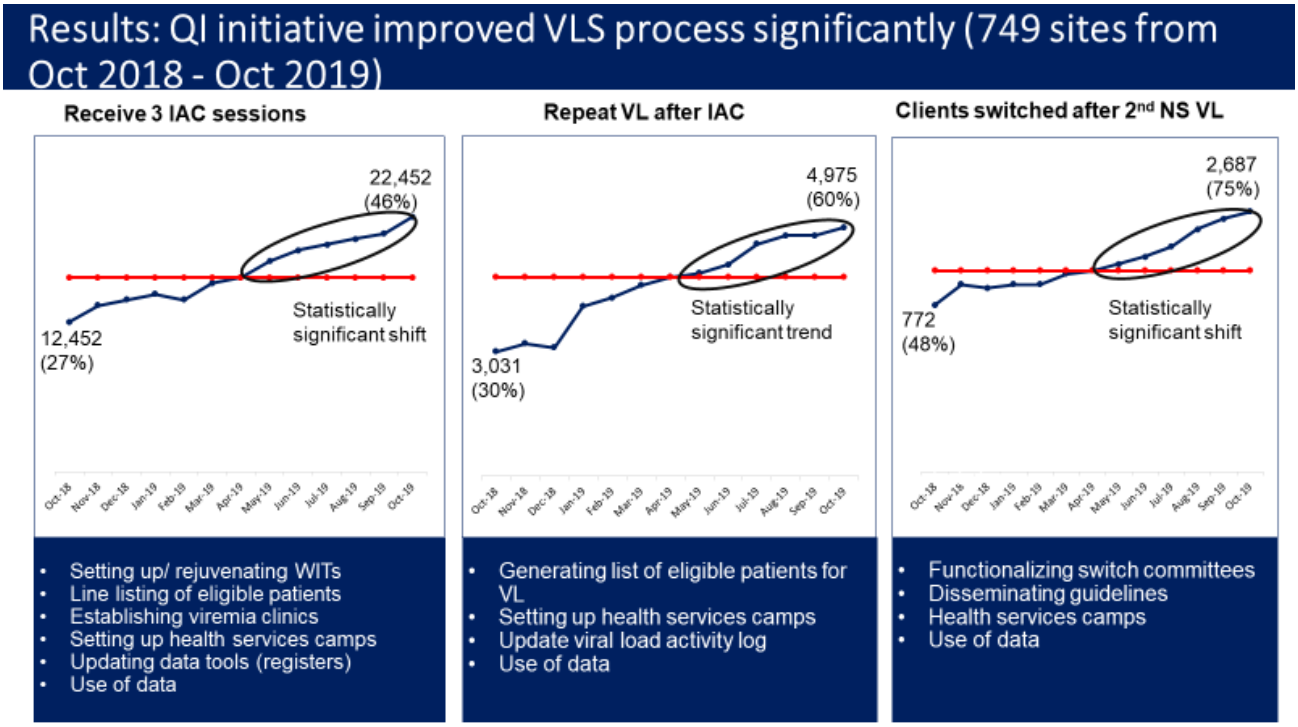


Figure 7: A graph showing the improvement made in the VLS between Oct 2018 and Nov 2019

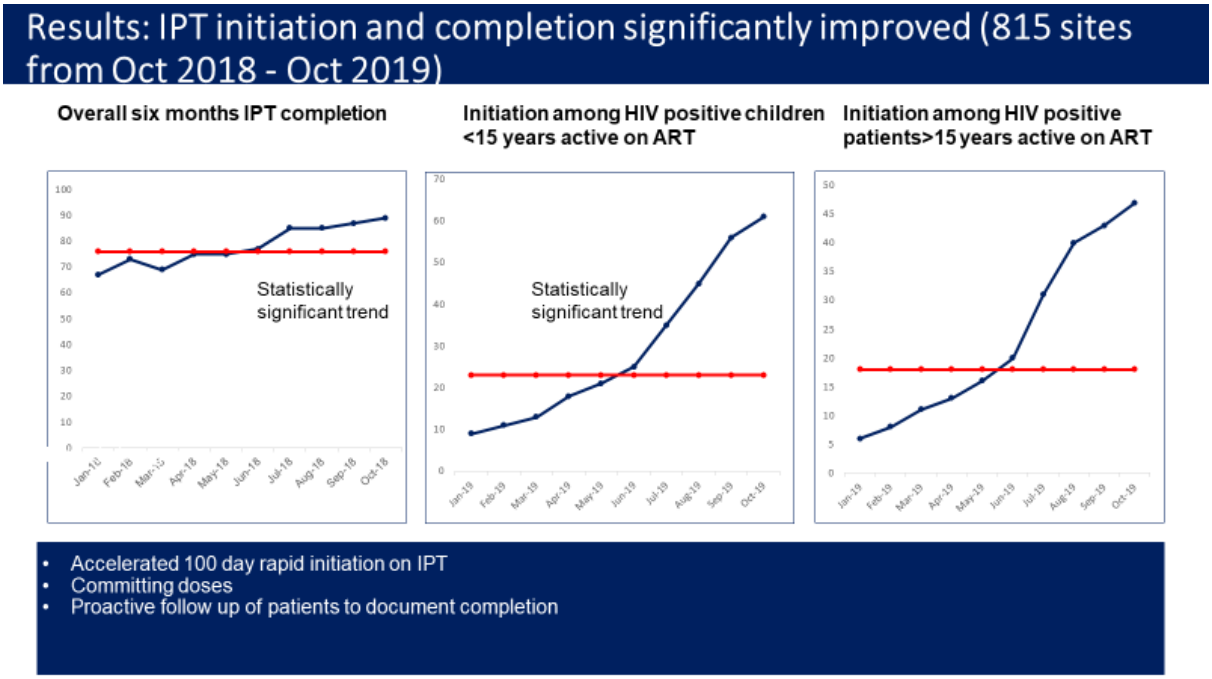
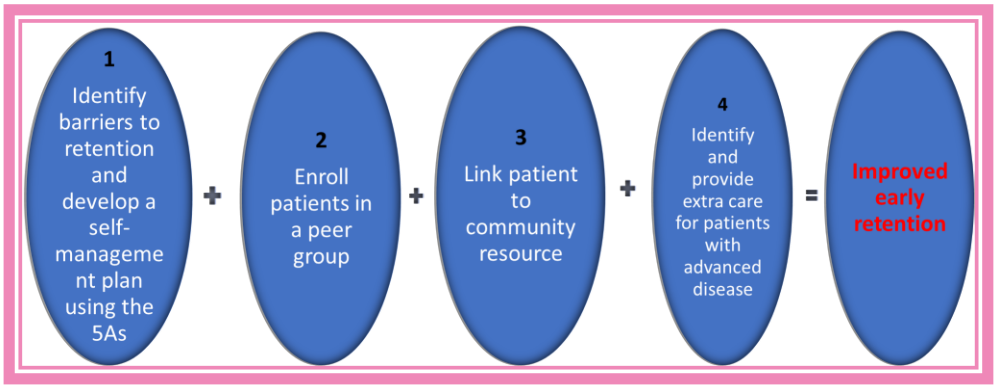


Figure 8: Graphs showing the progress made in IPT initiation and completion between Oct 2018 and Nov 2019.



Fgure 10: Summary of the retention Care Bundle

Dr. Kadama concluded his presentation by summarising the key lessons learned from the initiative:

1) Leadership engagement to support improvement at all levels is paramount
2) Implementing partners (IPs) and district leadership have a significant role in supporting theintegration of QI activities to achieve efficiency
3) There is a need for simple tools and approaches to facilitate timely up take of intervention
4) The importance of using existing systems and structures in improvement

5.0 Abstract Presentations

This year's conference included 126 abstract presentations; 61 of which were oral presentations and the remaining 65 were poster presentations. In addition to an overall increase in the number of selected abstracts this year, conference conveners also noticed that abstracts focused on QI interventions in other technical areas such as malaria, nutrition, sanitations, maternal and newborn health, NTDs, and tuberculosis. Both oral and poster presentations were made and below is a snapshot of the different presenters;

The link to all the abstracts presented during the conference has been provided in ***Annex 1*** *and details of the key lessons learnt in* ***Annex 5.***

Poster presentations by the different members

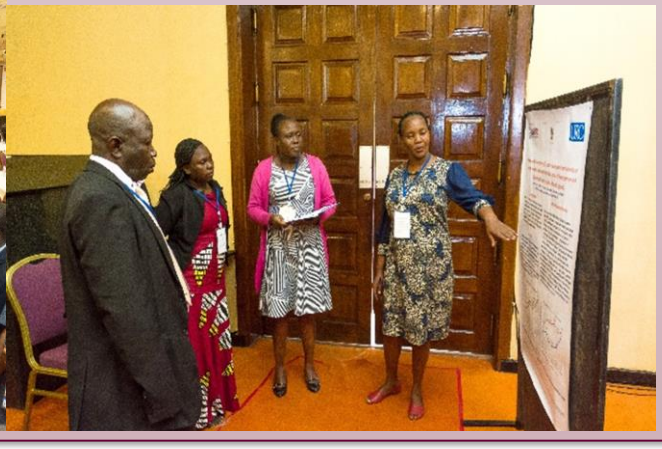


Figure 11: showing the highlights of oral and poster presenters at the conference.

6.0 Panel discussions

Panel discussions were consistent with the highlight of the conference. This year's discussions focused on building sustainable QI collaborative structures; enhancing newborn care;, and integrating QI approaches in all service delivery areas to improve accountability for health outcomes.

6.1 Building sustainable National Quality Improvement collaborative structure

The international team participated in the collaborative sessions during the breakouts. These included sessions: Coaching for collaboratives: This session involved small group discussions with case studies on coaching and how to integrate them into collaboratives effectively. Two case studies were used for skill building, both case studies were from Uganda. Each case study had a real-world problem pertaining coaching and questions for the groups to answer. Skills building case studies were organized and assessed how to integrate and build focus on the systems. Some details on virtual /distance caching was shared. Scale up of collaboratives: This session was engaging external representation of six countries. It was organized like a talk show format where each country representatives were interviewed about their scale up of collaboratives, accomplishments and barriers. This was concluded with plenary session on "creating change packages by Joseph Murungu. Finalized by another session on Measuring patient's experience and involving patients in collaboratives:

Figure 14: Participants in the collaborative breakaway session

6.2 **Newborn care learning by** RHITES N Acholi team.

This session was moderated by Dr Nakakeeto, chairperson newborn care Uganda. The session focused on the importance of improving newborn care, myths and misconceptions around maternal and newborn care, as well as success stories of patients who benefited from quality care. The presenters were; Ms. Beatrice, and Patricia from Anaka Hospital, Isaac wanyima (Nwoya DHO), Bena from Lalogi Health Center (HC)IV and this session highlighted the views of frontline health workers, as detailed below.

6.2.1 Myths and misconceptions around maternal and newborn care

The following key points came from a robust discussion on myths and misconceptions around maternal and newborn care in Uganda.

- Ms. Beatrice, a midwife at Anaka Hospital shared that her and her co-workers developed a functional newborn care unit at their workplace after attending a training led by RHITES-N Acholi. She said the following about the perspective of her co-workers and herself, "As staff we thought newborn care management was complicated. Premature baby issues were all clinical and difficult, we lacked knowledge on management of prematurity issues.
  We also felt our facility could not handle premature babies. Our community also had their own views. The community believes that premature deliveries were associated with witchcraft, and that premature babies were the responsibility of the mother alone. Many mothers feared common medical interventions used for premature babies, such as nasal gastric tubes (NGTs) and kangaroo mother care (KMC) because they believed premature babies were not normal and that they wouldn't grow like the other children." She went onto share that the game changer was introducing a neonatal care unit at the facility. Information began to flow from the main hospital to other health facilities in the community. Mothers were educated on common practices for premature babies and received explanations that put their minds at ease.
- Patricia from Anaka Hospital mentioned that, "Myths and misconceptions are not in the community only but among some of our health workers as well". She also shared that there are cases in which babies and mothers receive care together and that the designation of

newborn care units supports coupled care and ensures that newborns get the most possible attention and care.

- Isaac Wanyima, a representative from Nwoya District, stated that district health teams must take lead to ensure that newborn services are provided at the health facilities within the districts. He shared that initially, he and his team were not aware that newborn care services in their district were non-functional. When their regional partner, RHITES-N Acholi, came to train the team, they got an opportunity to have their health workers revitalized. After reviewing the data and realizing that there were many newborn cases, they were able to support a team to identify a room for newborn care, as well as ensure the necessary equipment and personnel were accounted for. Despite their efforts, they are still moving towards needed improvement. Wanyima shared that the newborn care room is small, the facility has one incubator and lacks sustainable power and water facilities.
- Bena, from Lalogi Health Center (HC)IV, reported that premature babies used to be referred to more advanced healthcare facilities. After receiving training from RHITES-N Acholi team, they identified a small room that has now supported 70 babies since opening in January 2019. Despite their success, Bena shared that the facility has infrastructural challenges, but has improvised by separating babies to help reduce risk of infection from the adults.

In addition to a fore mentioned experience of medical staff members, a success story from a family who has since directly benefited from the positive impact that the RHITES-N Acholi trainings have had on health facilities shared their story as well.

"My wife got pregnant again at about 5 months, one night she woke me up saying something was flowing out of her, it was not blood but water. we rushed to the hospital, they scanned and said she had lost amniotic fluid and what was left was not enough to support the baby. Eventually the baby was delivered, baby was very small and weak. The nurses said they were going to try treating the baby with the new knowledge they had received. I doubted them because this baby was even smaller than the ones that died in the past. The nurses continued to encourage and advise me. My wife encouraged me to accept the practice of the Kangaroo care and our baby is alive today. We thank the health team for supporting us".

Figure 15: The wife and husband showing off their baby after a successful KMC program.

6.3 Integrating QI approaches in all service delivery areas to improve accountability for health outcomes.

This panel discussion focused on ways to integrate QI approaches in all service delivery areas in Uganda to improve accountability for health outcomes.

Dr. Joseph Okware (CHS-SCAPP) moderated the panel discussion which included; Dr. Esther Karamagi, Ms. Jennifer Wabulya (CSO), Dr. Barbara Mukasa (Mildmay), Dr. Dithan Kiragga (COP- RHITES N Acholi), and Dr. Micheal Mwanga (Hospital Director -Soroti RRH). Each panelist was given a question to answer in line with the theme of the conference.

Discussed the path to institutionalizing QI frame works in Uganda – (*Dr. Esther Karamagi)*

QI frameworks have been developed and are in place all around the world, but in Uganda they are not being implemented. This is limited by the fact that QI is not integrated at all levels and in programs, its only being looked at as an HIV approach. With the existing tools, skills, we just need to look at the health systems and prioritize some of them and incorporate.

At the regional level, we have many referral hospitals and QI structures are in place and the framework has clear expectations; regional leaders just need to focus on what can be done in three years, focus in one, two, three, four five areas and assign roles and emphasize on learning areas

until they get to acceptable levels of improvement. There are lots of opportunities around integration, so we need to take advantage of that and be more efficient.

The role of Civil Society Organizations (CSOs) and development partners to institutionalize QI - *Dr. Dithan Kiraga, (Chief of Party RHITES North Acholi)*

IPs and development partners have a great opportunity; they have physical presence both at National, sub national and community level, strong partnership with MoH, good will of stakeholders, high opportunity while designing work plans with stakeholders which helps in capturing, integrating and incorporating QI into work plans with different stakeholders.

During quarterly and performance reviews, we should be able to pick out key priorities for QI and identify gaps and create a soft landing for QI initiatives. We have an opportunity to coordinate and work within existing QI structures (Regional, District committees) to strengthen QI initiatives at different levels.

Opportunity in mobilization, harness resources for QI and leverage on other existing opportunities in areas where we operate. IPs need to open partnerships with other partners, to ensure there's full implementation of QI initiatives. It's very important we participate in M&E activities. MoH with its supported role out of QI initiatives in key priority areas (viral road suppression, early retention, TB & VMMC) has showed statistical improvement.

The role of the Consumer in QI? – *Ms. Jennifer Wabulya*

The role of consumers is critical to ensure that consumers (clients) are part of the health care system. Successful QI can't be achieved without involvement of consumers, there's need to get consumers to know their rights. Empower patients demand for quality services, from safe environment and by a qualified health work. Consumers should be empowered to know about prevention within communities, identify incidents and report them, importance of seeking early diagnosis and treatment. Consumers need to be provided with patient voice-concerns where consumers are brought to levels of decision making and facilitate platforms for dialogues. Advocacy; to ensure that the concerns of health consumers and communities reach the areas where they can be addressed.

MOH wants to integrate QI in all service delivery points; what are the limitations hindering this implementation? - *Dr. Mwanga Michael*

Clients come to health facilities because they require quality services, from a client's perspective quality services ranges from good environment, accessibility, technical support and customer care.

We need quality improvement initiatives, design services where we put a patient at fore front, support QI initiatives as management at the health facilities, set up QI committees with clear terms of reference by the management team of the institutions.

Health facility work plans and budgets incorporate QI instead of QI being IP dependent. Provide training in QI, support clinical audit and discuss issues such as maternal death, disease complications and analyze the situations. Engage communities and obtain client feedback during exit interviews. Conduct Hospital weeks where the public is engaged

Need to move away from vertical implementation, we can integrate these meetings with other activities and let the hospital provide refreshments or conduct brief meetings that don't need refreshments which will promote sustainability of meetings currently being paid for. Recruit a quality officer at the districts or regional level for sustainability.

Concerning the role of research collaboratives as a QI model-do we need to use or innovate approaches visa-vie the traditional way? Dr. Barbara Mukasa

Dr. Mukasa reported that there are 3 core functions of care, these include training, treatment and research. However, the research section has been growing slowly; The public is not research oriented, with the support from CDC fellowship: it has embedded research into care by supporting teams to identify the problem seen in the health care system. "*QI is the missing piece between research, policy and practice".* Research has a role to institutionalize QI; Research is key in creating awareness, opportunities for capacity building and cross learning to improve the projects. Research should come in to question the progress. Can we define our process and justify our activities; objectively checking to see that we are getting to where we want to be. There is a general hunger to roll this out. Perhaps we need to define our way and say as a country, we don't call it QI until is ABC is well defined.

For sustainability research can be used to obtain experimental stages from PEPFAR programs to routine care system, expand from National level to facility levels and consolidate by setting QI targets for every session manager to measure performance based on QI indicators.

7.0 Closing remarks by the Country Director; US Centers for Disease Control and Prevention (CDC); Dr Lisa J Nelson.

Dr. Lisa acknowledged that most of the comments raised by the participants where very important and was happy that they were raised by the Ugandans, the ministry, CSOs and other stakeholders other than the development partners. She emphasized the importance of integrating QI beyond HIV, since the principles are the same.

Dr. Lisa congratulated the team for the successful event and for conducting fruitful discussions. She appreciated the Minister of Health for opening the conference and the government of Uganda for providing support for this conference. On behalf of PEPFAR, she thanked the government of Uganda for its efforts and commitment to strengthen public health and address inequities in health. Beyond HIV/AIDS and TB, it's important that there are other presentations that address other core issues such as waste management, paste prevention and control that are seen as critical towards prevention efforts and other health issues, and other discussions around reducing maternal and neonatal mortality and then QI efforts to be used to close the gaps.

Dr Lisa commented that CDC is excited about the partnership of strengthening the health system in Uganda with QI approaches. There is so much we can learn from each other and achieve together, for quality health care in Uganda.

She concluded by thanking the Ministry of Health and Government of Uganda for the great hospitality and all the participants for the active contributions and participation. Special appreciation to partners like METS, RHITES-N-Acholi and JICA for making the conference successful.

Representative of Minister of Health: Dr Olaro Charles (DHS/clinical services)

He communicated the final remarks by providing apology from the Hon Minister of health and Permanent secretary who were having other commitment and couldn't make it.

Acknowledgment

The organizing committee acknowledges all the Partners for preparing, facilitating, Participating and documenting the processes of the QI conference.

Figure 16: Members of the organizing committee for the 6th National QI conference.

Annexes

Annex 1: National QI Conference Presentations

The 6th National conference presentation are on this link below:

Final National QI Conf 2019 Material.zip

Annex 2: Conference program

National QI Conference Program 2019.pdf

Annex 3: list of Funders

- URC-RHITES ACHOLI -USAID
- METS-CDC
- JICA
- URMCHIP
- MOH

Annex 4: list of Members of the QI Conference organizing committee 2019.

No	Names	Role
1.	Dr. Mwebesa.G. Henry	Overall Coordinator
2.	Dr. Okware Joseph	Conference Chairperson
3.	Dr. Kakala Mushiso Alex	Conference Co- Chairperson
4.	Dr. Ssendyona Martin	Member
5.	Dr. Herbert Kadama	Member
6.	Ms. Clare Asiimwe	Member
7.	Dr. Tumwesigye Tuhwezeine Benson	Member
8.	Dr. Mwebesa.G. Henry	Member
9.	Ms. Barbara Komujuni	Member
10.	Mr. Naoki Take	Member
11.	Mr. Julius Ssendiwala	Member
12.	Mr. Hiroshi Tasei	Member
13.	Dr. Julius Amumpe	Member
14.	Dr. Juliet Tumwikirize	Member
15.	Dr. Namagala Elizabeth	Member
16.	Ms. Agnes Nagayi	Member
17.	Mr. Stephen Kalyesubula	Member
18.	Ms. Josephine Connie Ninsiima	Member
19.	Ms. Juliana Nabwire	Member
20.	Dr. Lawino Ann	Member
21.	Mr. Moses Kyamakya Bwambale	Member

Annex 5: Compilation of improvement projects presented at the conference:

Theme	**Leadership and Governance**	
Improvement Objective	**Problem identified /Gap**	**Intervention/lessons Learnt.**
Improving Functionalization of Regional QI structures.	-QI structures were non-functional. -There was no appointed committee. -No clear roles hence leading to poor performance of 5S and negatively affecting the quality of care.	• Appointed QI team conducted monthly QIT meetings and assessments, • Established 5S/QI coordination office with a focal person. • Supervision checklists were adapted, • Trained QIT • Assigned each facilitator 4 units, with setting targets
Engaging district leadership to improve PMTCT-EID service delivery in Lango sub-region	-Knowledge gaps in PMTCT service-delivery due to staff transfers; attrition and recruitment of fresh graduates -Missed opportunities due to weak integration; -Weak leadership support to facilitate data use, objective decision in staff transfer and recruitment, planning, supervision, and coordination	• Health facility in-charges and EMTCT focal persons oriented on key roles and deliverables • District meetings to review performance and share priority PMTCT-EID areas • Functionalization of eMTCT-EID WITs • Targeted eMTCT supervision and mentorships. • District and health facility level CME's on indicators and data tools. • Targeted integrated EPI/PMTCT/ANC/FP outreach schedules.

Improving Site Level performance through SIMS (Site Improvement through Monitoring Systems) assessments in selected MUWRP supported facilities	-Cross sectional comparison of performance where sites that were comprehensively assessed over a period of three years each with two comprehensive SIMS assessments one year apart; -Compared with sites that have been assessed thrice within same year. -Performance data from all sites was merged and cleaned in one excel file, -Analysis was done using stata 15. Paired t test was used for comparison.	Sites with more assessments within a year including follow up to focus on gaps and share remediations achieve sustained improved quality of service delivery compared to those assessed only once a year. **Lesson Learnt** • Supervisions and support awaken sites to be more accountable which fully improves site performance. • Supervisors provide comprehensive assessment. • MoH / IPs should conduct semi – annually / quarterly conduct cost effective assessments for program areas. • Immediate follow up ± one month after assessments is key to track progress towards improving identified gaps.
Results of 3rd M& Evaluation of 5S performance.	• In total 20 5S-CQI-TQM facilitators assessed the performance at 16 hospitals. • 2 M&E tools: (1) Management/QIT (18 questions) • (2) Unit and department (18 questions) • Comparison of 5 common areas among hospitals: maternity, laboratory, main theatre, medical record, main store • Progress of top 5 areas from 1st and 2nd evaluation at each hospital	• Good performers of 5S (Sort, Set and Shine) have good fundamentals to sustain Sort, Set and Shine; i.e. good scores of top management/QIT, leadership of WIT (e.g. action planning) and Standardize (esp. use of checklist and development of SOP) • Therefore, performance of Sort, Set and Shine is positively correlated with the fundamentals **Key to sustaining 5S**: · Top-management support · Active QIT: e.g. Frequent Internal supervision

	· Target score: 60%	· Action planning for both QIT and WIT · Development and use of checklists and SOPs for 5S.
Theme	**Health information**	
Ensuring Quality Data for Decision Making: Using Automation to Support Data Cleaning and Validation: Lessons from the Strategic Information Technical Support (SITES) Project.	-Given technological advances, there was a need to explore use of technology to address this challenge. • Automation developed using SQL Server Integration Service (SSIS) Extract, Stage, Verify, Transform Load • Validation: rules developed by the national teams, run against data in database (powered by Microsoft SQL Server) • Data failing the quality checks is flagged and availed through the web-based SQL reports (developed in SSRS) for remediation.	• Process designed to run on-demand (whenever data is available) • An automated process for validating data reported in DHIS2 was established & Implemented • Web-based error reports that can be viewed by any authorized-user with internet access. • These reports show facilities with data quality issues • Errors can be automated to run at selected intervals **lessons learnt** • Automated data cleaning is feasible as demonstrated in this pilot, and optimizes effort and eliminates errors associated with manual processes • Successful adoption by implementing partners who have used this system to support facilities and/or districts data reviews and address inconsistences before system closure.
Introducing interactive data dashboard for improved quality of	-A six months project of introducing interactive data dashboard in all the departments (October 2018 to March 2019). -The idea was shared with staff that were	Eighty percent (80%) of the departments were able to generate interactive data dashboards. Nearly a hundred percent (100%) of the departments that generated interactive data dashboards used them for decision making.

service delivery at Mubende RRH, Uganda	then trained and sensitized. -Tools for data dashboards were prepared, printed and distributed to the departments. -Supportive supervision, coaching and mentorship was done in the departments. -Dashboard generation and use for decision making was assessed monthly. -Check list incorporated in that of QI -Quarterly performance Review meetings were introduced: - to share experiences, innovations for improvement as way of sustaining the project.	**Lessons learnt** · Changing the mindset of service providers is vital for successful introduction of interactive data dashboard in organizations**.** · Idea discussed in morning meetings. · Support supervision Assessments · Communicating guidelines · Interactive data dashboard enables managers at all levels make decisions from real-time data
Theme	**Human Resources for Health**	
Leveraging on Available Human Resource to Provide Community TB Services in High TB Burden Communities: The Community Cluster Head Approach in Kisenyi- Kampala Central Division	-AIC established a partnership with Integrated Community Health Initiative Organization (ICHIO) - an initiative founded by students of Makerere University School of Public Health in 2014. -39 students (volunteers) were engaged and trained in the basics of TB control at community level.	• The 10 new cases identified through this approach demonstrated that communities have greatest and most sustainable human capital which needs to be harnessed and utilized. • Engaging students and fresh graduates' fosters Innovations. • Engaging students and fresh graduates build a huge mass of critical experts in specialized areas. **Conclusion**

	-Clusters of 10 to 15 households established and Cluster heads for neighborhood TB watch nominated by cluster members. -Volunteers and VHTs screened and educated cluster members about TB.	-Engaging district leaders promote ownership leading to allocation of resources and assigning human resource for improved service-delivery.
Health Worker Salary Enhancement: Have we had Value for Money? A Question and Answer from Tororo District	The District Health department staffing level by the start of FY 2019/20 stood at 65.3% (611 filled posts out 936 established posts) · With the above in consideration, the government of Uganda enhanced health workers salaries Starting with Financial year 2018/19 · This was to address the outcry of low payment that was said to be one of the contributors to the poor performance of Health service delivery indicators in the country. These included: · OPD new attendance · 1st ANC visit · 4th ANC visit	-We conducted a retrospective study in which five key performance indicators were selected. · From the quarterly comparison, performance of three Indicators (OPD,4th ANC and TB CNR) dropped. · The improvement of 6% (P = 0.3827, CI =95%) 1st ANC Visit and 1.7% (p = 0.7792, CI =95%) for Deliveries was not significant and worse still there was a drop in the overall performance. · The drop in the average performance indicates that the salary enhancement had no contribution to performance improvement in the 1st quarter 2018/19 **Lessons learnt** • According to the results it was leant that salary enhancement alone may not led to significant performance improvement in Health service delivery. • There is need to integrate salary enhancement with other interventions like Internal supervision by health facility

	· Deliveries in the Unit and TB case notification rate	managers, Daily/weekly departmental output reports and WIT meetings
Strengthening staff performance management to enhance attainment of the HIV 90-90-90 targets in Nwoya district	-An assessment identified gaps in attaining the HIV 90-90-90 Targets (1st 90-13% gap, 2nd 90-34% & 3rd 90- 62% gap) The Fish bone technique for problem analysis, was used to identify the root causes: · Inadequate orientation of managers on Performance Management · No allocation of targets to staff · No duty allocations done · Irregular performance review meetings · Manuals and tools not availed or prioritized.	• Oriented 25 Heads of Hospital Departments and the DQIT/DHT on performance management • Trained 30 in-charges in Performance Management • Targets for indicators for the UNAIDS areas were set for the facility and for each staff in the entry, care, treatment and support units • Guidelines and relevant forms were multiplied and distributed • In-charges then helped the staff develop their performance plans, Conclusions: · The intervention established a performance management · system with scores increasing from 61% to 90% and · improved the performance for the HIV 90-90-90 targets.
Theme	**Health Financing**	
Improving the quality of lives of vulnerable HIV positive children and adolescents with high viral load through	A local fundraising dinner was organized under the theme “Engaging families to achieve HIV viral load suppression among children and adolescents at TASO Gulu center”.	• The sale of cards, testimonies by HIV infected adolescents and on stage auctioning proved very effective in raising substantial amount of money which can lead to improved health outcomes Lessons learnt

resource mobilization in the aids support organization (taso)gulu	• Different categories of invitation cards were printed and sold. • A registration fee was charged. • Adolescent's testimony. • Items for auctioning. • Donation box	• Involving key stake holders is very crucial in mobilizing local resources. • Early preparation and communication ensured key stakeholders participated in the fund-raising drive. • Fundraising should not be locked to only local setting but should be open to the general population,
Theme	**Health infrastructure**	
Improve Functionalization and usage of medical equipment at all departments.	19.1% were lying redundant without being used yet some units where lacking, 17.5% were non-functional, 6.1% though in use but were very old and needed replacement while 4.2% were for disposal.	• Shared the updated data with all unit's top management administration and workshop manager. • Development of survey tool with an action plan. • Sensitization of the unit in charges on importance of having functional equipment • Simple geographic mapping information system (SGMIS). Feedback on equipment status per department during monthly quality improvement meetings.
Using Laboratory Quality Improvement Approach to Improve Equipment Functionality at Rukunyu Hospital, Kamwenge District, Uganda	By October 2018; 60% (n=3) of equipment were functional and 40% (n=2) were nonfunctional. This was due to; • Irregular equipment service, • Lack of service contracts,	MOH through CPHL in collaboration Baylor Uganda facilitated mentorships to strengthen LQMS. · QIP in Equipment management was emphasized · Equipment focal person was selected to identify Equipment nonconformities.

	• Incompetent equipment users methods ·	· Laboratory team conducted root cause analysis. Proposed action points · Training, Competency assessment · Orientation · SOP and equipment manuals accessibility. · Service contracts secured · Equipment Service schedule adhered to · Timely Follow up of service engineers Lessons learnt • The cost of repairing Brocken equipment and referring patients is higher than the cost of regular equipment maintenance and training users.
Theme	**Medicines and Supplies**	
Reducing wastage of medicines and health supplies (HS).	-Order from clinical departments not based on the number of cases. -Inadequate knowledge on the pharmacokinetics and pharmacodynamics of the new medicines. -Not enough space for departments to keep stocks **Resulted into:** Unnecessary accumulation of stocks at departments, increased expires medicines, Imposed unnecessary costs for medicines and health supplies.	• Established inpatient pharmacy (IPP) to directly dispenses medicines and health supplies to inpatients daily. • Medicines and Therapeutic Committee reviewed the list of emergency medicines and health supplies to be stored at each department. • IPP receives the requisition form of emergency medicines and health supplies from each department weekly. • IPP supervises amount and expiry of medicines as the way of management at the clinical departments monthly.

Improving Prescriber Rationality and Use of Injectable Malaria Treatment in East Central Uganda using Collaboration, Learning and Adaption Approaches: A Case Study of Jinja RRH (JRRH)	JRRH was consuming an alarmingly high rate of injectable Artesunate, an antimalarial drug used to treat severe malaria in adults and children and facing frequent stockouts of the medication.	· The hospital team conducted orientation and consensus building meetings with clinicians to discuss good prescribing practices for malaria treatment and distributed copies of the Uganda Clinical Guidelines to clinicians on patient wards · This good practice was adapted from Hoima RRH who had faced similar challenge of irrational prescription of Injectable Artesunate. · JRRH establishing dedicated space for a 24-hour in-patient pharmacy; · Instituted in place internal controls to ensure proper dispensation of Injectable Artesunate to only patients admitted with a diagnosis of severe malaria, · Used a tracking form to ensure that Injectable Artesunate was only dispensed to nurses with patients charts and prescription notes for the drug. · Each patient was to receive on average 3 doses in 24 hours, and this helped to improve accountability Conclusion: Dispensation of Injectable Artesunate at JRRH decreased from 1,130 doses in October 2017 to 225 doses in December 2018. This was a 80% reduction in the consumption of artesunate.

Integrating Quality Improvement approach with SPARS to improve availability of medicine health related supplies in Kapchorwa district.	A baseline assessment in November 2012 was conducted on five thematic indicators. • Two health workers were identified and trained in supply chain management. • Targeted initial support to health facilities was done involving coaching and mentorships on bimonthly basis. • This was done concurrently with initiation of QI projects to close gaps identified.	• Targeted QI projects are efficient means to conduct coaching and on-site mentorships for health workers on medicine management • Integrating QI and SPARS work synergistically to better service delivery
Evaluating Inter-rater reliability of Indicators to assess performance of medicines management in health facilities in Uganda	• Initially the MMS' IRR scores for the medicines management indicators in the SPARS assessment was poor; only 5 of the 24 indicators achieved an acceptable IRR of ≥75%. Our findings highlight the fact that IRR must be considered when designing indicator-based assessments, even when using well-known and globally recognized indicators and extensively trained data collectors.	• Independently scored the SPARS indicators using the standardized SPARS data collection tool and method A study investigator • We recorded the characteristics of MMS teams to explore possible relationships of IRR scores and rater team composition, including gender, profession, and experience • We classified the 24 SPARS indicators that were assessed into two groups based on their complexity (Simple or Complex) • This study suggests that focused and practical training and tailored instructions may improve IRR scores for pharmaceutical and medicines management indicators. IRR of indicators in all five domains improved following the

		interventions, reaching acceptable or almost acceptable scores; only the prescribing quality domain indicators continued to have low IRR. Both the IRR and the effectiveness of our efforts to improve IRR depended greatly on the type of indicator. • Despite overall improvement, the IRR score did not improve for all SPARS indicators. IRR for two indicators decreased by over 20% points: stock book is filled in correctly and accuracy of the health management information system (HMIS) report.
Improving Accountability for Health Commodities through Proper Utilization of Logistics Management Information Systems (LMIS) Tools	At the end of August 2018, Kamuli Mission Hospital had a **39.9%** variation between the number of Determine® HIV testing kits issued from the store (5,000) and the tests done (1,010 tests), affecting accountability of **3,990** Determine® tests during reporting. The team conducted a root cause analysis that informed implementation	-Conducted periodic review meetings to address challenges and performance gaps (August 2018-ongoing) -Displayed standard operating procedures (SoPs) and oriented staff on requisitioning and issuing health commodities (August 2018); -Hospital management introduced routine rotation of staff between pharmacy and stores to improve versatility and skills in logistics management (October 2018); Lessons learnt · Displaying of SOPs plays a vital role in guiding health workers to follow procedures. Eg filling the requisition and issue book.

		· Staff learnt and understood the different logistics management indicators through departmental rotations. · Use of data is vital in understanding trends of how things are happening.
Themes	**Service Delivery**	
subtheme	**MNCH**	
Strengthening implementation of Maternal Perinatal Death Surveillance and response (MPDSR).	▪ Average facility deliveries of 95 per month and registered an average of 23 perinatal deaths per quarter (DHIS2 July-Dec 2018). ▪ Only 26% of perinatal deaths were reviewed by Oct-Dec 2018. ▪ A root cause analysis identified a major gap in knowledge of MPDSR. ▪ The MPDSR committee was non-functional and lacked clarity in roles. ▪ Staff were skeptical about conducting MPDSR at the hospital, fearing potential reprimand due to negative pregnancy outcomes.	▪ The district MPDSR focal person (ADHO MCH) using the DHIS2 analyzed and shared the site performance dashboard with the hospital management. ▪ Onsite Mentorship that integrated Quality improvement framework was adopted to include practical support to conduct reviews, gap identification and implementation of corrective actions improved provider confidence. ▪ Availed the tools for periodic MPDSR reviews and reporting. ▪ A hospital level MPDSR committee of 14 people was established with a focal person identified to support implementation. ▪ Health workers taken through a 45 minutes CME on the MoH on the national MPDSR guidelines.

		▪ Facility led MPDSR work plan was made detailing onsite mentorship support, timelines for periodic reviews of all maternal and perinatal deaths ▪ Regular communication to the DHT leadership as soon as a death occurs at a facility using a WhatsApp platform backed up by the perinatal review reporting forms. ▪ DHT supported reviews and implementation of identified follow on actions at site level ▪ Working with the district biostatician to support timely reporting of the reviews into the DHIS system. ▪ Highlighting MPDSR performance during facility, HSD, district performance review and planning meetings.
Uptake of intermittent preventive treatment for malaria in pregnancy (IPTP) in Soroti district following a change in administration policy.	The current NMRP highlights some key strategies for increasing uptake of IPTp. These include; • Community mobilization, sending regular text messages (about the importance of IPTp) to HWs providing ANC services and Provision of IPTp as DOT by the HWs. (M.O.H, 2014). • Despite these interventions, uptake of IPTp is still very low in some areas, particularly in the Teso region (13.6%)	Whereas the study was conducted in only one subcounty in Soroti district, most of the findings are similar in other parts of the country and are therefore transferable. For uptake of IPTp to improve, there is need for a multi-faceted strategy: • Health education for pregnant women on the importance of IPT. • Improving stocks of SP at the health facilities • Training of the health workers in the new IPTp policy guidelines

	• This study sought to determine the uptake levels of IPTp and the associated factors among pregnant women in Soroti district.	• Improving documentation for IPTp at the health facilities is critical. • There is need for designing and institutionalizing QI interventions for increasing IPTp uptake
Reducing the incidence of obstetrical tears at general maternity ward -mengo hospital	To reduce the incidence of obstetrical tears from 2.5% (11) to 1.4% (6) by 9th October 2018 at General Maternity ward Key issues identified included; • Increased mothers with PPH due to tears • Gaps in management of second stage • Irrational use of oxytocic drugs during labour • No documented protocols for induction of labour • No health education of mothers at antenatal about use of native medicines	A combination of initiatives to address maternal and health worker factors were done. No study has been found stressing a specific initiative. Protocol training, supervisor monitoring, and CMEs contributed greatly in tears reduction **lessons learnt** o Institutional leadership involvement in audit meetings quickens decision making o Consistent audit meetings provide a good audience for communication of QI initiatives o Good record keeping practices quicken data collection in retrospective studies o Employee performance monitoring helps to keep each member of the team accountable
Implementation of health programs by bringing back mother baby pairs	Following sharing of the client level data at quality improvement and work improvement team meetings, a root cause analysis of the data showed that Financial constraints, travel difficulties and	· As a departmental Work improvement team reviewed our exposed infant register, appointment book and Family Support Group registers, data was abstracted to identify gaps in the PMTCT care cascade.

into care at RugazI HC IV, Rubirizi district	stigma in general were the top three problems preventing most HIV patients from keeping their scheduled appointment dates. Others included salient issues like Gender Based Violence, relocating to another district for work, lack of money for transport, over representation by treatment supporter. As many are still lost to follow-up, there is a need for interventions at all levels to ensure patients do and are able to return for the treatment they begin.	· At the facility, we streamlined the EMTCT client flow by moving of the Mother baby care point to Maternity away from general ART clinic. · Due to the limited knowledge of staff transferred from the lower non-PMTCT sites we conducted CMEs. · Made a schedule for client/mothers' health education to empower them demand for services. · Ensured all the HEI newly born get Documented in EI register and have an EI number before discharge from the facility at birth. · We decentralized DBS testing from main lab by creation of a min laboratory for MCH department with blessing rom ART, lab and facility in-charge. · Made a duty schedule with roles and responsibilities with much focus on identifying those lost to follow up by Updating registers after every FSG clinic day and generating search lists on same day of every FSG day.
Subtheme	**HIV**	
Prevalence and Factors associated with delayed	We conducted a retrospective review of HIV care documents of patients meeting the WHO criteria for virological failure at 3 public health facilities	We enrolled 114 patients that met the inclusion criteria. • The mean age (standard deviation) was 32.1 (16.6) years and 58.8% were females.

antiretroviral therapy switching at rural public health facilities in Kiboga district, Uganda: A Retrospective Review of Medical Records From January 2017 to December 2018.	in Kiboga district including a health centre III, a health centre IV and a district hospital. > Confirmed virologically failing patients (two consecutives viral load measurements of >1000 copies/ml) were included in the study to form a sample of 114. > A patient was considered to have had delayed switching to second-line ART if they were retained on a first-line ART regimen for >1 month after receipt of the second unsuppressed viral load measurement at the facility. > We performed logistic regression analysis to identify factors associated with delayed switching to second-line ART.	• The prevalence of delayed switching to second line ART regimen was 73.7%. • Factors associated with delayed switching were being single (adjusted odds ratio (AOR) 4.1, 95% confidence interval (CI) 1.04-16.25 p=0.044) and receiving care from Kiboga district hospital, a high-level health facility (AOR) 4.4, 95% CI 0.97-20.71 p=0.05). Lesson learnt • There was a high prevalence of delayed switching from first to second line ART regimens. This indicates that PLHIV with virological failure stay longer on a potentially ineffective ART regimen.
Improving Intensified Adherence Counselling intervention among Adolescents with non-suppressed Viral Load between 10 – 19 years using CQI approaches: Mukono H/CIV	Viral load suppression rates in FY18Q3 were 74% in MUWRP supported districts of Mukono, Buikwe, Kayunga and Buvuma. To ensure the third 90 target of a suppressed VL is achieved, through the national CQI collaboratives, MUWRP supported Mukono HC IV to implement IAC's intervention among adolescents with unsuppressed VL.	• Identification of files of Non-Suppressed (NS) clients through sorting and labelling. • Clients were initiated on IAC for three consecutive months by the social worker. • Barriers to adherence were identified and adherence scored. • In Oct 2018 to Sep 2019 charts of adolescents 10-19 years and NS register were reviewed in Mukono H/C IV, and

		documentation journals for NS clients who had received three consecutive IAC. lessons learnt Creation of viremia clinics mainly for Adolescents established good rapport between Health workers and Adolescents for acceptability of a positive living.
Using quality improvement approach to increase unsuppressed clients eligible for 3 IAC completing the 3 consecutive IAC sessions: A case in Olilim HCIII	-Conducted RCA for non-completion of the three (3) consecutive IACs despite having counsellors. -Identified attributing causes included • lack of responsible person for IAC, • Lack of NS clinic days, • poor counselling coupled with lack of NS clients tracking systems IAC appointments.	• Conducted one off CME in counselling for counsellors for uniform technical message to clients; • Established special non-suppressed clinic days with defined appointment system; • Identified IAC focal person an intern counsellor with clear defined roles and responsibilities; • Established pre-appointment remind call by the CLF with retrieval of the client files a day before the NS clinic; • Immediate follow up of clients with missed appointments and NS client champion as a member of the WIT to share experience • Establishing NS clinic days with streamline clinic systems impacts on clients' retention and adherence to IAC appointment schedule
Subtheme	**Pediatrics.**	

Using Quality Improvement Methods to Improve Appropriate Assessment, Diagnosis and Treatment of Pneumonia amongst children under five years: The Experience of Baitambogwe HCIII in East Central Uganda	Following a root cause analysis, the Baitambogwe HCIII OPD team initiated a Quality Improvement (QI) project to address the following Gaps • Rational use of antibiotics on children • Nonadherence to the MOH recommendation for assessment and treatment of pneumonia to improves management outcomes for the under five children with pneumonia • Irregular reviews of the prescription trends	• Improved compliance with the use of oral amoxicillin as the first line antibiotic treatment for pneumonia in children under five years of age: • Mentorship of clinical staff during clinic days on appropriate assessment, diagnosis and treatment of pneumonia according to Uganda Clinical guidelines. • Weekly review of the Out-Patient Department (OPD) register management of pneumonia Lessons learnt · There are many myths and misconceptions on Pneumonia · Health workers should use the case management approach. · Health facilities should be equipped, need referrals for better management.
Subtheme	**Nutrition**	
To Improve Nutrition Assessment, Counseling and Support (NACs) at 15 Collaborative Sites in Acholi Sub region.	Gaps in NACs at facilities · No/Low nutrition assessment for clients at the different entry points especially OPD as low as 11% . · Nutrition assessment being conducted but not reported-no reporting or under reporting.	· Facilities coached on appropriate NAC documentation · Completeness of all nutrition data elements · CMEs on documenting and reporting nutrition data. Ensure that facility teams, interns and non- clinical staff assigned at triage do the following: · Nutrition assessment using MUAC · Nutrition counseling conducted · MUAC documented in OPD register

	· To improve NACs, RHITES-N, Acholi with support from the National and Regional QI teams instituted a quality improvement collaborative at 15 sites.	· Every visit, health education centered on sensitizing patients/ attendants on nutrition assessment as first step
Strengthening Nutrition service delivery to improve treatment outcomes for malnourished children in Inpatient Therapeutic Care (ITC): A case of Pope John's Hospital-Aber, Oyam District.	In 2017, the hospital QI team and CUAMM staff carried out a Nutrition Service Delivery Assessment (NSDA) that revealed knowledge and skills gap in the management of SAM within the ITC. · The staff at the ITC had insufficient knowledge on use of the Critical Care Pathway for initial management · The death rate in the ITC was higher than the MOH, IMAM standard of <10% · There was only 1 OTC and ITC within the whole district of Oyam at PJHA making accessibility to management of SAM inadequate within the district. · Poor documentation in the Integrated nutrition register and poor reporting of performance indicators in the ITC.	· Staff were trained on management of SAM · A committee to audit deaths on a monthly basis was set up. · Continuous mentorship and supervision were done to staff in the ITC on use of the continuous Critical Care Pathway (CCP) to manage SAM with medical complications. · Supported the district to set up additional 4 OTC sites within the lower health facilities. · Targeting high burden sub-counties to improve on the accessibility of nutrition services for the malnourished. · Supported quick referral of those with SAM and medical complications to the ITC site by the use of vouchers · Engaged and trained VHTs within the community to identify early malnourished cases and refer them for management. · Biannual Mass MUAC screening for children 6-59 months in the community during Child days lessons learnt: · Malnourished children that were referred early to the ITC had better treatment outcomes than those that come late .

		· Use of the CCP is essential in initial management to identify and manage appropriately medical complications associated with SAM timely there by reducing mortality · Auditing of the deaths within ITC helped to identify gaps within service delivery so as to improve on treatment outcomes
Subtheme	**GIT**	
Improving estimation of prevalence of gastrointestinal bleeding and known factors associated with mortality on medical emergency ward at mulago hospital	• There was no data on the prevalence of GI bleeding and frequency of known factors associated with mortality in the emergency ward. • This data could easily be obtained from the casualty assessment form which was not adequately filled. • This would affect estimate of the prevalence of GI bleeding if the CAF was used their current state. • We set out to produce data on the prevalence of GI bleeding to inform planning of resuscitative care for these patients.	**Process mapping:** Areas of improvement in the documentation process were: 1. First attending doctor who decides on admission fills the CAF 2. Medical records assistant fills demographic section of the CAF and face sheet 3. Another doctor fills the admission sheet and other fields of the CAF 4. Nurse removes the CAF for filing into the box file at nurse station 5. MRA collects the CAF from box file and enters its data into electronic data base and the CAF is archived in records office. Conclusions · Education coupled with supervision caused remarkable improvement in completion of the CAF.

Subtheme	TB	
Using Quality Improvement Methods to Improve Assessment and Documentation of Hearing Loss for Drug-Resistant TB (DR-TB) Patients on Injectables: The Experience of Iganga Hospital in East Central Uganda	There has however been suboptimal performance in audiometry assessment (38%-July-Sept 2018) for Iganga General Hospital (IGH) which hosts 24 DR-TB patients, with an average quarterly enrolment of three new cases.	Following a root cause analysis, the IGH DR-TB clinic team initiated a Quality Improvement (QI) project and implemented the following interventions to improve assessment of audiometry for DR-TB patients: • Training of TB clinic staff in audiometry (July 2018-ongoing); • Timely purchase and stock of batteries for the audiometer before the clinic day in case of interrupted electric power supply (January 2019-ongoing); • Mentorship to strengthen real- time documentation of audiometry results (April 2019-ongoing).
Improving TPT completion in a high-volume setting: a case of lira regional referral hospital	In July –September quarter 2018, Lira regional referral hospital enrolled 190 clients and only 36% completed a course of TPT by Jan- March. Route cause analysis (RCA) conducted by the Hospital QI team and identified the following gaps: • Registers were not updated in real time since there was no assigned person to foresee documentation.	• Established and placed IPT registers at extra dispensing points at key HIV entry points in ART, triage/first track, Mother baby care points and TB ward to make One stop point for clients on TPT to track enrolment and completion. • Provided Counter book to track patients on CDDP and those transitioning from different models for updating the IPT registers and Synchronizing IPT and ART appointment date. • Assigned TPT focal persons at these points, to ensure documentation of IPT date start on client file and book.

	• Only 2 IPT dispensing points (ART clinic and TB ward) with 4 ART dispensing points within the Hospital (1st track, EMTCT, pharmacy and TB ward). • Non-documentation of IPT numbers and initiation date on client held books and files making file retrieval and tracking of completion cumbersome • Lack of provision for ART numbers in IPT registers	• Updating backlog of clients' registers refills was done in real time while committing doses. • Review and monitor monthly performance targets. • Give TPT unique numbers to clients initiated. Also the documentation of TPT start month, improvised a column for ART numbers in the IPT registers
Theme	**Special groups**	
Improving IPT coverage among Children and Adolescents aged 0-14yrs living with HIV through designating ***special clinic days***, designing and administering ***targeted Health Education messages***, a case of Kapelebyong Health Centre IV	Findings of the problem analysis process identified the following gaps: • Lack of special clinic days for the target age group. • No tailored health education sessions • Knowledge gap amongst health workers regarding IPT/TPT • Over representation of children during clinic days	• Files were retrieved and reviewed to assess eligibility for IPT and possible barriers to enrollment. • A multidisciplinary team was put in place to facilitate planning, implementation and monitoring of all progress. • Special clinic days were singled out from the calendar months, typed, printed and displayed on main notice board and also at clinician's desk. • Clinicians observed synchronization of appointments for the target group • Special and targeted health education messages were prepared and carefully

	• Parents/or Caretakers lacked essential knowledge regarding IPT/TPT and its benefits.	**Lessons Learnt** • Certain special groups require ***special time*** to be set apart to adequately address their pressing needs, this will give room to achieve optimal health outcomes. • ***Teamwork*** is a very crucial factor in improving systems and processes in service delivery. • ***Documentation*** is key, good documentation ensures correct baseline information which will guide an informed planning process and is pivotal in the entire M&E progress. • There is need to ***empower parents and/or Caretakers*** of children and ALHIV with right information.
Scaling Up Pre-exposure Prophylaxis (PrEP) Services to Key and Priority Populations (KPs/PPs) in South West Uganda	AIDS Information Centre (AIC) with funding from RHITES-SW began providing PrEP services to KPs/PPs in the districts of Kabale and Kisoro at government health facilities and two drop-in centres (Kigongi under Kamukira HCIV and Katuna boarder under Kamuganguzi HC III). However, it was noted that the KPs/PPs hardly visited those premises with only 543 clients accessing services (October 2018 to March 2019) against a target of 1,406 (38.6%). Low retention in care (43%).	• KP Hotspots in different sub-counties and divisions of Kabale and Kisoro were mapped out. • KP leaders were identified and trained in peer community mobilization and follow up • HIV prevention services including PrEP were taken directly to these hotspots. • Data was collected by service providers together with KP leaders on a weekly and monthly basis and analyzed descriptively Lessons learnt:

		• KPs and PPs are highly mobile and so they need a more flexible service provision option, enhancing sensitization for PrEP requires combined efforts. • KPs and PPs have organized peer movements and therefore use of peers for mobilisation enhances PrEP initiation and retention. • KPs and PPs are scared by the law enforcers; when dealing with them, there is need to reassure them of protect

For more presentations please refer to Annex 1