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STRENGTHENING UGANDA'S SYSTEMS FOR TREATING AIDS NATIONALLY

TB CARE CHANGE PACKAGE



**Synthesis of the most robust and effective QI interventions to improve
TB Care in SUSTAIN supported hospitals in Uganda**

AUGUST 2017

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Quality Improvement Change Packages Series

The purpose of the quality improvement change packages is to provide a synthesis of the most robust and effective QI interventions for effective HIV programming. The quality improvement change packages series thematic areas include: prevention of mother to child transmission, laboratory, monitoring and evaluation, adolescent friendly health services, voluntary medical male circumcision, nutrition, HIV care and treatment, supply chain, Tuberculosis, and quality improvement.

USAID/SUSTAIN acknowledges the work of the project staff, technical officers at MoH, and counterparts at supported facilities who have been instrumental to the project's many successes through implementation of the quality improvement interventions.

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The views and opinions expressed here do not necessarily state or reflect those of USAID or the United States government.



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List of Acronyms

CME	Continuing Medical Education
DR-TB	Drug Resistant Tuberculosis
HC	Health Center
MDR	Multi-Drug Resistant
MoH	Ministry of Health
PDSA	Plan-Do-Study-Act
QI	Quality Improvement
RRH	Regional Referral Hospital
SUSTAIN	USAID Strengthening Uganda's Systems for Treating AIDS Nationally
TB	Tuberculosis
USAID	United States Agency for International Development

Introduction

Since 2010, the United States Agency for International Development (USAID) has been working with Uganda's Ministry of Health (MoH) to improve HIV and AIDS service delivery at select health facilities, mostly in the public sector. Over the last seven years, this USAID Strengthening Uganda's Systems for Treating AIDS Nationally (SUSTAIN) project has aimed to:

- Support the MoH to scale up prevention of Mother-to-child transmission of HIV (PMTCT) and voluntary medical male circumcision (VMMC) as HIV infection prevention interventions within selected public regional referral hospitals (RRHs) and general hospitals
- Ensure provision of HIV care and treatment, laboratory and tuberculosis (TB)/HIV services within selected public RRHs, general hospitals and health center (HC) IVs
- Enhance the quality of PMTCT, VMMC, HIV care and treatment, laboratory and TB/HIV services within selected RRHs, general hospitals and HC IVs, and
- Increase stewardship by the MoH to provide sustainable quality HIV prevention, care and treatment, laboratory and TB/HIV services at project-supported healthcare facilities.

The USAID/SUSTAIN project has provided technical, coordination and operational support to 13 health facilities to deliver quality TB services, including accelerating TB case detection and strengthening TB/HIV collaborative activities through the continuous quality improvement (QI) approach. Health facilities have been supported to implement QI interventions through integrated mentorship, which focuses on improvements in both content and processes of care.

The project's approach to QI was guided by the Model for Improvement that uses the Plan-Do-Study-Act (PDSA) cycles. Quality Improvement experts from SUSTAIN supported the formation of multi-disciplinary improvement teams at all supported health facilities, through which QI interventions were implemented. This improvement

Table 1: List of hospitals supported by the USAID SUSTAIN project to improve TB, TB/HIV and MDR-TB services in Uganda: 2010 – 2016.

Name of Facility	Level of Facility
Arua	Regional referral hospital
Fort Portal	Regional referral hospital
Gulu	Regional referral hospital
Hoima	Regional referral hospital
Jinja	Regional referral hospital
Kabale	Regional referral hospital
Kawolo	General hospital
Lira	Regional referral hospital
Masaka	Regional referral hospital
Mbale	Regional referral hospital
Moroto	Regional referral hospital
Mubende	Regional referral hospital
Soroti	Regional referral hospital

collaborative approach, where teams work to identify and address a myriad of challenges affecting the content and processes of care, is consistent with the Ministry of Health's Quality Improvement Framework and Strategic Plan. On a monthly basis, the improvement teams received coaching and mentorship on how to identify gaps in care, how to prioritize areas for improvement, and how to develop, test and eventually implement change ideas that could lead to improvements.

This change package represents a synthesis of the most robust and effective changes in improving TB care and treatment in a total of 13 hospitals in Uganda. The change ideas recommended here are substantiated by data collected over the last six years, which shows significant improvements in:

- a) linking of TB/HIV con-infected patients to ART services,
- b) treatment completion among TB patients, and
- c) culture monitoring among MDR-TB patients.

Harvest Meeting

After six years of project implementation, medical officers, clinicians and senior nursing officers from the 13 hospitals gathered at a harvest meeting in August 2016 to reflect on their results, discuss both successful and unsuccessful change ideas, and share evidence on which pathways resulted in positive results. Guided by their experience in using QI to improve TB services, they agreed on a set of best practices that could guide other hospital teams to improve TB care and TB/HIV services at similar health facilities. Divided into small groups, teams discussed the change ideas they had tested, the steps they followed in introducing and testing these changes, and the results they had observed that could be attributed to the tested changes. During plenary sessions, the changes were discussed further by a larger and wider group of representatives, who also evaluated and scored them

based on relative importance, level of simplicity and how scalable they were.

All the parameters (relative importance, simplicity and scalability) were scored 1-5 by the participants. A score of 1 (one) for relative importance, for example, means that that change idea was not important, yet a score of 5 for scalability means the change is easily scalable. **Figure 1** explains the scoring, and how each value should be interpreted.

The average scores are presented in **Tables 2–4**. **Tables 5–7** provide a comprehensive list and description of all the change ideas tested, with notes on the specific steps taken to implement the change, the observed results and the number of facilities (scale) that implemented the specific changes.

Figure 1: Guide to interpreting the rating of change ideas



Table 2: Scoring of change ideas to improve linkage of TB/HIV co-infected patients to ART services

SN	Change idea	Number of facilities testing this change	Rating Criteria			Total score	Average score
			Relative importance	Simplicity (not difficult or complex)	Scalability		
1.	Physical escort of clients to ART clinics	13	4.7	4.2	3.9	12.8	4.3
2.	Continuing Medical Education (CME) for all staff on TB treatment and care of HIV/TB clients	11	4.7	4.2	3.8	12.7	4.2
3.	Mentorship of TB ward staff by more senior colleagues trained in TB/HIV co-management	13	4.8	4.4	4.5	13.8	4.6
4.	Enroll all patients on ART before transfer-out to nearby TB treatment sites	13	4.8	3.8	3.8	12.4	4.1
5.	Ensure and train staff in correct and timely documentation in the TB unit register	13	4.6	4.0	4.2	12.8	4.3
6.	Intensify health education and counselling	13	4.5	4.2	4.2	12.9	4.3

Table 3: Scoring of change ideas to improve TB treatment outcomes by increasing treatment completion rates at supported health facilities

SN	Change idea	Number of facilities testing this change	Rating Criteria			Total score	Average score
			Relative importance	Simplicity (not difficult or complex)	Scalability		
1.	Physical and phone follow up of missed appointments and lost-to-follow patients	13	4.9	4.2	4.3	13.4	4.5
2.	Regular update of patient information in TB unit registers and appointment book	12	5.0	4.4	4.5	13.9	4.6
3.	Transfer of patients to nearer TB treatment health facilities	13	4.8	4.6	4.7	14.2	4.7
4.	CME, orientation of new staff, and mentorship of old staffs by senior colleagues	13	5.0	4.5	4.7	14.2	4.7
5.	Reminder cues in the TB unit register on when to order for sputum tests at 2,5 and 6 months	11	4.7	4.5	4.4	13.6	4.5
6.	Mentorship of staff on correct documentation in the TB unit register	13	4.8	4.3	4.4	13.5	4.5
7.	Increased inter-facility communication and coordination to track self-transfer outs and updating of the TB unit registers	13	4.9	4.5	4.6	14.1	4.7
8.	Closely monitoring TB patients to manage emerging co-infections to minimize treatment interruption and/or lost-to-follow up	13	5.0	4.6	4.5	14.2	4.7
9.	Redistribution and reallocation of drugs amongst the facilities experiencing low stock levels	13	5.0	4.2	4.3	13.5	4.5

Table 4: Scoring of changes to improve interim MDR-TB treatment outcomes by increasing culture monitoring at supported health facilities

SN	Change idea	Number of facilities testing this change	Rating Criteria			Total score	Average score
			Relative importance	Simplicity (not difficult or complex)	Scalability		
1.	Use of hub rider for sample transportation from DOT sites to MDR TB initiating sites	7	5.0	4.0	4.7	13.7	4.6
2.	Train staff on sample collection and labelling techniques	7	4.7	4.4	4.7	13.9	4.6
3.	Use of emails and tracking tools to follow up sample delivery and results from National TB Referral Laboratory	7	4.9	4.4	4.4	13.7	4.6
4.	Transport facilitation for patient's daily facility visit for directly observed treatment (DOT)	7	5.0	4.6	4.7	14.3	4.8
5.	Phone call reminders to patients for monthly reviews, sample collections for sputum culture monitoring	7	5.0	4.3	4.6	13.9	4.6
6.	Linkage with VHTs, health workers and DTLS from peripheral sites for follow up of lost-to-follow up patients	7	5.0	4.0	4.7	13.7	4.6

Change package for improving TB services at high-volume hospitals in Uganda

Intended Use

Hospital administrators, TB department heads and front-line health workers taking care of TB patients and those providing care to TB/HIV patients are the primary intended users of this change package. Others like NGOs involved in improving access, quality and safety of TB and HIV services, district health officers supervising health facilities and Ministry of Health officials working on strategies for improving TB/HIV services are will find the evidence-based high impact changes described in the following pages useful. It should be noted that improvement teams should not necessarily copy and paste these change ideas, rather, they should adapt them to suit their circumstances and context challenges.

The next section of this change package provides a detailed description of what changes led to improvement, and how such improvement was arrived at. It is structured into three sub-sections, corresponding with the three improvement aims that the SUSTAIN project set out to

achieve in relation to TB and TB/HIV services. Each sub-section outlines the problem being addressed, the change ideas tested, steps followed in introducing each change idea and the evidence that it led to improvement.

Improvement Aim 1:

To improve TB/HIV collaborative services at regional and general hospitals by increasing linkage to ART for TB/HIV co-infected patients from 35% to 80% over six years.

Figure 2 illustrates steady increments in the proportion of TB/HIV co-infected patients who were linked to continuous ART care over a four-year period. Aggregated performance amongst SUSTAIN supported hospitals substantially improved from a baseline of 52.6% in 2012 to an average of 81% in 2016.

Figure 2: Proportion of identified TB/HIV co-infected patients not receiving ART who were followed up and initiated on ART during the month

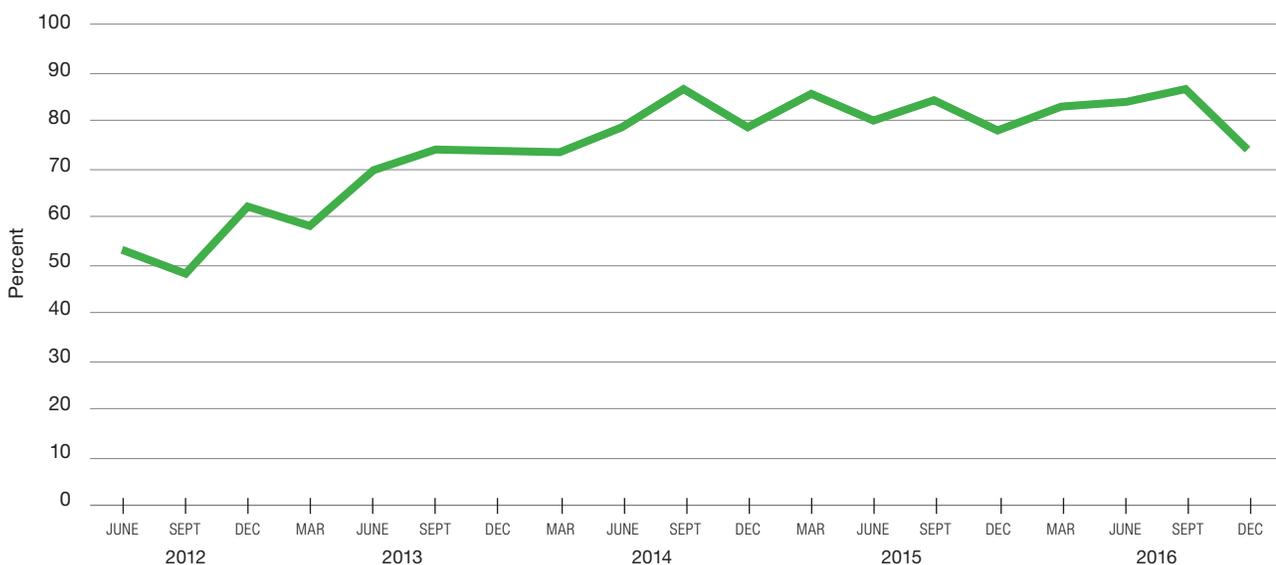


Table 5: Specific changes introduced to improve linkage of TB/HIV patients to ART

Change concept	Specific problem being addressed	Change ideas tested	Steps in introducing the change ideas	Evidence that the changes led to improvement	Scale of implementation
Offer services wherever patients want them	TB/HIV patients would be discharged from the TB clinic without ART enrolment	Physically escorting TB patients testing HIV+ to ART clinic	<ul style="list-style-type: none"> Assigned volunteers, students or clinic/ward staff to physically escort patients to ART clinic Assigned focal person at ART clinic to receive patients from TB ward/clinic Organized for ART clinic staff come and review and counsel patients on the TB ward, in preparation for ART initiation. 	ART enrolment greatly improved as facilities started escorting TB patients to ART clinics	13 hospitals tried out this change
	Hospitals were observing loss-to-follow-up of TB/HIV patients, even before initiating ART	Enroll all patients on ART before transferring out to other facilities	<ul style="list-style-type: none"> Phone calls to clinic or health facility to ensure availability of ART before transferring patients to other facilities Phone reminders to patients on appointments for initiating care Involvement of DTLS in tracking TB/HIV co-infected patients lost to follow-up prior to ART initiation Physical escort of patients to respective clinic or health facility 	In the 13 hospitals that tested this change, more patients were enrolled into ART within TB premises, before referral to HIV clinic	13 hospitals tested this change
Mentorships and other capacity building efforts	Knowledge gap of staff with regards to treatment regimens for HIV/TB co-infected clients	Health worker capacity building through training and supervision	<ul style="list-style-type: none"> All clinic staff in the respective clinics were involved in trainings by peer-experts to review TB/HIV care Internal supportive supervision to check staff knowledge and skills Regular QI meetings for the respective units In-charges ensure availability of information, education and communication materials for continuous on-job training of staff 	As more clinic staff were given knowledge on TB and HIV, enrolment of TB patients onto ART improved	13 hospitals tested this change
	Incomplete documentation of patients' details in the TB unit register upon enrolment	CMEs that focused on ensuring all staff were trained in how to correctly, accurately and consistently use the standard documentation tools	<ul style="list-style-type: none"> Scheduled weekly review and updating of TB and HIV registers, and patient care charts Mentorship of ward staff on correct documentation Training of TB staff on how to fill in the TB unit register Monthly QI and performance review meetings 	With complete, accurate and timely documentation practices, more TB patients were accurately appearing in the ART register and completeness of the TB Unit register improved	11 hospitals implemented this change

continued

Table 5: Specific changes introduced to improve ART initiation among HIV patients in care, continued

Change concept	Specific problem being addressed	Change ideas tested	Steps in introducing the change ideas	Evidence that the changes led to improvement	Scale of implementation
Give patients access to information	Inadequate counseling of clients leading to non-disclosure, delays in starting treatment, poor adherence, and loss-to-follow-up	Intensify health education and counselling	<ul style="list-style-type: none"> Involve counsellors from ART clinic in giving counselling on the TB ward Involved expert clients in giving counselling to peers Emphasized all staff and counselors to health educate at every contact with the patient Ongoing counselling to emphasize importance of early initiation on treatment and continued adherence 	Informed patients were more aware of the ART services available, and willingly enrolled into ART care and treatment	13 hospitals tested this change

Improvement Aim 2:
 Improve TB treatment outcomes at supported hospitals by increasing treatment completion from 20% to 85% over six years

Figure 3 illustrates how the proportion of pulmonary TB patients completing treatment once initiated improved by 46% among the SUSTAIN supported hospitals. From an aggregate of 25% completion rates in 2011 to completion rates of 71% in 2016, the 13 hospitals demonstrated how much can be achieved with the application of continuous quality improvement principles. As the hospitals started applying QI principles in 2012, an initial 21-point improvement was observed between 2011 and 2012.

Figure 3: Percentage of new smear positive PTB patients enrolled 12 months ago, that were eligible for follow up and have a documented TB treatment outcome after tracking

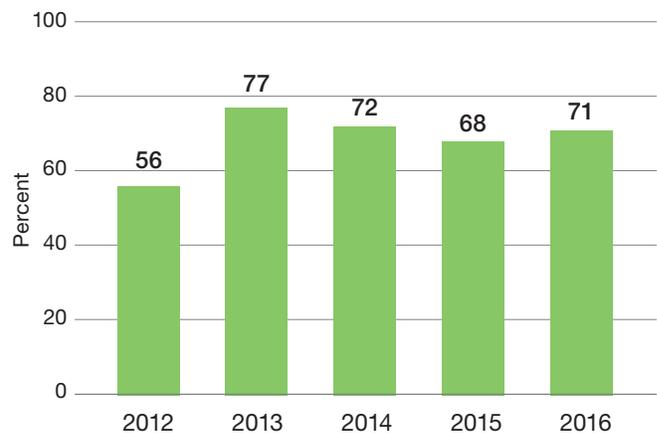


Table 6: Specific changes introduced to improve completion of TB treatment among TB patients

Change concept	Specific problem being addressed	Change ideas tested	Steps in introducing the change ideas	Evidence that the changes led to improvement	Scale of implementation
Taking services closer to the patients	Patients were often lost to follow up due to difficult terrain, wrong contact information, inadequate health education, poor health education on importance of adherence	Regular update of patient information in TB unit registers and appointment book	<ul style="list-style-type: none"> Staff tasked with ensuring documentation of correct patient contact information in the TB unit registers Staff review and update contact details of individual patients on every visit 	Regularly calling patients that missed scheduled appointments encouraged them to complete treatment	12 hospitals tested this change

continued

Table 6: Specific changes introduced to improve completion of TB treatment among TB patients, continued

Change concept	Specific problem being addressed	Change ideas tested	Steps in introducing the change ideas	Evidence that the changes led to improvement	Scale of implementation
Taking services closer to the patients	Patients were often lost to follow up due to difficult terrain, wrong contact information, poor health education on importance of adherence	Physical and phone follow up of patients	<ul style="list-style-type: none"> • QI team generated list of clients lost-to-follow-up • District TB and Leprosy focal-persons were informed of transferred-out clients and those lost to follow-up for tracking • During phone follow-ups or home visits, they would emphasize the importance of treatment adherence and completion 	Regularly calling patients who missed scheduled appointments encouraged them to complete treatment	13 hospitals tested this change
		Transfer of patients to nearer health facilities	<ul style="list-style-type: none"> • During initiation of treatment, patients would be asked about their villages • Nearby facilities that provide TB services would be mapped out, and mentioned to the patients • Patients would then be asked and encouraged to seek services from the nearer facilities, and reduce on the transportation costs 	Patients getting care from facilities nearer to home were more likely to adhere and complete their treatments than those that didn't	13 facilities tested this change
Building the technical capacity of health workers in relation to TB care	Observed knowledge gaps among health workers when they missed giving adequate information relating to TB during counseling, care and treatment of TB patients	Orientation of new staff and mentorship of all staffs by senior colleagues, mainly through CMEs	<ul style="list-style-type: none"> • Facilities held monthly departmental meetings to identify problematic areas and existing knowledge gaps • TB experts were identified among the staff, and tasked with leading CME sessions on counseling and treatment of TB 	Once trained, health workers could aptly support and encourage TB patients to complete treatment	13 hospitals tested this change
		Mentorship of staff on correct use of TB register, and documentation of tested change ideas	<ul style="list-style-type: none"> • Weekly review and update of the TB registers and unit meetings to continuously monitor documentation • Cross checking registers to ensure correct documentation • Support supervision of documentation in TB data collection tools 		13 hospitals tested this change
Use of reminders	Health workers would forget to order for sputum tests for patients on TB treatment	Reminder cues on when to order for sputum tests at 2, 5 and 6 months	<ul style="list-style-type: none"> • Visual reminder cues placed on charts in the clinic and TB unit registers that were placed in areas where they can easily be viewed by clinicians during their interactions with patients 	Treatment completion rates were high among hospitals that relied on reminders	11 hospitals tested this change
Offer TB services wherever patients want them	Self-transfers and transfer outs of TB patients would lead to loss to follow-up of patients already on treatment	Increased inter facility communication and coordination	<ul style="list-style-type: none"> • Liaised with lower-level health facilities (HC IVs and HC IIIs) to formally receive transferred-out patients from regional referral hospitals • Communicated on phone with the recipient facility ensure readiness to continue treatment • Continuously updated the TB register to indicate patients who had transferred out, and those self-transferred • Shared details of the transfer-outs with the area TB focal person to conduct further follow-ups and home visits 	Across the 13 hospitals that tested this change, information sharing amongst facilities enabled patients to continue with their treatment even when they transferred out	13 facilities tried this change

continued

Table 6: Specific changes introduced to improve completion of TB treatment among TB patients, continued

Change concept	Specific problem being addressed	Change ideas tested	Steps in introducing the change ideas	Evidence that the changes led to improvement	Scale of implementation
Offering additional services to TB patients	Patients would fail to complete TB treatment due to co-morbidities	Closely monitoring TB patients to manage co-infections as they emerge	<ul style="list-style-type: none"> During each clinic visit, TB patients would receive a thorough clinical evaluation checking for any co-infections If any is found, patients would receive appropriate medication They would also receive counselling on proper adherence to the given medication, and continued adherence to TB medication 	Hospitals were patients were offered additional care services registered higher treatment adherence rates	13 hospitals tested this change
Re-distribution of TB drugs	Drug stock outs in some hospitals due to a large volume of patients, even when other hospitals have a surplus of TB drugs	Identification of over-stocked and under-stocked facilities, and embarking on redistribution procedures	<ul style="list-style-type: none"> As part of areas to cover during supportive supervision, TB focal persons instructed supervisors to review anti-TB stock levels vis-à-vis the need/consumption With the information above, the district TB focal person would avail vehicles and teams for transferring medicines from facilities with excess to facilities with inadequate stocks 	Re-distribution ensured facilities that were on the verge of stock-outs had enough drugs to sustain their patients on treatment	13 hospitals tested this change

Improvement Aim 3:

To improve interim MDR-TB treatment outcomes by increasing culture monitoring from 25% to 100% over 3 years

Table 7: Specific change ideas tested at the supported hospitals to increase culture monitoring

Change concept	Specific problem being addressed	Change ideas tested	Steps in introducing the change ideas	Evidence that the changes led to improvement	Scale of implementation
Facilitate transportation of samples	Samples being transported in less ideal conditions, with many becoming inadmissible	Use of hub riders for sample transportation	<ul style="list-style-type: none"> Hub riders were employed to ferry samples to the lab, and results back to the hospitals SUSTAIN would provide motor bikes, with fuel, for this purpose 	Hospitals that conduct culture monitoring received more samples	7 hospitals tested this change
Capacity building for laboratory staff	Poor sample collection techniques, and poor labelling practices	Conduct trainings of lab staff on proper sample collection and labelling techniques	<ul style="list-style-type: none"> During QI meetings, gaps in the quality of samples were identified Hospital and especially lab staff were trained on correct collection and labelling of samples and lab request forms Upon joining, new staff and student interns were oriented and on the good practices in collecting and labelling sputum samples 	All 7 facilities registered improvements in labeling and quality of collected samples	7 hospitals tested this change

continued

Table 7: Specific change ideas tested at the supported hospitals to increase culture monitoring, continued

Change concept	Specific problem being addressed	Change ideas tested	Steps in introducing the change ideas	Evidence that the changes led to improvement	Scale of implementation
Put in place affordances that improve efficiency	Delays receiving culture results at hospitals	Reliance on e-mails and online platforms to track flow of samples and results with the National TB and Leprosy Program	<ul style="list-style-type: none"> An online platform for tracking the movement of samples and results between hospitals and the National TB and Leprosy Program lab was built A computer, printer and internet connection were provided and set up at the hospitals Patient results would then be e-mailed directly to hospitals, and communicated to lab staff Results would then be communicated to patients in a timely manner 	Culture monitoring improved as hospitals used emails and other online platforms to track samples	7 hospitals tested this change
Address barriers to accessing TB services	Low patient turn up for monthly culture monitoring follow up visits	Transport facilitation for patients' monthly review appointments	<ul style="list-style-type: none"> Ongoing counselling of patients on the importance of culture monitoring Distant patients were financially supported to come for culture monitoring appointments Monthly onsite clinics were held for MDR-TB patients, during which patients were reviewed and culture samples would be obtained 	Access to culture monitoring services improved as hospitals provided monthly transportation stipends	7 hospitals tested this change
		Phone call reminders to patients for monthly culture monitoring	<ul style="list-style-type: none"> List of TB patients expected to report to a hospital for monthly culture monitoring was generated A volunteer was assigned to make reminder calls to these patients, asking them to report to the facility and submit a sputum sample 	Patients that had been called managed to report for cultural monitoring	7 hospitals tested this change
Offer TB services whenever patients want them	Difficulty in collecting samples and follow up of patients from peripheral health facilities	Linkage with village health teams, health workers and TB focal persons from those peripheral facilities for follow up of patients	<ul style="list-style-type: none"> Contacted staff at peripheral sites to mobilize MDR-TB patients to attend onsite clinics scheduled within their communities Assigned area TB focal persons to follow up patients in their homes and give counseling and treatment support 	Hospitals that tested this change saw their performance greatly improve	7 hospitals tested this change

Key Challenges

As expected, some health facilities and improvement teams faced significant challenges while testing the different change ideas aimed at improving TB services which included:

- High staffing attrition rates across majority of the health facilities — competency in quality improvement is acquired incrementally, through continuous application of QI principles and iterative PDSA cycles. Staff attrition affects this continuity, and the institutional memory lost during staff departures greatly affects the sustainability of implemented change ideas.
- Health workers on TB wards viewed as extra work the new practice of initiating TB/HIV patients on ART, and following them up to make sure they are adhering to both ART and TB medications.
- The practice of providing meals and/or financial facilitation for MDR-TB patients was misconstrued to mean remuneration. At some health facilities, it even resulted in violence against health workers on occasions when the meals/funding were not available.

Moving Forward

To get the best benefit from the change ideas in this document, health facilities should establish and cultivate an environment that embraces change to nurture improvements. The following ideas can help QI teams in getting started:

- **Improve documentation** — Existing national documentation and data monitoring tools need to be accurately and consistently used. It is through these tools that teams will be able to determine whether their performance is stagnating or improving, both before and after introducing these changes.
- **Establish team work** — For any improvement work to yield positive results, health workers should collaborate and view themselves as members of a team responsible for the different steps in the processes of providing health services.
- **Analyze the entire process of care, and prioritize** — After analyzing their processes of care, and identifying existing gaps, health workers should prioritize which challenges need to be and can be tackled first and which ones can wait. Addressing one challenge at a time (while introducing a few changes at a time) will enable health workers to systematically monitor the effectiveness of each change in addressing a challenge, and the effect of a process gap on the overall service delivery.
- **Constantly communicate with your patients** — Improvements are designed to primarily benefit patients. Health workers should constantly seek feedback of their patients on the quality of service they are provided, and whether the changes being implemented are benefitting them as well.

In addition to health facility QI teams, other stakeholders have differing roles (as indicated in the table below) in the spread of these change ideas:

Ministry of Health	<ul style="list-style-type: none"> • Ensure the required tools, standard operating procedures and other resources are available throughout all levels of the health system • Support coordination, capacity building, supportive supervision, resource mobilization as they relate to scale-up of QI interventions
District Health Officials	<ul style="list-style-type: none"> • Supportive supervision, coaching and mentorship of health facilities attempting QI projects
Development Partners	<ul style="list-style-type: none"> • Provide technical support and avail resources to bridge funding gaps within the MOH

Appendix:

List of contributors during the harvest meeting

SN	Participant name	Designation	Affiliation	Telephone no.
1	Aloket Ruth	Senior Nursing Officer	Soroti RRH	0774081017
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4	Amatiyo Wildred	Nursing Officer	Hoima RRH	0751995239
5	Sylvia Mirembe	Medical Clinical Officer	Mbale RRH	0782494963
6	Nambuuzu Peace	Medical Officer	Masaka RRH	—
7	Ndelta Margaret	Nursing Officer	Jinja RRH	0777948113
8	Ruhweeza Nicdemus	Senior Clinical Officer	Fort Portal RRH	0702570821
9	Alebo Joy	Enrolled Comprehensive Nurse	Lira RRH	0782482864
10	Awor Hellen Ongom	Senior Nursing Officer	Lira RRH	0782668291
11	Nakazibwe Getrude	Nursing Officer	Jinja RRH	0704777266
12	Nakku Harriet	Registered Nurse	Kawolo General Hosp	0782195084
13	Kihika Betty Eunice	Nursing Officer	Fort Portal RRH	0773468663
14	Abigaba Hellen	Nursing Officer	Mubende RRH	0782829047
15	Nyirazihanawe Isabella	Nursing Officer	Masaka RRH	0782522461
16	Nikumu Jimmy	Enrolled Nurse	Moroto RRH	0789862124
17	Namuyodi Damalie	Principle Clinical Officer	Mbale RRH	0701947815

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