

EAPHLN Uganda Newsletter

EDITION 5 ISSUE 1



Above: Environmental safeguards contractor inspecting the site for the MDR TB ward in Moroto

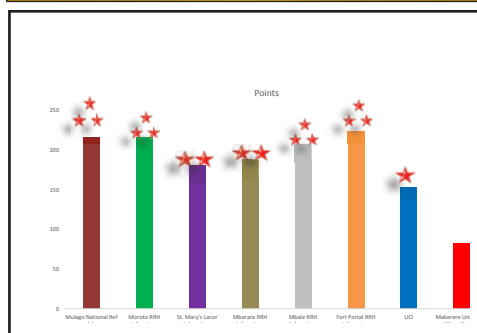
LOOK OUT FOR:

Mentorship model for medical laboratories in East Africa



Also:
Operational Research done by EAPHLN

Scores for WHO-AFRO SLIPTA audit April 2018



Senior World Bank Director visits SRL in Uganda



Implementing Laboratory Quality Management systems in Uganda

By Patricia Akello-Anok



“There is a misconception that the QMS implementation is an expensive activity which increases workload and adds extra layers of bureaucracy. However, if well planned, appropriately resourced, and efficiently implemented, QMS provides a cost-effective management system.”

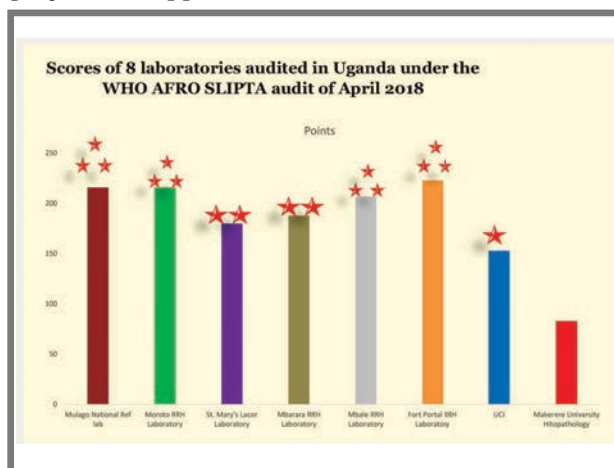
Before the Maputo Declaration on Strengthening of Laboratory Systems in 2008 and the 2012 African Society for Laboratory Medicine Ministerial Call for Action, the concept of quality management systems in laboratories was uncommon in Africa. Fortunately, in the last few years, Health ministries and health implementing partners have given considerable attention to support laboratories effectively manage and deliver quality services. The adoption of the quality management approach to deliver quality services has been driven by a number of imperatives such as the aspiration to satisfy the increasing demands by laboratory users. Health laboratories have now embarked on establishing quality management systems in order to improve the quality of service they offer.

A quality management system (QMS) is a coordinated aggregate of interrelated and interactive activities that determine quality policy and objectives and provides health care organisations with guidance and rules in their goal attainment. The implementation of quality management systems enables health care organisations to define and manage processes that ensure delivery of services that meet customer needs and expectations. It also instils trust in both the organization and clients in respect to service quality and conformity to standards.

Quality improvement unites the health workforce by enhancing individual performance, job satisfaction and retention. Quality in health care is the guiding principle in assessing how well the health system is

performing in its mission to improve the health of the citizens. The experience of QMS implementation and lessons learnt are shared herein.

The EAPHLNP has been supporting six laboratories for the past eight years and an additional two laboratories for the past two years. These laboratories have undergone progressive transformation since they adopted and integrated quality management in their system. Among other achievements, the project has improved testing capacity by provision of state of the art critical equipment necessary for efficient laboratory service delivery. Technical assistance to facility personnel has been provided by mentors who have built capacity through on-site and off-site trainings. Mentors also identify training needs and other associated gaps, and make recommendations to the project for support.



However, despite concerted efforts by different players to strengthen QMS in the recent past, medical laboratories in Uganda have not received full implementation although the current ISO 15189 standard requires that every laboratory should have a documented quality system to manage all its technical and management processes. Laboratories in the public sector continue to face challenges in implementing and maintaining documented quality systems. These challenges include inadequate knowledge and resources required to implement a QMS and achieve accreditation. The success

of a QMS is dependent on resources devoted to meet specified requirements. Also key is active participation of individuals and teams whose attitude play a pivotal role for better execution. Quality experts urge that top management commitment to quality is crucial for provision of adequate resources and motivation of employees. The need to increase support to strengthen and improve the quality of medical laboratory services in the country is paramount.

Implementation Strategies

Mixed method strategies have been used to offer technical assistance to personnel, most notable being the mentorship strategy. Mentorship models used vary from the one to one approach and the one to many approach, trained personnel then cascaded acquired knowledge to their colleagues through different fora like continuous medical education sessions. Trainings were offered either onsite or off site depending on the scope. Opportunities to visit already accredited laboratories helped staff appreciate and have a clearer picture of the desired QMS. Progress of QMS implementation was measured using the World Health Organization Regional Office for Africa Stepwise Laboratory (Quality) Improvement Process Towards Accreditation (WHO/AFRO– SLIPTA).

At the onset, laboratorians received QMS implementation with mixed feelings: many thought it was a fad that would come to pass; others tagged QMS to individuals; and there was resistance in some instances as implementers thought it was tedious, expensive and time consuming. Other laboratories, however, quickly embraced and integrated QMS in their systems. These “early-adopter” laboratories soon stood out as seen in their SLIPTA performance although their oscillating star performance clearly reflect inconsistent implementation.

Documenting QMS implementation is a process that requires changes in all laboratory processes. It is therefore helpful that mentors study and understand laboratory operations before suggesting changes. It is important that change processes are calculative, consultative and agreeable to

managerial staff otherwise changes will be resisted or reluctantly adopted. Key personnel guide and quicken change processes, however, the rate at which personnel incorporate changes in their operations varies and this impacts on success of the QMS implementation.

In some laboratories mentors employed an incremental approach where a QMS was developed in small areas to raise confidence and staff buy-in, leading to the implementation of QMS in other broader areas. Mentors helped the sites to develop quality teams which are a key factor in the success of a QMS.



Accreditation TWG Members' Meeting

A full-time quality manager (QM) at a senior level is strongly recommended. It is important that this individual is committed to service during the development, implementation and subsequent phases of the QMS. Laboratories that changed quality managers during QMS development have grappled with implementation. The QM is the driving force behind the QMS and its associated pertaining issues. A QM with a specific set of skills, knowledge, and character traits earns the trust of top management and directly accesses it. The appointed individual should have a strong desire and interest in undertaking challenges associated with developing and implementing a QMS. Forced or political appointments usually undermine the QMS and result in its failure.

First-hand experience also suggests that factors such as the size of the organisation, maturity of the organisation's processes and documentation, availability of resources, and facility top management and staff commitment directly affect the rate and duration of QMS implementation.

Lessons learnt

Although there has been overall improvement in the pre analytic, analytic and post analytical phases as seen by improvement in the SLIPTA scores, the country needs to invest more and tackle issues hindering laboratories from attaining international accreditation.

There is a misconception that the QMS implementation is an expensive activity which increases workload and adds extra layers of bureaucracy. However, if well planned, appropriately resourced, and efficiently implemented, QMS provides a cost-effective management system.

The adoption of a QMS should be a strategic management decision with specific needs, objectives and activities to influence the development and implementation of the QMS.

It is important to identify and train appropriate staff with the right qualities and attitude to undertake specific roles such as internal auditors.

It is worth noting that when top facilities' managers got involved in laboratories management review meetings outstanding issues were resolved, enabling laboratories to progress faster.

To overcome the challenge of staff buy-in, mentors should involve every staff member from the onset. Regular staff meetings to create awareness and recognising exemplary performance helps to boost morale and team spirit.

Facilities' top management should strive to attract, retain, and motivate qualified personnel especially in the public health sector. To address shortcomings of staff performance, all personnel should undergo basic trainings such as LQMS, ISO 15189 and continuous improvement. World Health Organisation recommends training of health workers to ensure quality service delivery and the retention of these trained workers if the service is to be sustainable. It is also recommended that trained health workers who are providing essential health services receive adequate wages and appropriate and commensurate incentives.

A major short coming laboratories face is documenting non-conformities. Emphasis should therefore be placed on documenting of non-conformities as it was observed that staff frequently

misunderstood documenting non-conformities as a means of reporting an individual for punitive purposes. It therefore should be clear that such documentation are only intended for tracking system improvement,

The QMS foundation should be built on its Principles (Customer Focus, Leadership, Involvement of people, Process Approach , System Approach to management, Continuous improvement, Factual Approach to Decision making and Mutual beneficial supplier relationships) woven into the processes, outcomes and overall culture of the organisation.

A key to a successful QMS is the availability of data to provide objective information as a measure of conformity to policies, objectives, goals and key performance indicators such as customer satisfaction measures

Several factors have contributed to the sluggish implementation of QMS in public health laboratories: issues such as supply chain management (reagents stock-outs, internal quality controls), equipment calibration and maintenance inconsistencies, unavailable or inconsistent supply of EQA, information management tools not aligned to ISO 15189 requirements.



Patricia displaying awards to Mulago lab

Achievements of QMS implementation

Although many laboratories are not yet accredited, health facilities implementing QMS are already realising significant benefits from QMS adoption throughout the organisation. Below are some gains these laboratories have made;

- Created consistency in laboratory systems and operation; a standard guideline based on

ISO 15189 and documented procedures have improved consistency for easy output

- Sample rejection have markedly reduced
- Turnaround times have tremendously reduced
- Utilisation of laboratory results for clinical decisions have improved
- Laboratory staff have become more responsive to client needs and requirements, there is improved client satisfaction
- There is better communication within and out of the laboratory
- Better record keeping and data utilisation
- Faster identification and resolution of non-conforming aspects; corrected at lower cost and gradually creating a continual improvement culture
- Better process integration, work flow and reduced operational cost as a result of less wastages
- Improved decision making skills based on evidence



Robert Ocakacon-Lab Manager of Lacor Hospital Lab

- Improved health and safety due to better environmental working conditions
- Self-checks by performing internal audits
- Involvement of other hospital departments to understand, appreciate and support laboratory operations
- Established quality teams and strengthened networking

EAPHLNP mentorship model for satellite labs towards Accreditation

By Charles Manyonge



"In Uganda, LQMS implementation towards accreditation has been slow"

In order to achieve a universal access to quality-assured laboratory diagnostic services in Uganda, the MOH and EAPHLNP has developed, a strategic plan and roadmap depicting the mentorship model that guides on strengthening laboratory quality management system towards accreditation and for massive scale-up of quality laboratory services as an essential first step in effectively addressing the diagnostics, patient management and safety challenges of various communicable and non communicable diseases faced in laboratories.

The main goal of the MOH has been to have all laboratories in Uganda attain accreditation due to the emerging infectious diseases and cross border disease out breaks that have been hampered by limited staff competence, poor attitude, traditional and or conventional diagnostic systems as well as equipment maintenance and poor quality assurance system within the laboratories for confirmation of a given out break. However, to bridge this gap within our laboratories, there is need for laboratory networking, knowledge sharing and training on new diagnostics techniques, skills in managing laboratory and elevated technical competence of personnel in diagnostics.

Therefore, the MOH in collaboration with EAPHLP under the World Bank recruited laboratory mentors, trained them on LQMS implementation and tasked them to offer mentorship and stewardship for selected laboratories with an aim of establishing LQMS, elevating laboratory management and

technical competence with periodic planned evaluation of LQMS implementation towards ISO15189 accreditation.

Two mentorship approaches (Receptor and Preceptor) were employed by EAPHLNP involving facility based approach; a central mentor from MOH/NTRL and identified quality officer who is a preceptor mentor for mentorship and follow up of QIPs respectively.

The output of mentorship process was then assessed independently using the stepwise laboratory quality improvement process towards accreditation tool, by trained and certified ASLM assessors on LQMS implementation and follow up within the facility, as well as the pace of LQMS implementation by the mentees in different laboratories.

In Uganda, LQMS implementation towards accreditation has been slow, this was conventionally been attributed to various factors like limited/ short mentor-mentee contact time, mentors expertise and training, laboratory staff attitude and commitment, limited laboratory management support towards LQMS implementation, non standardized mentorship and reporting mechanisms across laboratories and finally lack of adherence to mentorship program respectively. These factors instigated the MOH and EAPHLNP mentors to evaluate the best approach that could be employed in presence of all these attributes, but ensuring laboratories attain and sustain the accreditation status within a short time accordingly.

Mentorship model

Uganda's experience has shown that Laboratories could be helped to achieve accreditation through mentorship programmes believed to be important vehicle to establish and a sustainable quality management systems (QMS).

However, due to various challenges such as short mentor-mentee contact time, mentors expertise and training, laboratory staff attitude and commitment, laboratory management support towards LQMS implementation, non standardized mentorship

and reporting mechanisms across laboratories and finally lack of adherence to mentorship program has made the accreditation status and establishment of a strong and sustainable LQMS to be farfetched in Uganda.

EAPHLNP in Uganda adopted a mentorship model by utilizing local trained and experienced mentors to strengthen the laboratory quality management system in selected laboratories within the environment surrounded by the above attributes respectively.

The mentors are teamed up at a site for two weeks by having side by side mentorship, develop QIPs and leave the site to implement the activities and remotely follow them up.



Mentorship by SRL/NTRL Mentor in Eritrea

Verification of the LQMS progress is done in the following quarter (after 2months) by going through the activity plan respectively. To avoid monotony and promote objectivity mentors conduct programmed semiannual mock assessment by rotating mentors in the satellite sites for evaluation process and ensure development of QIPs for follow up.

To ensure sustainability of the LQMS implementation in these satellite sites, mentors have trained site specific quality officers on LQMS and equipped them with skills that enable them follow up action points and QIPs in these satellite sites. However, they need regular monitoring and guidance through side by side mentorship that is offered on quarterly basis.

Epidemic preparedness & response: EAPHLNP takes surveillance and outbreak response to higher notch in EAC region

By Atek Kagirita

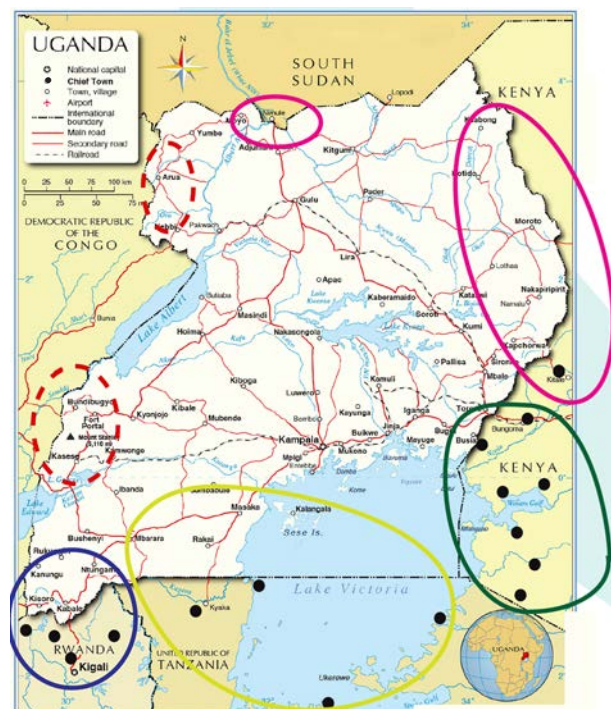
The EAPHLNP has stepped up efforts to increase capacity for EAC states to prepare and respond to numerous outbreaks. Given the geographical location of EAC states and the number of emerging and remerging public health emergencies that have hit the states in the last one decade, the EAPHLNP has moved towards enabling early preparedness and response actions.

The project has devised new innovative ways to enable countries to communicate easily, work together and even respond together not only across borders but also in multisectoral manner. The formation of zonal crossborder committees that combines several districts across each country that share administrative boundaries has ushered in a new era of cross border cooperation in health and equally the management of zoonotic public health events or trans-boundary management of diseases.

This approach has been tested in Busia crossborder Zone for cholera outbreak, and during the recent H5N8 outbreak along the lake Victoria Lake shores.

In addition to this approach, the project is also strengthening surveillance and outbreak to all regional sites it works in and much more importantly has dedicated funds for supporting 112 districts to respond to any outbreaks.

The EAPHLNP project has set up cross border zonal disease surveillance committees to implement cross border interventions. This approach has been tested successfully in the Busia CBZ (Cholera) and the Lake Victoria shores CBZ (H5N8).



- TO BE SERVED BY: Moroto Hospital (Uganda) & Kitale Hospital (Kenya)
- SERVED BY: Mbale Hospital (Uganda) & Busia Hospital (Kenya)
- - - Future CBZ committees
- SERVED BY: Mbarara Hospital (Uganda) & Musoma Hospital (Tanzania)
- SERVED BY: Mbarara Hospital (Uganda), Nyagatare Hospital (Rwanda) & Byumba Hospital (Rwanda)



Personal protective equipment is being provided



Thermal scanner soon to be installed at Entebbe International Airport

Uganda hosts 8th Annual Regional ICT Technical Working Group Meeting

By Thomas Alinaitwe



Regional ICT working group meeting

The Republic of Uganda was privileged to host the 8th Annual Regional Information and Communication Technology Working Group Meeting. The meeting was held at Esella Country Hotel from 28th to 31st of May 2018.

The specific objectives of the meeting included reviewing the utilization of the electronic innovations developed by the project, which are a web portal, an electronic learning platform, a regional electronic disease surveillance system, an electronic platform for monitoring and evaluation among others. Other objectives included a review of the status of implementation of ICT activities at the country level.

The meeting was officially opened by the Project Coordinator-EAPHLNP and Assistant Commissioner National Disease Control Dr Allan Muruta who welcomed the delegates and reiterated the support of the top leadership of the Ministry of Health in Uganda.

“The partnerships that you have developed at the local, national and regional levels will play a key role in overcoming the challenges that may arise during the course of implementation of your work”, noted Dr Muruta.

Participants were able to share county experiences and insights. In addition, participants drafted work plans for the 2018-2018 financial year.

The meeting drew participants from Burundi, Kenya, Tanzania and Uganda. The Ugandan delegation was led by Ms. Carol Kyoziira, Assistant Commissioner Health Information Division, MOH.



Uganda ICT working group

Cancer control in Uganda : World Bank support to cancer control efforts and activities in Uganda.

By Annette Nakaganda

Data from the Kampala Cancer Registry (KCR) shows a high yet growing burden of cancers in Uganda since 1960s. Several interventions have been implemented with notable achievements that include: comprehensive cancer services and Cancer treatment Outreaches, having a National Cancer Bill, all intended to reduce cancer incidence, cancer deaths and improvement of the quality of life among cancer patients. However, significant challenges persist that include; lack of actual estimates for national burden of cancer, inadequate funding for establishing and implementing the Uganda national Cancer Control Plan (UNCCP) among others.



Cancer outreach clinics

The age standardized incidence rates for all sites combined among males and females have increased overtime from 69.1 in 1960s to 212.3 in 2010 among males and from 87.1 in 1960 to 201.7 in 2010 among females,

The five commonest cancers in Uganda include; Prostate, Cervix, Kaposi's sarcoma, Breast and Oesophagus.

The current estimates of cancer burden (incidence) are based on Kampala Cancer Registry that is urban based and located in the central region thus covering about 7% of the total population.

Hence, there are no actual estimates of the cancer burden for the whole country and among different regions of the country.



Cancer Registry Training participants at UCI August 2018

Cancer Research:

UCI also has a Research and Training Directorate that is responsible for developing and translating scientific knowledge from promising laboratory discoveries to new treatments for cancer patients while informing national research, prevention and treatment priorities.

EAPHLNP support in establishing the NCCP

The East Africa Public Health Laboratory Network Project (EAPHLNP) has secured a small grant worth US\$: 500,000 for the East Africa Community (EAC) region (about US\$ 100,000 for national level activities in Uganda). These will include among others: establishing two sub-national Cancer Registries in Mayuge and Arua districts. This intervention has the potential of expand cancer registry coverage from the current 9% to about 14%.

Capacity Building and Training

Two laboratory staff (Henry Wannume and Geoffrey Waiswa) from Uganda Cancer Institute have been trained by the East, Central and Southern Africa Community (ECSA-HC) / WBG / EAPHLNP, on Fine Needle Aspirate and Fine Needle Biopsy (FNA/FNB) in aid of diagnosis of cancer.

Dr. Tim Grant Evans, Senior World Bank Group Director of Health visits Butabika NTRL/SRL

By Miriam Schneidman, Dr Peter Okwero, Dr Simon Kalyesubula and Thomas Alinaitwe



Dr. Evans, Dr. Okwero and the EAPHLN Team

Dr Tim Evans, the Senior Director of Health, Nutrition and Population at the World Bank Group visited the World Health Organization (WHO)-designated Supranational Reference Laboratory (SRL) in Uganda on October 27, 2017.

Dr Evans visited the SRL on the sidelines of the Fourth Annual Global Health Security Agenda (GHSA) meeting which was held at Speke Resort in Munyonyo from October 25 – 27, 2017. The theme of the GHSA meeting was ‘Health Security for All: Engaging Communities, Non-Governmental Organizations and the Private Sector’.

The SRL building, situated in Butabika, is a state of the art high-end public health laboratory funded by the World Bank Group under the East Africa Public Health Laboratory Networking Project. The laboratory was awarded SRL status in 2013 by the WHO through complimentary support from the EAPHLN project, becoming the second SRL in Africa. Full operations at the new facility commenced in June 2017 after a commissioning ceremony by the President of Uganda His Excellency Yoweri Museveni.



Dr. Evans meets trainees from the horn of Africa

The SRL was designed with support of the US Centers for Disease Control and prevention, demonstrating the importance of partnerships.

Dr Evans was accompanied by the World Bank Group Co-Task Team Leader for the EAPHLN project Dr Peter Okwero. He was received at the laboratory by the Director of the SRL, Prof. Moses Joloba, Laboratory Scientist Charles Manyonge and the Acting EAPHLN Project Coordinator Dr Joseph Senzoga. Others present during the tour were Dr Simeon Kalyesubula, Patrick Ademun, Patricia Akello and Thomas Alinaitwe.



While at the laboratory, Dr Evans was able to view samples that had been referred to the SRL from other sub-Saharan countries like Somalia and Somaliland. He was also able to operate the Sistema BD Bactec MGIT instrument as well as print patient results. Dr Evans was also able to meet trainees from other African countries that are receiving mentorship from the SRL.

Some of the countries in sub-Saharan Africa whose national tuberculosis reference laboratories receive technical support from the SRL in Uganda include Botswana, Burundi, Eritrea, Kenya, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, Somalia, South Sudan, Tanzania, Zambia, and Zimbabwe.

“This is wonderful work!” noted Dr Evans as he scanned tested samples against the MGITs bar code reader. “Utilization of the Gene-xpert technology has further reduced the turnaround time for relaying the results to supported countries”, said Prof. Moses Joloba, Director of the SRL. “We call up the supported countries as soon as we get cases of extremely drug-resistant tuberculosis”, said Charles Manyonge, Laboratory Scientist, Auditor and Mentor with the EAPHLN Project.

The SRL received a grant of US\$6.0 million from the GFATM to operationalize the SRL model.

Dr Evans praised the staff of the laboratory for achieving high standards. He also offered insights on the implementation of mobile isolation units for the cross-country laboratory network supported by the Bank.

Impact of interventions at the NTRL:

Reduced turnaround time for MDR TB management (diagnosis to initiation to treatment from 42 days to 2 days).

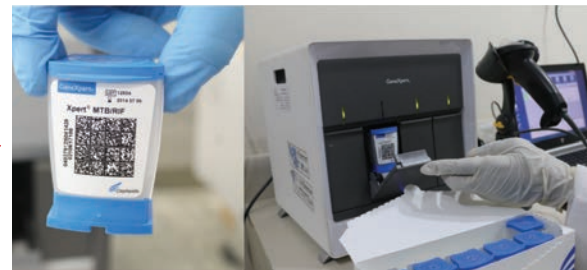
BEFORE EAPHLNP EQUIPMENT



42 Days

EAPHLNP deployment of Xpert/MTB/RIF technology escalated thus popularising the technology in Uganda from 26 machines at 25 sites in 2011 to 240 machines at 217 sites nationwide by 2018.

AFTER EAPHLNP EQUIPMENT



GeneXpert Technology
2 Days

The project - supplied equipment has reduced TAT for MDR TB management (diagnosis to initiation to Treatment from 42 days to 2days. The Xpert is highly sensitive, robust and easy to operate machine that detects presence of MTB and screens for Rifampicin resistance at the same time among presumptive cases.

Impact of interventions at the NTRL:

Construction of the Uganda National Tuberculosis Reference Laboratory (NTRL).

BEFORE EAPHLNP CONSTRUCTION



NTRL in wandegeya

AFTER EAPHLNP CONSTRUCTION



NTRL in Butabika

Building cross-country networks for laboratory capacity and improvement

Miriam Schneidman, MA, MPH^{a,*}, Martin Matu, PhD, MSc, MBAb, John Nkengasong, PhD, MSc, Willie Githui, PhD, Simeon Kalyesubula-Kibuuka, MD, MPH, Kelly Araujo Silva, MBA, MPH

Cross-country laboratory networks have historically played a critical role in supporting epidemiologic surveillance, accelerating disease outbreak response, and tracking drug resistance. One of the nascent laboratory networks is the East Africa Public Health Laboratory Network. The network is currently supporting 41 laboratories that serve as centers of excellence in 5 countries in East Africa (Uganda, Rwanda, Tanzania, Burundi and Kenya). These laboratories have benefitted from state-of-the-art investments, capacity building, essential and specialized equipment & supplies, training and mentorship with more than 13,000 experts trained.

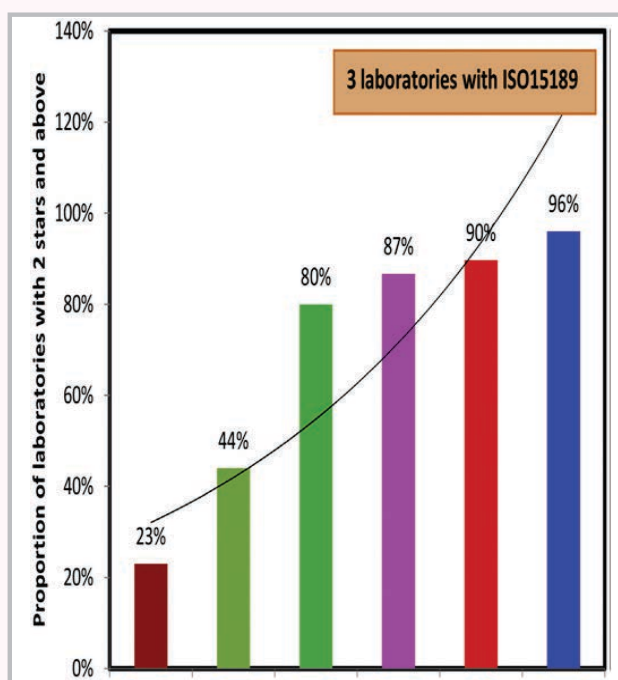


Fig. 1. Proportion of networked laboratories with at least 2 stars, 2011 to 2017.

Key results include: improvements in quality systems towards accreditation with four laboratories having reached ISO 15189 accreditation, including the Uganda Supranational TB Regional Laboratory, which is now providing specialized services and technical assistance to

more than 20 National TB Reference Laboratories across the continent; roll out of new diagnostic technologies, such as the GeneXpert machines that have improved access to more accurate testing for underserved populations in cross-border areas with 956 MDR-TB cases confirmed out of 3847 MDR-TB cases detected; support for operational research to promote an evidence-based approach; and enhanced disease surveillance and outbreak preparedness capacity stemming from the upgraded facilities, novel technologies, staff training, and modern information and communication systems.

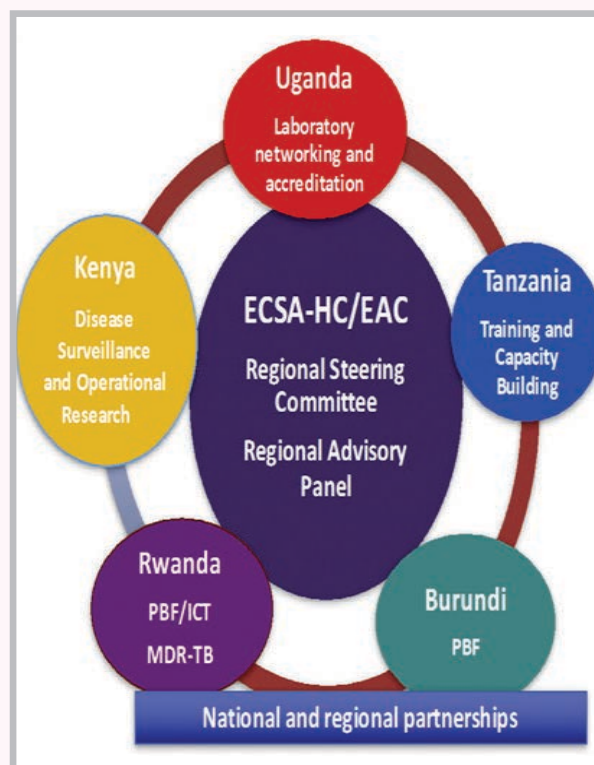


Fig. 2. East Africa Laboratory Network governance structure and model with countries technical leadership and regional coordination EAC, East Africa Community; ECSA-HC, East Central and Southern Africa Health Community; ICT, information communication technology; PBF performance-based financing.

Some of the key lessons learned that may be of relevance to other stakeholders include: the importance of establishing well-defined governance structures, clear mandates, and concrete deliverables; the potential to strengthen regional cooperation, facilitate peer learning, and foster mutual accountability; and the need for consolidating and sustaining achievements of cross-country networks.

Health seeking behavior among individuals with cough symptoms at regional referral hospitals in Uganda; Missed opportunity for early tuberculosis diagnosis

Winters Muttamba¹, Winters Muttamba², Willy Sengoba³, Bruce Kirenga⁴, Achilles Katamba⁵, Moses L Joloba⁶
Makerere University Lung Institute, Makerere University Lung Institute, Department of Medical Microbiology College of Health Sciences Makerere University, Kampala, Uganda³, Makerere University Lung Institute, College of Health Sciences, Makerere University, Makerere University, Kampala Uganda⁴, School of Medicine, College of Health Sciences, Makerere University, Kampala, Uganda⁵, Department of Medical Microbiology, College of Health Sciences, Makerere University, Kampala Uganda⁶

Introduction:

Studies on delays in Tuberculosis (TB) diagnosis in Africa have revealed not only patient important factors but also health system inefficiencies. We assessed the health seeking behavior among individuals who were presumptive TB cases presenting with a cough symptom at regional referral hospitals.

Methods:

Across sectional study of adult presumptive TB patients conducted from October 2015 to December 2016 at five regional referral hospitals in Uganda. All study participants were interviewed about TB symptoms, health seeking behavior following cough symptoms and had a GeneXpert test done.

Results:

Of the 1862 participants interviewed, majority 1795 (99.9%) reported cough as a symptom, followed by fever 1223 (68%). Weight loss 1192 (66.4%), night sweats 1161 (64.6%) and hemoptysis (13.1%). Of the respondents, 1352 (75%) had sought care for their cough and this was mainly at public health facilities (60%), followed by private facilities (21.4%), and drug stores/pharmacies (13.5%). Of those that sought care at public health facilities only 27.5% were asked to provide a sputum sample. Only 13.5% of those that sought from a private health facility were asked to provide a sputum sample. The estimated crude odds ratio of the association between seeking care at a private health facility and positivity on Gene Xpert was 1.5 (95% CI 1.1-1.9), p=0.011.

Conclusion:

Cough is a main symptom for presumptive TB patients at regional referral hospitals. The study revealed that there are still health system inefficiencies for patients that make an attempt at seeking care that could result in delayed diagnosis.

MANAGING HEALTH TECHNOLOGIES TO ADVANCE UNIVERSAL HEALTH COVERAGE IN UGANDA.

Published in April 2018 by School of Public Health, College of Health Science Maker-ere University with support of the European Union

Angela N Kisakye, Simeon Kalyesubula, Sam Wanda, Freddie Ssengooba, Suzanne NKiwanuka,

Key Messages

- Efficient procurement, deployment, maintenance and the use of equipment and technologies require effective implementation of the Health Technology Management (HTM) harmonisation policy at the different levels of the health care system.
- A national health technology audit and needs assessment will be necessary to provide a landscape of HTM in Uganda in order to establish gaps, diagnose wastages, estimate requirements or human resource expertise and vital supplies as well as maintenance costs.
- The Ministry of Health (MoH), working with the National Advisory Committee on Medical Equipment/Technologies (NACME), should lobby for equipment and technologies for non-communicable diseases (NCDs) such as cardiovascular conditions, blood pressure, diabetes and the treatment of injuries for better coverage and to mitigate catastrophic expenditures associated with seeking private sector services.
- The regional laboratory hub system – where several facilities send samples to an upgraded laboratory nearest to them – has improved access to diagnostics, especially for HIV and TB services. However, there is need to strengthen these hubs to address human resources shortages and irregularities in the supply of reagents and consumables.
- The current competency gaps in the use and maintenance of medical equipment/technologies can be mitigated by standardisation of equipment specifications and training of all users. This is critical during the formative professional training as well as during the installation of new generations of equipment/technologies.
- A robust health technology information system will be needed to improve the monitoring of equipment/technologies and related resources as well as ensuring smooth functioning of the diagnostic sub-systems by enabling quick turnaround time of laboratory results at all levels.

Tuberculosis: new hope for an ancient disease:

By Miriam Schneidman



“Health workers remain the unsung heroes of the battle against this deadly disease.”

The global community is coming together to tackle an ancient disease that still inflicts interminable human suffering. Globally, one person dies of TB every 20 seconds. While progress has been made over the past decade much remains to be done. Annually, there are still 10.4 million new cases and 1.7 million deaths. One of the key challenges is to find the 4 million missing cases, individuals who develop TB but are missed by health systems and continue to transmit the disease. With the global commitment to end TB, there is a renewed sense of hope in the battle against TB.

Lives and faces behind the numbers

On a hot afternoon in New Delhi, a 45-year old woman explained to visiting guests the devastation unleashed on her family when several members were diagnosed with multi-drug resistant tuberculosis (MDR-TB), a lethal form of the disease. Due to delayed diagnosis and overcrowding, the disease spread to other family members and several succumbed, including the main breadwinner.

Patient testimonies sound strikingly similar in Africa. I recall Justin, a brave Rwandese father of two young children who battled both TB and HIV. His weight dropped to barely 84 pounds, he suffered from anemia, and his immune system was seriously compromised. At the Jamot Hospital in Yaounde, 45-year old Rene recounted how stigma persists and many patients travel hours to reach a facility, often at an advanced stage of the disease.

The global epidemic

The global community has set a laudable target to end TB by 2030. Much remains to be done to reach this target, as progress remains slow. According to the 2017 WHO Report on Global TB Control [1], TB has now surpassed HIV/AIDS as the leading cause of death from an infectious disease. Seven countries account for 64% of the incident cases (India, Indonesia, China, Pakistan, Philippines, Nigeria and South Africa). Globally, there are nearly 500,000 MDR-TB cases, of which India, China and the Russian Federation represent nearly half of all cases. While enrollment in treatment for MDR-TB has improved, only 130,000 people are on treatment globally, and only 54% are successfully treated. One of the single biggest challenges is to find an estimated 4 million missing individuals who are infected and continue to transmit the disease.



Main achievements

Looking back over the past decade considerable progress has been made on several fronts. In Africa, individuals co-infected with TB/HIV had to shuttle between health clinics for TB drugs and district hospitals for antiretroviral drugs. Many countries, including Kenya, Malawi and Rwanda, have now established one stop clinics, are systematically testing TB patients for HIV, and have improved uptake of antiretroviral therapy. Globally, 85% of notified TB cases are on antiretroviral therapy which represents a remarkable accomplishment.

Health workers remain the unsung heroes of the battle against this deadly disease. Nurses at the

Jamot Hospital, the premier referral facility for complex TB cases in Cameroon, explained that working with TB patients placed staff at great personal risk.

Community health workers provide a vital link between patients and medical providers. With community-level care, patients travel shorter distances and are more likely to remain on treatment. The battle against TB cannot be won without passionate and dedicated community health workers, who actively identify missing cases, and trace defaulters.

Over the past decade, we have seen substantial improvements in diagnostic services. For example, under the Bank-funded East Africa Public Health Laboratory Networking Project (Burundi, Kenya, Rwanda, Tanzania, and Uganda), the roll out of molecular technologies has improved access to TB diagnostic services, shortened turnaround time, and picked up missing cases of Rifampicin resistant TB.

“Two months before I visited the Mbale Hospital I had been receiving treatment for fever and flu at a clinic near my home without any sign of recovery. I thought it was HIV,” noted Aliyi, a recovering patient at the Mbale Regional Referral Hospital in Uganda. The GeneXpert machine correctly diagnosed his illness as multi-drug resistant TB, and he was immediately placed on the proper treatment.

Another notable achievement is the establishment of the Uganda TB Supranational Reference Laboratory (SRL), a state of the art facility that has reached international accreditation and is now providing support to over 20 national TB reference laboratories on the continent.

“My dream was to set up a center of excellence to serve fellow Africans”, notes Dr. Moses Joloba, who spearheaded the establishment of the second SRL on the continent.

Key challenges

Globally, several key challenges persist. Active case finding needs to be stepped up dramatically to find the missing cases in high burden settings. Mobilizing resources for new and effective vaccines, estimated at a hefty US\$1.25 billion, is critical for

ending the epidemic. Accelerating progress on new and better drug treatments for TB, and point of care diagnostics is essential.

Ensuring that TB control is an integral part of the Universal Health Care (UHC) agenda, and realizing that the UHC goals will not be met without addressing TB is ultimately key to success. As Mahatma Ghandi said, “A nation’s greatness is measured by how it treats its weakest members”.

Looking forward

“The global community needs to galvanize high-level political commitment,” reiterates Lucica Ditiu, Executive Secretary of the Stop TB Coordinating Board. “We are looking forward to the September 2018 UN High-Level meeting on TB, a historical event that will raise the TB conversation at the level of heads of states and governments,” she notes.

With the recent Delhi call to End TB in South-East Asia, Prime Minister Modi has set a high bar to end TB in India by 2025, five years ahead of the global targets. While TB remains a significant public health problem in India, there is reason for hope and optimism given the political will, increased allocations, and the “Team India” spirit that we heard about during the Delhi Summit on TB. India is an incubator for innovations in service delivery and financing, such as use of mobile phone technology for reporting on drug adherence, production of indigenous molecular technologies and drugs, and expanded collaboration with the private sector to boost case notification.

With the bold new vision and strong commitment to universal access to a comprehensive set of TB interventions, India is walking the talk on TB. There is a renewed sense of optimism that India will set a high bar for other high-burden countries.

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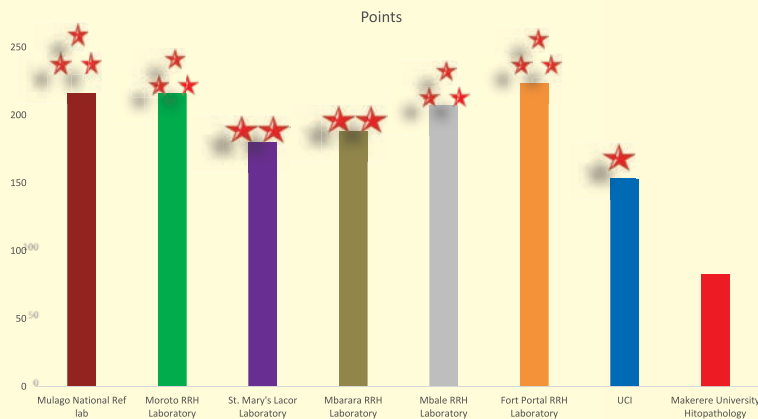
Dr. Alex Opio,
EAPHLN
Project Coordinator,
Commissioner National
Disease Control.

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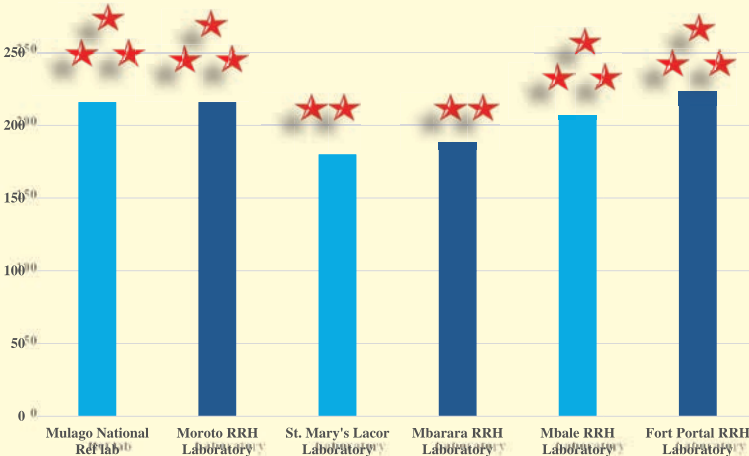


Dr. Allan Muruta
EAPHLN
Project Coordinator,
Commissioner Integrated
Epidemiology, Surveillance
and Public Health
Emergencies

Scores of 8 laboratories audited in Uganda under the WHO AFRO SLIPTA audit of April 2018



The six labs that ASLM certified in April 2018-by SLIPTA star rating



Incoming staff



Mr. Denis Kyabaggu
Laboratory Scientist.

Incoming staff



Mr. Nelson Modi
Laboratory Scientist.

← Adapted from Jacob Lusekelo's debrief

Editorial Team:

Mr. Nelson Modi, Laboratory Scientist
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Mr. Charles Manyonge, Laboratory Scientist
Dr. Allan Muruta, PC EAPHLNP/CIESPHE

Contributors:

Ms. Miriam Schneidman, Dr. Peter Okwero, Dr. Winters Muttamba,

Comments: info@eaphln.go.ug
Telephone: 0772 460 297