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USAID ASSIST Project

Annual Performance Monitoring Report FY13

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October 1, 2012 – September 30, 2013

NOVEMBER 15, 2013

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DISCLAIMER

This performance monitoring report was authored by University Research Co., LLC (URC). The views expressed do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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

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Acronyms

AIDS	Acquired immunodeficiency syndrome
AIMGAPS	Assuring Infants and Mothers Get All PMTCT Services
AMTSL	Active management of the third stage of labor
ANC	Antenatal visits
ART	Antiretroviral therapy
ASSIST	USAID Applying Science to Strengthen and Improve Systems Project
CCC	Care and treatment centers
CCM	Chronic Care Model
CDC	U.S. Centers for Disease Control and Prevention
CDO	Community Development Officers
CHF	Community-health facility
CHMT	Council Health Management Teams (Tanzania)
CHW	Community health workers
COE	Centres of Excellence
COP	Chief of Party
CPA	Core program areas
CSA	Community Support Agents
CSI	Child Status Index
CSO	Civil society organization
CTC	Care and treatment center
CVSU	Community Victim Support Units (Malawi)
DBS	Dried Blood Sample
DCS	Department of Children's Services (Kenya)
DHMT	District Health Management Team
DHO	District Health Office
DHT	District Health Team
DOD	Department of Defense
DOTS	Directly Observed Therapy
DQA	Data quality audit
DSWO	District Social Welfare Office (Malawi)
ECD	Early childhood development
ECSA	East Central Southern Africa
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EID	Exposed Infant Diagnosis
EmONC	Emergency Management Obstetric Neonatal Care
eMTCT	Elimination of mother-to-child transmission of HIV
ENBC	Essential Newborn Care
ENC	Essential newborn care
EONC	Essential obstetric and newborn care
EP	Expert patient
FISP	Farm Input Subsidy program (Malawi)
FP	Family Planning
GWHA	Global Health Workforce Alliance
HBB	Helping babies breathe
HBC	Home-based Care
HCI	USAID Health Care Improvement Project
HEI	HIV exposed infant
HEW	Health extension worker (Ethiopia)
HIV	Human immunodeficiency virus
HQ	Headquarters

HR	Human resources
HSA	Health Surveillance Agents (Malawi)
HSS	Health systems strengthening
HTC	HIV testing and counseling
IAP	Indian Academy of Paediatrics
IBP	Implementing Best Practices
IF	Infant feeding
IP	Implementing partners
IPT	Isoniazid preventive therapy
IRB	Institutional Review Board
IUCD	Intrauterine contraceptive device
IYCF	Infant and young child feeding
KM	Knowledge management
QQMh	Kenya Quality Model for Health
LTFU	Lost to follow-up
MGLSD	Ministry of Gender, Labor and Social Development (Uganda)
MHTF	Maternal Health Task Force
MLSS&S	Ministry of Labour, Social Security, and Services (Kenya)
MMAS	Ministry of Women and Social Action (Mozambique)
MMR	Maternal mortality rate
MNCH	Maternal, newborn, and child health
MOH	Ministry of Health
MSLS	Ministry of Health and the Fight Against AIDS (Cote d'Ivoire)
MSU	Marie Stopes Uganda
MVCC	Most Vulnerable Children's Committee (Tanzania)
NASCOP	National AIDS and STI Control Programme (Kenya)
NCLS	National Clinical Laboratory Services (Swaziland)
NCS	National Core Standards for Health Establishments (South Africa)
NGO	Non-governmental organizations
NHSRC	National Health System Resource Centre
NIHFW	National Institute of Health and Family Welfare
NTCP	National TB Control Program (Swaziland)
NTF	National Task Force
OHA	USAID Office of HIV/AIDS
OPD	Outpatient department
OR	Operations Research
OVC	Orphans and vulnerable children
PCR	Polymerase chain reaction
PEE	Pre-eclampsia/eclampsia
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHA	People with HIV and AIDS
PHC	Primary Health Care
PHFS	Partnership for HIV Free Survival
PLHIV	Persons living with HIV
PMTCT	Prevention of mother-to-child transmission of HIV
PNLS	National Program for the Fight against AIDS/STIs (Burundi)
PNPEC	National Program for the Medical Management of People Living with HIV/AIDS (Cote d'Ivoire)
PPFP	Post-partum family planning
PPH	Post-partum hemorrhage
QAP	Quality Assurance Project
QI	Quality Improvement

R&E	Research and Evaluation
RCH	Reproductive and child health
RCQHC	Regional Center for Quality in Health Care
RHMT	Regional Health Management Teams
R-MNCH+A	Reproductive Health, Maternal, Neonatal, Child, and Adolescent Health
SCC	Safe Childbirth Checklist
SES	Standard Evaluation System
SLMTA	Strengthen Laboratory Management Towards Accreditation
SMC	Safe male circumcision
SMGL	Saving Mothers Giving Life
SNAP	Swaziland National AIDS Program
SNIS	National Health Information System (Burundi)
SOP	Standard operating procedures
SOW	Statement of work
SRH	Sexual and reproductive health
TACAIDS	Tanzania Commission for AIDS
TAG	Technical Advisory Group
TB	Tuberculosis
TBD	To be determined
TOT	Training of trainers
URC	University Research Co., LLC
USAID	United States Agency for International Development
VHT	Village Health Team
VMMC	Voluntary medical male circumcision
WHO	World Health Organization
WI-HER	Women Influencing Health Education and Rule of Law, LLC

Executive Summary

University Research Co., LLC (URC) and its partners have completed the first year of implementation of the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project. This report is the first Annual Performance Monitoring Report for the project and aims to summarize the accomplishments and results toward the program objectives of USAID ASSIST activities during Fiscal Year 2013 (FY13).

The overall objective of the USAID ASSIST Project is to foster improvements in a range of health care processes through the application of modern improvement methods by host country providers and managers in USAID-assisted countries. The project's central purpose is to build the capacity of host country systems to improve the effectiveness, efficiency, client-centeredness, safety, accessibility, and equity of the services they provide. In addition to supporting the implementation of improvement strategies, the project seeks to generate new knowledge to increase the effectiveness and efficiency of applying improvement methods in low- and middle-income countries.

During FY13, USAID ASSIST provided technical assistance with field support funding in 13 countries: Botswana, Burundi, Cote d'Ivoire, Kenya, Malawi, Mali, Mozambique, Nigeria, South Africa, Swaziland, Tanzania, Uganda, and India. The project also provided technical assistance to the Regional Center for Quality in Health Care with field support from the East Africa Region. Core funds supported work in family planning (FP) in Mali, Niger, and Uganda and global technical leadership. Maternal, neonatal, and child health core funds supported activities in Uganda as well as regional initiatives in Latin America and East/Central/Southern Africa (ECSA). In addition, core funds supported global activities in HIV and AIDS, including Nutrition Assessment Counseling and Support (NACS) and the Partnership for HIV-Free Survival (PHFS), mHealth, vulnerable children and families, and health workforce development.

The activities implemented under USAID ASSIST all use a deliberate design process to link improvement objectives with larger health system strengthening initiatives and to intentionally plan for scale-up, sustainability, and institutionalization of the improvement effort. The country improvement plans were negotiated with, agreed upon, and signed by both USAID and host country government counterparts. This agreement worked to build country capacity and ensure country ownership of objectives and strategies. In addition, the country improvement plans emphasized advancing the frontier of the science of improvement – using evidence-based methods, deliberately defining aspects such as technical content, improvement strategy, spreading and sustaining results, addressing factors that affect human performance, and defining the learning agenda in each country that will be supported through knowledge management (KM) and research and evaluation (R&E) activities.

To support the project's learning agenda, two regional trainings were held involving ASSIST staff from 11 African countries: the first was held in English in March 2013 in Durban, South Africa, and the second was held in French in June 2013 in Abidjan, Cote d'Ivoire. The four-day trainings built the capacity of country staff to incorporate KM into improvement programs and involved a cross-section of staff and representatives from partner organizations. These trainings also further informed the design of the ASSIST Knowledge Portal, which will serve as the central repository of improvement knowledge that is generated by every project activity and country program. Development of the ASSIST Portal was finalized in FY13, complemented by the project's transition of its Twitter handle to ASSIST and preparation of the ASSIST Facebook page, set to launch shortly before the ASSIST Portal is made live in FY14.

The project's R&E activities are being designed to help show country programs how and why investment in improvement adds value to health care delivery. Another aspect of the R&E agenda is to build up the body of evidence of what works and what does not in terms of improvement methods. In FY13, the R&E team supported several country-led research programs including the study of pediatric TB diagnostic testing in Swaziland, the effectiveness and efficiency of using brief physician interventions to decrease alcohol and tobacco use in pregnancy in Ukraine, integrated HIV care for mothers and their infants, studies on PMTCT services and retention in care in Tanzania, and studies on testing and follow-up for HIV services in Burundi. The R&E team also provided technical assistance for orphans and vulnerable children (OVC) service quality measurement plans in Nigeria, Kenya and Uganda as well as assistance with validation of country-reported data. During the year, the team conducted work on thirteen studies; six studies have begun or have been cleared to begin data collection, and two studies have begun data collection.

During the year, ASSIST staff made 47 presentations at 20 regional and international conferences,

thereby sharing knowledge of lessons learned from the use of modern improvement approaches. A major global technical leadership activity was ASSIST's support of a "Thoughtful Conversation on National Improvement Strategies and Infrastructure for Improving Health Care" in Kenya in February 2013. This three-day policy seminar brought together leading stakeholders to share experiences and ideas from different countries on successful models for leading and providing support for improving health care at the national level, including developing policies and plans for improvement; to exchange ideas on appropriate infrastructures that enable Ministries of Health to lead and support health care improvement; and to stimulate a thoughtful conversation around this topic area. Similarly, during the third quarter, ASSIST supported the Ministry of Health (MOH) of Uganda to convene its Second National Quality Improvement (QI) Conference: Evidence-Based Improvements in Health Care. The conference provided strong evidence of the priority placed by the MOH on improving health care quality throughout the health system.

While the technical work under ASSIST is proceeding, there are some delays in continuing with FY14 work due to funding uncertainty and delays in obligation of funds. Many field support obligations have been delayed while being processed, and some Country Operational Plans as well as the Headquarters Operational Plans for the USAID Office of HIV/AIDS (OHA) core funds still await approval. As a result, some core-funded multi-year initiatives are stalled and FY14 work plans for many field support activities cannot proceed as originally designed in their Country Operational Plans as negotiated with Mission Activity Managers.

1 Field Support-Funded Activities

AFRICA

1.1 Botswana

Background

USAID invited URC to conduct a rapid analysis on existing quality improvement (QI) initiatives being implemented within the Ministry of Health (MOH). Botswana has made serious investments in the health care sector during the last several years. Multiple improvement frameworks under various names have been developed. However, despite these efforts the country is not seeing an improvement in key health indicators. The maternal mortality rate (MMR) increased from 163 per 100,000 live births in 2010 to 189 per 100 000 live births in 2011. The top three causes of maternal death were post-partum hemorrhage (PPH), eclampsia, and post-abortion complications. The Government of Botswana therefore has decided to focus on addressing maternal and neonatal mortality and has asked the USAID ASSIST Project to provide one staff person to fill a high level position in the ministry and support them in designing and implementing an improvement project to reduce mortality. This will be done through the implementation of evidence-based high-impact interventions including: reduction of PPH through active management of the third stage of labor (AMTSL); promotion of the use of partograph in every delivery to identify obstructed labor and early onset of complications that will require immediate intervention; immediate administration of magnesium sulphate in patients with pre-eclampsia/eclampsia; and the immediate uterine evacuation of products resulting from an incomplete/inevitable abortion within two hours of the diagnosis. In addition, early identification and management of obstetric complications (hypertensive disorder of pregnancy, anemia, others) will be promoted during antenatal visits (ANC) in outpatient department (OPD) services in hospitals and clinics.

Program Overview

What are we trying to accomplish?	How will we know?	At what scale?
1. Reduce maternal mortality through implementation of evidence-based high-impact interventions	<ul style="list-style-type: none"> MMR reduced from current 163 deaths/100,000 (2010) live births to target 81 deaths/100,000 live births (target set in the MDG) 33% of women who deliver are HIV+ 	Countrywide (27 Health Districts) Population: 2,098,018 Births per year: 46,000 Estimated # of HIV+ women is ~19,000

Key Activities, Accomplishments, and Results

Activity 1: Reduce maternal mortality through implementation of evidence-based high-impact interventions

- **Completed job aids:** All job aids including partograph, management of severe pre-eclampsia & eclampsia, management of PPH, and management of complications of abortion as major causes of maternal mortality in Botswana were completed. They will be reviewed by the expert committee to reach agreement and consensus before publishing. The management of complications flow charts will be posted in maternity wards all over the country for easy reference.
- **A monitoring and evaluation (M&E) framework was finalized** including the development of indicators and data collection tools were designed and pilot tested. Findings from the piloting were used to adapt the data collection tools accordingly.
- **Supported the MOH to conduct two Emergency Management Obstetric Neonatal Care (EmONC) trainings** in Francistown and Palapye. Forty (40) attendees participated in a two week training on identification and management of obstetric emergencies, including doctors and midwives. We have included a QI component applied to the maternal mortality reduction activities.
- **Supported the MOH to initiate the first training for Obstetricians in Gaborone in EmONC.**

High impact interventions to reduce maternal mortality were discussed with specialist to reach consensus in project activities implementation. An introduction to the QI project methodology was presented during the training. A high advocacy meeting with directors of hospitals was scheduled to inform and engage them in the QI activities implemented by the initiative.

- **Conducted stakeholder’s forum** with USAID, UNFPA, European Union and UNICEF to coordinate efforts in common areas of programs operations.
- **The MOH released funds** to provide vehicles, cell phones, projector, computers and other work aids to enable the implementation of the QI strategy.

Improvement Strategy

The Maternal Mortality Reduction Initiative is run by the MOH through the Sexual and Reproductive Health Division. ASSIST is working hand in hand with the Ministry providing support in the implementation of the QI component of the initiative.

What Are We Learning?

The EmONC training is being conducted in different districts in the country instead of previous centralized training in the capital Gaborone. This allows ASSIST and the MOH to increase the number of trainees in each region. In addition, because the trainees work in primary and referral hospitals, the regional training serves to strengthen personal communication between the participants working at several levels of the health system.

Directions for FY14

- A baseline assessment will be carried out during Q1 FY14.
- During Q1 FY14 two EmONC trainings will be conducted: one in Serowe and other in Maun. The training will be provided by previous Training of Trainers (ToT) personnel.
- During the next senior management meeting with the Permanent Secretary, senior management in the Ministry and District Health Management Teams (DHMTs), ASSIST will provide an update of the maternal mortality status in Botswana and the project activities.
- ASSIST will support the Ministry in developing a QI framework for the health sector.
- Implementation of a QI approach will be conducted in all health facilities (hospitals and clinics) with maternity services countrywide. The strategy will focus on high impact interventions to reduce maternal deaths during the delivery as well as preventive services provided during ANC visits.

1.2 Burundi

Background

Since FY12, PEPFAR – Burundi requested technical assistance from the USAID Health Care Improvement Project (HCI) to ensure that PMTCT, antiretroviral therapy (ART), and orphans and vulnerable children (OVC) services offered in Burundi respond to quality requirements. The USAID ASSIST Project began being implemented in Burundi in January 2013, building on and expanding previous HCI successes. In Burundi, ASSIST is working in close collaboration with the Government of Burundi, MOH, other USAID implementing partners (IPs) (e.g., FHI 360, Measure Evaluation, SMS, EngenderHealth) and local non-governmental organizations (NGOs) to address these concerns.

Program Overview

What are we trying to accomplish?	How will we know?	At what scale?
1. Implementing a PMTCT improvement intervention in four provinces in the Northern Region of Burundi 2. Improve uptake of PMTCT services (by mothers, infants, and partners;	<ul style="list-style-type: none"> • Proportion of pregnant women attending ANC visits • Proportion of pregnant women covered by PMTCT services • Proportion of HIV positive women receiving care and treatment • Proportion of newborns of positive women tested at adequate periods 	70 sites (of 115 PMTCT sites); 2,669,858 inhabitants (of 9,420,248)

improve retention of mothers and infants along the PMTCT cascade; improve quality of PMTCT services)	<ul style="list-style-type: none"> • Proportion of HIV-positive children receiving care and treatment • Proportion of partners tested (husbands or partners of women enrolled in PMTCT services) 	
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Key Activities, Accomplishments, and Results

Activity 1. Implementing a PMTCT improvement intervention in four provinces in the Northern Region of Burundi

- **Conducted meeting of supervisors in the four provinces** with 20 participants on the creation of QI teams and the monitoring plan of the change package.
- **Conducted baseline data at 70 sites (facilities).**
- **Conducted coaches' training** on improvement, data measurement, and documentation (March 2013). In July 2013, ASSIST organized a refresher session for coaches on integration of changes in human resource (HR) performance development and the reinforcement of the community health system. During September 2013, in collaboration with the National Program for the Fight Against AIDS/STIs (PNLS), ASSIST conducted a training session for 20 new coaches from PNLS (6) and DHMTs (14) covered by ASSIST. Participants were trained on basic QI principles and the collaborative approach.
- **Created 70 QI teams and job descriptions for all health care workers involved in PMTCT in all 70 target sites.** A QI orientation workshop was held in December 2012. QI teams met on a weekly basis to discuss QI implementation.
- **Held three learning sessions for the 70 sites in the four provinces implementing PMTCT QI activities.** One session per province was organized and a total of 178 participants attended the trainings, including site representatives, coaches and members of District and Provincial Health Management Teams. The main objective was to strengthen the capacity of key stakeholders in the process of the QI collaborative for PMTCT. In collaboration with PNLS, participants were trained on QI principles and improvement models; how to build a QI team and the functionality of a quality assurance (QA) team; how to make detailed process diagrams and steps of analysis in order to generate ideas for change and improvement plans; on HR performance factors; and on quality indicators and the monitoring plan. Sites also shared their experiences through presentations. At the time of this learning session, the participants chose the best sites per district and province referring to predefined criteria.
- **Tested changes.** Changes tested included:
 - Advantages of partners testing posted at all gathering venues
 - A female community leader sensitizing women on the advantages of going early for their first ANC visit as well as the importance of HIV testing and counselling (HTC) among couples
 - A male community leader organizing outreach activities that reach men on the advantages of HTC among couples
 - Increasing the number of ANC delivered per week
 - Giving pregnant women a unique ID number throughout the period of pregnancy (ANC, HTC, Maternity, postnatal care)
 - Providing Community Health Workers (CHWs) that accompany the couple in ANC activities soap from sites as motivation
 - Sites introduced the withdrawal of ANC cards and mosquito nets by the partners
 - Doing HTC in the ANC room and giving HIV results on the same day of ANC visit
 - ANC provided to all pregnant women regardless of reason of presence at health facility
 - Nurses assisted CHWs in community outreach activities on PMTCT and the advantages of early ANC

Results show that the percentage of women enrolled in ANC whose partners are tested for HIV increased from 0.2% in September 2012 to 17% in September 2013 (see Figure 1 below). Figure 2 shows that the gap between women receiving ANC services and getting tested for HIV continues to decrease. In the baseline data, half of pregnant women were not tested for HIV.

Figure 1: Burundi: Percentage women from ANC facilities whose partners are tested for HIV (July 2012 – Sept 2013)

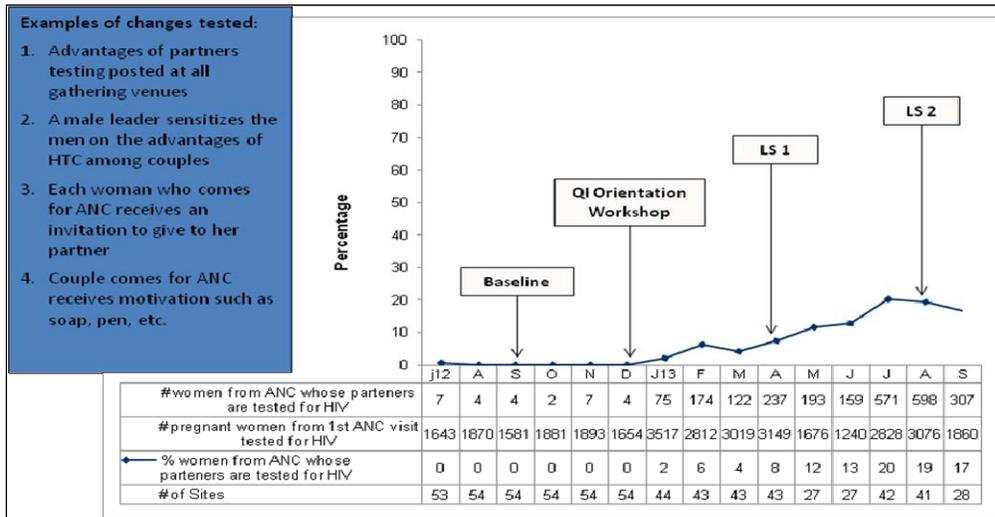
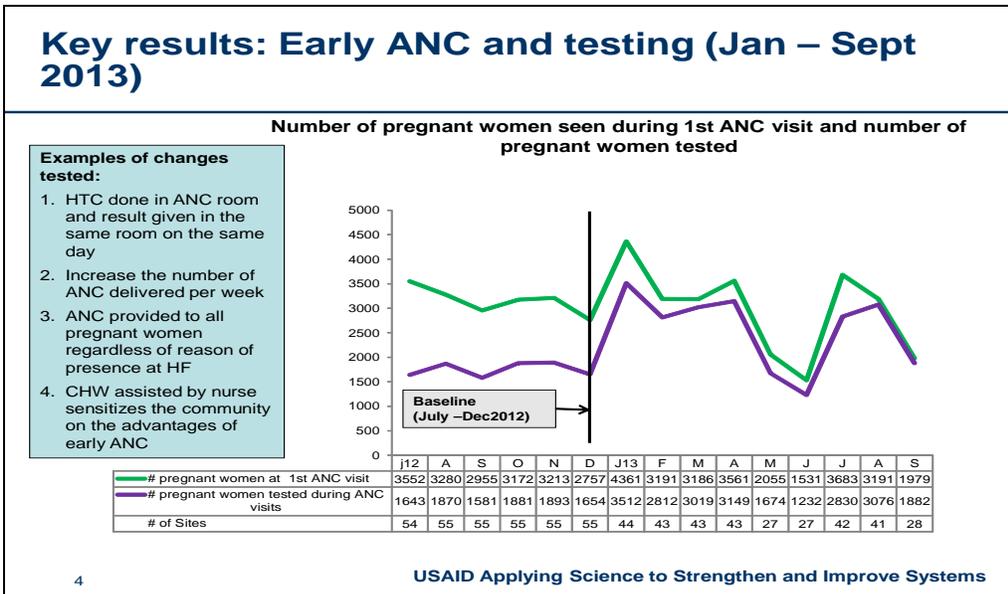


Figure 2: Burundi: Number of pregnant women seen during 1st ANC visit and number of pregnant women tested for HIV, from baseline (July – December 2012) to ongoing improvement period (Jan – Sept 2013)



- **Conducted site coaching visits:** Coaches visited all 70 sites (4 visits). ASSIST staff accompanied the coaches in 13 sites.
- **Conducted community QI activities assessment within Giteranyi Health District as pilot site (Muyinga):** ASSIST began community activities in Giteranyi health district located in Muyinga province. During this quarter, the collection of basic information was carried out through the mapping of the existing community groups. The database is now available while analysis is ongoing.

Improvement Strategy

The improvement collaborative approach is being implemented. QI teams were created in the targeted sites. Learning sessions were organized between QI teams and onsite visits were organized. QI teams were formed in the 70 facilities and ASSIST provided technical support during learning and coaching sessions. The collaborative approach is implemented in close collaboration with the National AIDS/STIs Program.

Spreading and Sustaining Results

Our strategy for sustaining results focuses on involvement of all levels of the health system in implementation of the collaborative approach.

Improvement in Key Indicators

Activity	Indicators	Baseline	Last value
1. Improve uptake of PMTCT services	• Proportion of pregnant women tested during ANC visits)	47% (July 2012)	96% (Aug 2013)
	• Proportion of pregnant women covered by PMTCT services	NA	NA
	• Proportion of HIV positive women receiving care and treatment	NA	NA
	• Proportion of newborn of positive women tested at adequate periods	NA	NA
	• Proportion of positive children receiving care and treatment	NA	NA
	• Proportion of partners tested (husbands or partners of enrolled women in PMTCT services)	0% (July 2012)	17% (Sept 2013)

What Are We Learning?

- Is it essential that facility staff participate in the analysis of their data? Sites do not have the habit of analyzing data collected before it is transmitted. We discovered that analyzing the data with QI team representatives during learning sessions and coaching visits helps them understand the importance of improving documentation in the QI process.
- While working with the HIV program, the inclusion of other programs such as the National Health Information System (SNIS), HR and National Council Against AIDS showed the absolute necessity of cooperation and collaboration at the strategic level.

Directions for FY14

- Continue implementing Wave One (documentation, HCT, and HR performance) of improvement activities in all targeted sites in the four provinces.
- Expand collaborative interventions to other areas identified as gaps in the baseline assessment (i.e., retention, clinical care).
- Implement the integrating Health Workforce Performance Improvements into QI interventions for PMTCT Services.
- Scale up of PMTCT collaborative approach in other sites within the same provinces and in four new provinces.
- Implement Community QI approach in pilot district (Giteranyi Health District in Muyinga province).
- R&E activities: Conduct a study to identify factors associated with testing among male partners of women seeking antenatal care in Burundi.
- Document lessons learned, success stories, best practices and challenges.
- Organize stakeholders' meeting to disseminate best practices from PMTCT and CHW QI collaborative.

1.3 Cote d'Ivoire

Background

Since 2007, HCI has been implementing QI interventions to support the fight against HIV/AIDS. Since April 2013, the USAID ASSIST Project has been supporting the MOH and the Fight against AIDS under the PEPFAR/USAID mission to address the main PMTCT challenges of the country. These include: retention and adherence of mother-infant pairs; linkages and referral to treatment and care services plus food and nutrition support; male involvement; couples counselling and testing (CT) services to increase PMTCT uptake; integration of PMTCT with routine maternal-child health/reproductive health services; adult and paediatric treatment services; and broader prevention programs. ASSIST's interventions are at system levels (site, district and region), integrating different technical domains to optimize resources and effectively help the country to reduce the transmission of HIV from mothers to children.

ASSIST is providing support to strengthen the health system through district and regional level collaborative improvement activities including: assessing and promoting institutionalization of QI activities at all levels; clarifying roles and responsibilities for all levels to apply QI into their routine work; as well as establishing a national QI team for senior managers to implement, institutionalize and monitor activities. In addition, ASSIST is continuing work started under HCI to support the MOH institution CRESAC to implement the laboratory accreditation program of the World Health Organization (WHO) African Regional Office in partnership with the Centers for Disease Control and Prevention (CDC) RETROCI labs and ASCP. Also, in the area of strategic information, ASSIST is developing national standards to improve the Health Information System (HIS) and M&E activities. Lastly in the area of research, given the resource constraints on providing HIV services in Côte d'Ivoire, understanding the budget impact of QI interventions and/or their cost-effectiveness remains an important area of research. In FY13 ASSIST conducted a study that sought to inform MOH policies regarding HIV treatment.

Program Overview

What are we trying to accomplish?	How will we know?	At what scale?
1. Build capacity of providers and MOH district and regions staff members to improve service uptake at each step of the PMTCT cascade	<ul style="list-style-type: none"> Percent of sites which use QI methods to increase the quality of PMTCT service. Number of ART sites using the national document of best practices. 	40 PMTCT sites located in 30 districts out of 82 districts in the country; 20 regions, serving a total population of 12 million out of 24 million (In Cote d'Ivoire, there are 633 PMTCT sites)
2. Improve ART activities and community links	<ul style="list-style-type: none"> Percent of sites using QI methods to improve HIV care and treatment services. Number of ART sites using the national document of best practices. 	40 PMTCT sites are located in 30 districts out of 82 districts in the country: 20 regions, serving a total population of 12 million out of 24 million. (In Cote d'Ivoire, there are 477 ART sites)
3. Support the MOH institutions (CRESAC) to implement the laboratory accreditation program of the WHO African Regional	<ul style="list-style-type: none"> Percent of laboratories which reach five stars in the steps for accreditation Percent of assessors who can conduct coaching visits Percent of thematic workshops (Strengthen Laboratory Management Towards Accreditation - SLMTA) 	21 laboratories located in 10 of the country's 20 regions. The regional and central laboratories of the country are included. We have 78 labs in these regions out of 101 in the country involved in the HIV program.

Office in partnership with CDC-RETROCI labs and ASCP.	<p>organized</p> <ul style="list-style-type: none"> • Percent of laboratory staff trained on use of the WHO-AFRO accreditation checklist 	
4. Strengthen the Health Systems through District and region collaborative improvement	<ul style="list-style-type: none"> • Number of senior managers trained in quality management 	30 districts out of 79 districts in the country and eight out of the 20 regions, are involved in the project
5. Lost to Follow-Up study	<ul style="list-style-type: none"> • What are factors influencing lost to follow up rate in ART programs in Cote d'Ivoire? 	

Key Activities, Accomplishments, and Results

Activity 1. Build capacity of providers and MOH district and regions staff members to improve service uptake at each step of the PMTCT cascade

- **Participated in PEPFAR PMTCT program review.**
- **Collected PMTCT best practices to improve retention in care for HIV patients from PEPFAR implementing partners:** finalized a document of best practices.
- **Conducted focus group discussions** about the challenges for access to PMTCT services and care in Bouake, Abidjan, Daloa, Biankouma and Divo.
- **Conducted coaching visits** in 21 out of 40 PMTCT sites.

Improvement Strategy

We involved MOH decision makers in the improvement process by coordinating all activities at each level of the health pyramid. These activities were closely organized with the National Program for the Medical Management of People Living with HIV/AIDS (PNPEC) and Health Directorate (DGS).

Activity 2. Improve ART activities and community links

- **Collected ART best practices to improve retention in care for HIV patients from PEPFAR implementing partners.** A document of best practices is being drafted.
- **Organized PNPEC's QI team training and designed an improvement plan for implementing QI activities with PNPEC.**
- **Defined improvement targets and indicators to monitor regions and districts activities** to improve the coverage of HIV care, patient retention in care, drug and supply management, patients' wellbeing.
- **Facilitated with MEASURE Evaluation a national workshop to develop procedures for the Strategic Information System.**
- **Provided technical assistance to the Cardiology Institute on data analysis** (June 2013).
- **Conducted coaching visits** in 21 out of 40 ART sites.
- **Conducted refresher training of QI coaches in Bouake:** Trained nine coaches. For this training we analyzed the participation rate of males and females to address gender considerations.

Improvement Strategy

We involved MOH decision makers in the improvement process by coordinating all activities at each level of the health pyramid. These activities were closely organized with PNPEC and Health Directorate (DGS).

Activity 3: Support the MOH institutions (CRESAC) to implement the laboratory accreditation program of the WHO African Regional Office in partnership with CDC-RETROCI labs and ASCP

- **In collaboration with CRESAC (National laboratory accreditation institution), organized and participated in the fourth assessment visit of 21 laboratories.**
- **SLMTA workshops:** Organized the third SLMTA workshop where assessors and laboratory staff were trained on the SLMTA process by master trainers in Cote d'Ivoire.
- **Conducted coaching visits:** Organized coaching visits on 21 laboratories involved in the WHO/AFRO accreditation process.

Improvement Strategy

Coaching activities were organized and achieved with CRESAC (MOH institution).

Spread Strategy

ASSIST's attendance at the SLMTA TOT course at ACILT (South Africa) will increase the number of trainers in Cote d'Ivoire. This will allow the project to train many sites' actors in lab improvement activities.

Activity 4: Strengthening the health system through district and regional collaborative improvement

- **USAID ASSIST conducted a workshop on QI:** Workshop was conducted for 20 regional health managers and 30 district health managers.

Activity 5: Lost To Follow Up (LTFU) study

- **The LTFU study was initiated under HCI and is currently ongoing with data analysis under UASID/ASSIST.** We finalized data collection and data entry while Data analysis is in progress. Draft report developed and shared for inputs.
- **Conducted debriefing on LTFU study:** Finalized first draft of LTFU report; developed presentation of primary result of LTFU study data; debriefed with PNPEC; USAID/CDC/PEPFAR; and local ART IPs.

Preliminary Key Results:

- *Social demographic:* Age, marital status and occupancy status were associated with the drop out of ART care. The study did not find a statistically significant association between alcohol consumption and dropping out or maintaining patients in ART care.
- *Knowledge, Attitude and Practices:* Ignorance of the benefit of ARTs, and socio cultural and religious determinants were found associated with dropping out of ART care.
- *Clinical:* The longer the patient is in care and on ART, the less likely they are to drop out. But the risk of patients dropping out of ART care is higher if they are not feeling better.
- Logistic regression bivariate analysis:
 - There was also no statistically significant association between patients living in the same or a different geographical area as the ART clinic and dropping out or maintaining the patient in ART care.
 - In the two groups, no significant difference was found by means of transportation (walk, bike, motorcycle, public transport, personal car) used by patients moving to seek care at the ART clinic.
 - However, when a patient who says that the distance adversely affect its ART care, he is three times more likely to drop out of ART care.
 - Patients who perceived long waiting times, unsuitable appointment timeframes and breach of confidentiality were at least two times more likely to be dropping out of ART care than the others.
 - Patients who claim to have problems that makes it difficult to regularly take ARTs (lack of food) are more likely to drop out of ART care than others.
 - The poor treatment preparation before initiating ART and the poor patient-provider relationship was three fold associated with the risk of dropping out of ART care.

What Are We Learning?

- Lack of coaching of QI teams causes a regression of QI activities in sites, therefore it is necessary to make regular coaching to maintain these activities.
- Commitment and involvement of directors of health institutions allows better monitoring of activities to achieve the objectives.
- KM training has allowed a better understanding of the development of best practices

Directions for FY14

- Support establishment of unit in the Ministry of Health and the Fight Against AIDS (MSLS) that will be supervising the care and treatment sites at University Hospitals.
- Set up a QI system for the University Hospitals.
- Support development of national tools for QA/QI (National HIV standards, indicators, procedures, M&E).
- Technical support of ASSIST to conduct QI activities with CDC in-country clinical partners.
- Improve the strategic information system.
- Support the WHO-AFRO/CDC laboratory accreditation program.
- Promote KM concepts among PEPFAR IPs.

1.4 East Africa Region

Background

A recent Regional Center for Quality in Health Care (RCQHC) assessment found that competency based health worker education and training on QI at the pre-service and in-service levels was to be largely absent in many African countries, with the exception of a few case examples limited to particular localities or institutions. Almost all newly trained health workers enter the health system without the requisite set of knowledge, skills, attitudes and behaviors (or competencies) for improvement practice. Stakeholders from 13 African countries took formative steps towards the development of a QI competency framework at a forum convened by RCQHC with the support of HCI in Kampala, Uganda, October 17-21, 2011.

This activity further contributes to the limited but growing body of knowledge on what QI competencies are needed and how these can be built at various levels to meet the needs of health systems and health workers. Specifically, this activity seeks to contribute to local, regional and global learning by focusing on the following questions:

1. What core competencies do health workers need in order to lead and apply improvement approaches?
2. How can a core competency framework be used to inform the development and improvement of education and training on QI?
3. What type of technical assistance and guidance do pre-service education and in-service training providers need in order to establish or further develop programs that build core competencies for improvement?

Lessons learned will be published through case studies, technical reports, a manuscript for a peer reviewed journal, and practical guidance targeted to pre-service education and in-service training program providers.

Key Activities, Accomplishments, and Results

Activity 1. Technical assistance and support to the Regional Centre for Quality of Health Care to Develop and Validate a Health QI Core Competency Framework

- **Provided technical assistance to RCQHC to lead development and technical review of the competency framework.**
 - Initial workshop held with RCQHC staff to build familiarity with competency based education and training literature and trends. ASSIST guided RCQHC through undertaking an iterative process of critical review and development of the draft competency framework. Regular weekly – monthly coaching provided through Skype to support the final stages of competency framework development in preparation for independent expert technical review. Supported RCQHC to facilitate a modified Delphi process for independent technical review to improve

the framework's content and face validity. Expert members of technical review panel identified in collaboration with RCQHC, including regional and global improvement experts.

Directions for FY14

- Completion of activities by March 2014

1.5 Kenya

Background

In Kenya, ASSIST aims to support the MOH and the Ministry of Labour, Social Security, and Services (MLSS&S) and other relevant partners to design, develop and implement strategies that will enhance the quality of service delivery in the health sector and the care of vulnerable children in the country. Our approach is guided by the National Health Sector Strategic Plan II and MLSS&S outlined priorities for improving quality of services. In particular we focus on 1) operationalizing a national QI framework which includes developing a national QI policy and revising standards of care, supporting a national quality management program and improving the voice of the client in health care; 2) establishing a framework to develop an accreditation mechanism for health facilities, 3) ensuring Government has systems in place to address problems identified in quality of care and a policy to support it; and 4) reviewing and developing standards of care for vulnerable children with the MLSS&S and facilitating their roll out to service delivery points.

Program Overview

The improvement is mainly at the national level supporting the MOH and MLSS&S to strengthen systems to support quality service delivery efforts in the country. ASSIST is supporting improvement learning centers in six sub-counties (districts) out of the 47 counties in the country.

What are we trying to accomplish?	How will we know?	At what scale?
1. Develop and operationalize a national QI framework which includes developing a national policy and revising standards of care, supporting a national quality management program and improving the voice of the client in health care	<ul style="list-style-type: none"> • An evidence-based national QI policy developed • Robust national quality management systems actively setting and coordinating the improvement agenda • Robust QI teams at county and sub-county levels actively identifying and prioritizing opportunities for improvement for their facilities • Robust work improvement teams actively developing and testing change ideas to improve integrated services. 	National Six counties initially, increasing to all the 35 counties supported by USAIDAPHIA Plus partners
2. Establish a framework for, and put into place a national accreditation mechanism for the health sector	<ul style="list-style-type: none"> • A mechanism exists to certify healthcare professionals and assure they maximize their training and skills through life-long learning. • A process exists to accredit health provider institutions that comply with standards for safe and reliable care 	National
3. Ensure Government has systems in place to address problems identified in quality of care and a policy to support it	<ul style="list-style-type: none"> • National, county and local efforts to improve health care quality based on common national aims, priorities, targets and evidence-based interventions and a monitoring framework 	National Six counties initially, increasing to all the 35 counties supported by USAID APHIA Plus partners
4. Review and develop standards of care for	<ul style="list-style-type: none"> • National psychosocial support (PSS) guidelines in place 	National level 7 counties and

vulnerable children with the MLSS&S and facilitate their roll out to service delivery points	<ul style="list-style-type: none"> National directory of service providers in place National referral tool in place National training manual for QI Seven counties demonstrating QI through centers of excellence 	7subcounties
5. Support national programs such as the National AIDS and STI Control Programme (NASCOP), Primary Health, Family Health, Preventive and Promotive Services to institutionalize QI at national and service development level	<ul style="list-style-type: none"> TBD by NASCOP and other Divisions in the MOH 	National Support to NASCOP to hold HTC symposium

Key Activities, Accomplishments, and Results

Activity 1. Develop and operationalize a national QI framework which includes developing a national policy and revising standards of care, supporting a national quality management program and improving the voice of the client in health care

- **Worked to strengthen national level systems for QI:**
 - ASSIST has been mandated to support the government health departments and Department of Children's Services (DCS) to update and review standards of care. In the second quarter of FY13, ASSIST supported the MLSS&S in developing the psychosocial guidelines for OVC care.
 - ASSIST has also engaged and built clear national ownership and coordination through the MOH Department of Standards and Regulatory Services and the national technical working group on QI. ASSIST's work is mainly to support the Department to implement QI work planned for in their annual operational plans. In addition, at the DCS, ASSIST has established a Technical Working Group (TWG) chaired by the government to guide implementation. To ensure this support, QI work has been included in their annual work plans.
 - In February 2013, ASSIST supported the organization of the first National Policy Seminar to bring together international and national experts to share experiences and best practices on QI policy, infrastructure, and accreditation. In this process, stakeholder mapping, analysis, and engagement will be ongoing to identify who should be involved in developing policy and accreditation.
 - The dissemination of the national QI framework, the Kenya Quality Model for Health (KQMH), has been completed in the eastern, central, and north Rift counties. Overall, 44 out of the total 47 counties in the country are now covered. During dissemination, officers from the MOH and Department of Standards and Regulatory Services worked together with ASSIST staff to take the county health teams through the KQMH.
 - Conducted joint FY14 work planning with the MOH Department of Standards and Regulatory Services to facilitate the harmonization of the ASSIST and MOH work plan.
 - The project supported the MOH to hold a national QI conference on August 23, 2013 with the county executive members for health, county health coordinators from all the 47 counties, stakeholders and national parliamentary committee for health to discuss mechanisms for rolling out QI in the new devolved governance structures. The conference resolved that all 47 counties should establish focal departments to oversee quality and standards. The project will continue providing support the national MOH in capacity building of these departments as they develop.
 - A workshop was held to finalize the draft national QI training syllabus for use in both pre-service and in-service training. The draft curriculum is undergoing final editorial work in preparation for its publishing and launch later in FY14.

- Worked to strengthen QI as a core training need for health care providers.
- Supported QI training as part of building the capacity of health care providers to roll out QI as a government strategy.
- Supported MOH and other stakeholders to hold a workshop to develop a draft national QI training syllabus (June 2013).
- ASSIST supported the use of this draft syllabus in training of seven counties, six sub-counties and over 300 coaches in QI. Lessons gained will be used to finalize the syllabus for MOH approval (July-Sept 2013).
 - The Kenya Medical Training College is a key stakeholder in developing this syllabus and intends to use it to actively include a course in QI as part of its medical training program

Activity 2. Establish a framework for, and put into place a national accreditation mechanism for the health sector

- Finalized terms of reference and scope of work for a consultant to conduct a situational analysis that will inform development of a national QI policy. The policy will inform current and future MOH efforts and strategies to improve, institutionalize, and standardize QI.
- Developed partnership framework to consolidate private and public sector engagement for support in the national framework for QI. A partnership memorandum of understanding (MOU) was signed with the Funzo project to foster multi-sectoral response to address national level efforts in QI.

Activity 3. Ensure Government has systems in place to address problems identified in quality of care and a policy to support it

- Engaged APHIA Plus, Regional Ministries of Health, MLSS&S and other regional partners in QI:
 - Completed trainings of all six APHIA Plus partners (APHIA Plus Kamili, APHIA Plus Imarisha, APHIA Plus Nairobi-Coast, APHIA Plus Nuru Ya Bonde, APHIA Plus Western Kenya and AMPATH Plus) and established 160 improvement teams for health service delivery in the six sub-counties (see Table 1).
 - All health service delivery sites are in the process of consolidating their baseline data for roll-out of the QI work. The 23 community QI teams have finalized their baseline data collection through the administration of the Child Status Index (CSI) and self-assessment tools.

Table 1: Facility-based QI teams established in the six model sub-countries in Kenya

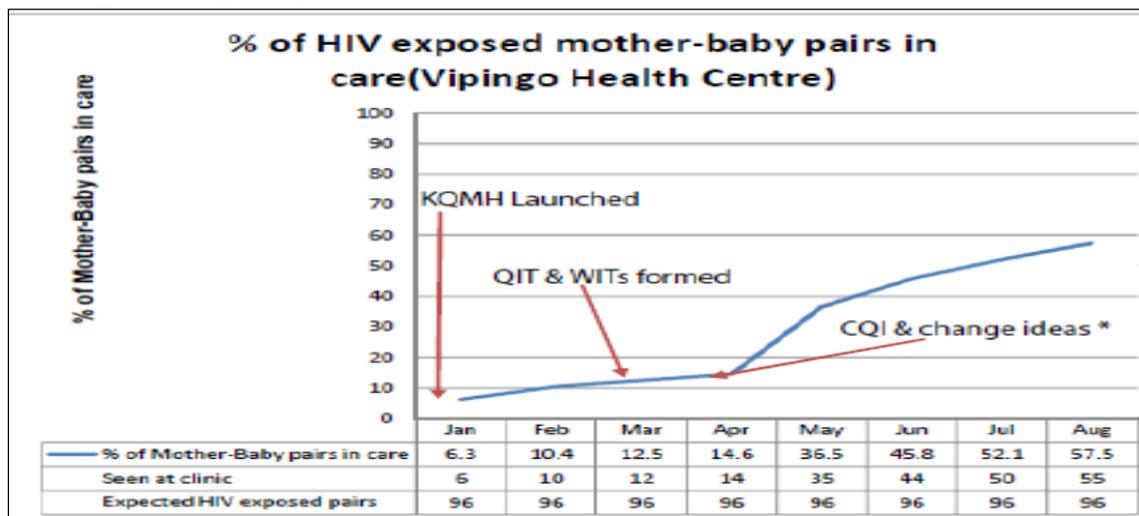
Project	# of QI teams	Remarks
APHIA Plus Kamili	29	APHIA Plus Kamili funded the dissemination of the KQMH to all 11 counties they are working in. ASSIST, together with Kamili, identified one county (Meru) and one sub-county (Imenti South) to establish a center of excellence in QI. ASSIST trained 40 coaches from county, sub-county and Kamili. 15 of these coaches are supporting the 29 initial improvement teams. Kamili is planning to train two other counties and sub-counties in the coming financial year with their funding and technical support from ASSIST.
APHIA plus Imarisha	23	Imarisha funded the dissemination of KQMH in its eight counties of operation with ASSIST providing technical assistance. A center of QI excellence is fully established in Isiolo county, Isiolo sub-county and 50 coaches were trained and 20 of them are full engaged in supporting the improvement teams.
APHIA plus Nairobi – Coast	64	After dissemination of the KQMH in its six counties of operation, Nairobi Coast identified two counties (Nairobi and Kilifi) with two sub-counties (Kasarani in Nairobi and Bahari in Kilifi) to establish centers of excellence in QI with a total of 64 facility based improvement teams. Close to 100 coaches were trained and 30 are actively involved in coaching the teams.
APHIA	21	Similarly, Nuru Ya Bonde supported the dissemination of KQMH in 11

plus Nuru Ya Bonde		counties. A center of excellence was established in Nakuru county (Njoro and Molo) sub-counties involving 21 facilities. The regional referral hospital is part of this initiative with three improvement teams working in Maternity, MCH and Comprehensive Care Clinics. ASSIST trained 50 coaches in this county
APHIA plus Western Kenya	23	Dissemination of KQMh in Nyanza and Western region covered all the 11 counties and was supported by five APHIA Plus and six other CDC funded partners with technical assistance from ASSIST. A center of QI excellence was established in Nyamira county and Nyamira sub-county. More than 50 middle and high level officials from MOH and respective partners were trained in QI and 12 are actively involved as coaches for the improvement teams.
Total	160	ASSIST is currently working with the partners to plan for learning sessions across all the six counties

Technical areas of focus in the six counties:

- **Maternal Newborn and Child Health (MNCH).** The main focus here includes improving retention of pregnant women in ANC, increasing health facilities deliveries, scaling up AMSTL and improving postnatal care with a focus on review of mother baby pairs at 48-72 hours, and 7-14 days after delivery.
- **HIV care and treatment.** ASSIST Kenya's focus is on the classical dimension of coverage, retention and wellness. Nutrition in HIV care and treatment is a key integrated component
- **Elimination of Mother to Child Transmission of HIV|AIDs (eMTCT).** Applying QI to drive eMTCT is a key focus area across the continuum of care (ANC, delivery and postnatal care including breastfeeding and nutrition).
- **Partnership for HIV-Free Survival**
 - ASSIST supported NASCOP to launch the Partnership for HIV-Free Survival (PHFS) initiative in the country. This initiative will see the application of QI to drive the National eMTCT Strategic Plan 2012-2015.
 - ASSIST supported NASCOP to identify and train 17 high-volume PMTCT sites in four sub-counties (Kwale, Kinango, Msambweni and Kilifi) for fast learning on how to apply QI to address eMTCT as a first phase of PHFS. Each facility developed an implementation work plan that guides the process. Figure 3 shows what change ideas were implemented in the Vipingo Health Centre in Kilifi and dramatic improvement in the percentage of mother-baby pairs in care from 14.6% in April 2013 when the QI and change ideas were implemented to 57.5% in August.

Figure 3: Vipingo Health Centre in Kilifi, Kenya: Percentage of HIV exposed mother-baby pairs in care (Jan – Aug 2013)



- **Change ideas implemented through QI:**
 - Open and manage files for each mother-baby pair
 - Integration of HIV care and treatment centers and PMTCT at Maternal and Child Health (MCH) clinic
 - Psychosocial support through mentor mothers
 - Active screening and linking women to care at all entry points (out-patient department, labor, MCH, etc.)
 - Active follow up of missed clinic appointments

Activity 4. Review and develop standards of care for vulnerable children with the MLSS&S and facilitate their roll out to service delivery points

- **The USAID ASSIST project, jointly with PSI, finalized work on the job aid for community volunteers with the final draft presented to the TWG for endorsement.** The job aid has been translated into Kiswahili for ease of use by community volunteers at the point of care.
- **ASSIST engaged a consultant to conduct a situational analysis on PSS service provision in the country.** The final report was presented to the Ministry’s QI TWG and later to the Director and Secretary of children’s services. The government, through the ASSIST, will conduct a national launch of the report to lobby for wider stakeholder engagement for the national PSS framework development.
- **Developed national training manual, directory of service providers and referral tool.** Realignment within the Ministry and government delayed the roll out of this activity. The project is in discussions with the new team at the Ministry to agree on how to fast track this process.
- **Created a change package for QI in OVC programs in Kenya** and finalized a collection of stories describing the experiences of community based organizations (CBOs) in improving the lives of vulnerable children by implementing the service standards.
- **Rolled out of the QI standards to service delivery points.** Through partnership with the Ministry, APHIA Plus and AMPATH Plus a total of 300 community improvement teams linked to CBOs, faith based organizations (FBOs) and the government at the point of service delivery have been established (see Table 2 below). These teams have been supported to implement OVC programs with reference to the standards.

Table 2: Distribution of community QI teams in Kenya

Project	# of QI teams	Remarks
APHIA Plus Kamili	183	The project allocates 5% of their funding to support community QI activities
APHIA plus Imarisha	17	The teams were formed this quarter after a second training in August
APHIA plus Nairobi – Coast	47	The project will close in December and is building the capacity of the teams for transition and sustainability of OVC interventions beyond December 2013
APHIA plus Nuru Ya Bonde	21	The project has challenges in supporting QI interventions due internal leadership challenges
APHIA plus Western Kenya	28	Six of the 28 teams were trained in September
AMPATH plus	4	The project is using the four teams for demonstration at their level. Transition of additional teams from APHIA Plus Nuru ya Bonde to AMPATH Plus is yet to be finalized.
Total	300	ASSIST will train Volunteer Children’s Officers from the counties to coach and mentor the community QI teams for sustainability

- **Demonstration of QI through Center’s of Excellence.** Trainings for seven centers of excellence (Uasin Gishu, Busia, Migori, Kilifi, Meru, Isiolo and Nakuru counties) for OVC interventions in QI were finalized this quarter reaching 41 community improvement teams. The work in the centers of excellence is designed around building the capacity of government, APHIA Plus the CBOs and the community to take responsibility for OVC care and to support initiatives for improved child outcomes.
 - APHIA Plus Nairobi Coast
 - Kilifi and Kasarani counties were selected jointly by the MOH and DCS for demonstration.
 - 12 community improvement teams were trained between June and September this year. Three of the trained teams are from the government-led OVC Cash Transfer program.
 - Five of these teams have conducted their baseline data collection through administration of the CSI tool and the self assessment tool and are in the process of problem identification and development of change ideas. The baseline CSI and self assessment has identified the following services as performing poorly as shown in Table 3. The other seven teams are in the process of consolidating their CSI data.

Table 3: Baseline CSI and self-assessment for community QI teams in Kenya

QI team	Priority Services for improvement (CSI and self Assessment)	CSI scores (%) (Bad and very bad)
Bamba	Food Security	30
	Shelter	44
Ganze	All six services scored an average of 52% as bad and very bad	52 in 12 factors
Sokoke	Food security	74
	Nutrition and growth	59
	Shelter	69
	Legal protection	51
Mtwapa APHIA plus	Food security	50
	Nutrition and growth	44
	Shelter	42
Vipingo CT	Shelter	25
Korogocho OVC CT	Shelter	15

APHIA plus Western Kenya

- Migori County is the project center of excellence site with four community QI teams linked to four CBOs (i.e., Kawiri, Dago Dala Hera, WESAPHE and OBACODEP). The teams were trained in July 2013 and have since collected baseline data, conducted a self assessment based on the standards, problem identification and root cause analysis. Each of the teams have defined their change ideas for testing as is demonstrated in Table 4 below.

Table 4: Change ideas for testing in OVC programs in Kenya

QI team	Priority services for improvement CSI and Self Assessment	CSI scores (%) (bad and very bad)	Change ideas
Kawiri	Food and nutrition	20 and 15	Improve attendance performance of OVC in school Caregiver adult literacy classes and household
	Shelter	17	
	Education	19 and 14	

			economic strengthening
OBACODEP	Food Security	36	Identifying change ideas
Dago Dala Hera	Food security	69	Identifying change ideas
	Nutrition and growth	54	
WESAPHE	Food Security	70	Identifying change ideas on food security and nutrition and growth
	Nutrition and growth	43	

AMPATH Plus

- AMPATH plus has six QI teams with four in Uasin Gishu county and two in Busia county. The teams were trained between June and July and have since communicated standards to the community and the CHWs, conducted self-assessment and administered the CSI tool (see Table 5). The teams are all at the stage of problem identification and defining their change ideas.
- Langas and Bunyala South QI teams had a delay in collecting their baseline data because of logistical problems at the QI team level.

Table 5: AMPATH Plus Baseline data, Kenya

QI team	Priority Services for improvement (CSI and self-assessment)	CSI scores (%) (Bad and very bad)
Kapsoya	Food Security	53
	Nutrition and growth	44
	Shelter	43
	Emotional Health	42
Kasperet	Food security	39
	Emotional health	25
Bunyala North	Performance	33
	Education and work	35
Tulwet	Food security	42

APHIA plus Nuru ya Bonde

- The project has two QI teams in Nakuru county (Njoro and Molo sub counties). The teams were trained in August 2013 and have since communicated standards to the CHWs and gave them a one day orientation on the CSI tool. The CSI tool was administered on a sample 182 children and 240 children in Njoro and Molo respectively. An analysis of CSI data revealed that the tool was not correctly administered hence the need to re-administer the tool. The QI teams have received minimal coaching from their APHIA Plus team on the ground, hence their struggle with implementing their work plan.

APHIA Plus Imarisha

- APHIA Plus Imarisha has seven QI teams in Isiolo County (Waso, Ngeremara, Ordha, Kambi Bule, Burat, Bula Mpya and Bule West). They were trained in September and are in the process of finalizing their QI work plans.

Improvement Strategy

ASSIST involved MOH and MLSS&S at all levels to provide leadership in the improvement process. The project further lobbied for inclusion of our activities in the work plans of the two ministries for ownership and sustainability of improvement activities.

Spread Strategy

ASSIST advocated for spread of QI activities through lobbying the county MOH health Directors and health Secretaries to include a department of quality within their structure to facilitate the spread and institutionalization of QI activities.

What Are We Learning?

- National level: There must be an integrated effort to build structures that support improvement work on the ground.
- Priority setting: Plans must focus national, county and local efforts to improve health care quality on common aims, priorities, targets and interventions.
- Continuity: Plans must build on work in progress by showcasing current initiatives addressing similar priorities.
- Support action to address priorities: Strategic frameworks should link domains for quality interventions (leadership, information, organizational capacity, models of care, patient and population engagement, regulation and standards) to national decision-making processes.
- Define guiding principles: Plans must be guided by core principles of quality.
- Ownership: National and county leadership is important for developing ownership.
- Spread: The spread strategy needs to be defined from the start to facilitate the knowledge harvest that will guide scale-up.
- Devolution: With the ongoing country strategy, ASSIST needs to pay attention to changes on leadership as this will affect our work.

Directions for FY14

- Support institutionalization of QI at the national level under the MOH.
- Support the MLSS&S at the national level in institutionalization of QI in OVC, child protection and national social protection programs.
- Support the MOH, APHIA Plus and other USAID IPs to improve health service delivery by applying QI techniques and rolling out a patient safety program in 10 high volume health facilities jointly with WHO.
- Strengthen systems within the county governments to support the institutionalization of QI in child protection to improve the welfare of children.
- Support national programs and departments such as NASCOP, Family Health, Primary Health and the Department of Standards and Regulatory Services to institutionalize QI at the service delivery level.

1.6 Malawi

Background

In 2010, HCI began working in Malawi providing technical and administrative support to the Ministry of Gender, Children, and Social Welfare (MOGCSW) to pilot OVC service standards in four districts. ASSIST started working with the Government of Malawi in January 2013 to complete the process of piloting and finalizing the national OVC service standards, using QI techniques. A transparent M&E system was established to provide information on how well children are doing (using the CSI) and to assess adherence to the service standards.

Program Overview

What are we trying to accomplish?	How will we know?	At what scale?
1. Pilot and finalize the OVC service standards to see if they are feasible and effective in improving outcomes	<ul style="list-style-type: none"> Final set of standards developed and tested 	National level 1,000,000 single and double orphans (<i>UNICEF, HIV and AIDS Stock taking reports, 2009</i>)
2. Improve care for vulnerable children	<ul style="list-style-type: none"> Using CSI core measurements on children's wellbeing 	Four pilot districts

Key Activities, Accomplishments, and Results

Activity 1: Pilot and finalize OVC standards

- Reviewed OVC service standards in collaboration with various Ministries (Ministries of Gender, Education, Health, Agriculture) and OVC IPs.
- IPs conducted CSI assessments of 2,945 children in the piloting communities to identify the priority areas to focus on as QI teams.
- Piloted standards in four districts (Blantyre, Karonga, Lilongwe and Mangochi).

Table 6: Progress on testing OVC standards in the four pilot districts

	Blantyre	Karonga	Lilongwe	Mangochi
Child Status Index (CSI)	Completed 19 CSIs	Completed 60CSIs Completed 30 CSIs (2 nd CSI)	Completed 106 CSIs Completed 19 CSIs (2 nd CSI)	Completed 2,790 CSIs
How many recommended actions have been tested?	CP - 5/5 ¹ ECD -9/9 Educ -5/5	F&N-5/5 HES – 6/6 PSS - 6/6 ²	CP-5/5 ECD-9/9 PSS – 6/6	CP-5/5 ECD-9/9 Educ-5/5
How many recommended actions have data?	CP - 5/5 ECD 9/9 ³ Educ -5/5	F&N-4/4 ⁴ HES – 6/6 PSS - 6/6	CP-5/5 ECD-9/9 PSS – 6/6	CP-5/5 ECD-9/9 Educ-5/5
QI team maturity index	3.0	3.0	3.0	3.0
District government involvement	District Social Welfare Offices, Health Surveillance Assistants (HSAs), Police, Group Village Heads, Primary school heads were involved	District Social Welfare Offices, HSAs, Group Village Heads and Ministry of Agriculture were involved	District Social Welfare Offices, HSAs, Police, Group Village Heads, Primary school heads were involved	District Social Welfare Offices, HSAs, Police, Group Village Heads were involved

- National QI group presented final draft standards to the national OVC TWG who reviewed

¹ The recommended actions under child protection were reduced from 6 to 4 actions

² The recommended actions under PSS were revised by the core group from 8 to 6 recommended actions

³ The recommended actions under ECD were revised by the core group from 7 to 9 recommended actions

⁴ The recommended actions under F&N were reduced from 5 to 4 recommended actions

and approved the standards.

- **Started developing an implementation plan for the OVC service standards with the MOGCSW for the four districts:** After the approval of the OVC standards ASSIST and MOGCSW agreed to promote community ownership and involvement in the four districts by involving the District Executive Committees in the pilot districts. This Committee includes all government heads of departments which include the District Commissioner, District Social Welfare Officer, District Health Officer, District Agriculture Officer, Director of Planning and Development and other NGOs active in the districts. This activity is significant during the period because it is a period when the district starts developing their implementation plans and budgets (District Implementation Plans). These discussions with the DEC are significant for the districts to start strategizing how communities would use the standards in the districts' to improve service delivery.⁵

Improvement Strategy

ASSIST supported QI teams and government staff to use QI approaches to identify and solve complex problems. Approaches include focusing on the child as a person with multiple needs and working in a multi-sectoral team to improve services and using the CSI to identify priority areas for improvement.

Use the OVC service standards to decide what actions to take to improve services and test changes to learn what works in their context. Encourage teams to compile and use data to make decisions about what services to provide and how to provide them.

The project involved Social Welfare Officers and Community Child Protection Workers to oversee the implementation of the PSS services provided in the area to ensure quality and continuity of the improvement process in the service area. IP Save the Children worked with the CBO and QI team to identify gaps to work on in this service area. The QI team used the recommended actions in psychosocial support service area to improve the quality of the services and activities conducted at the children's centers.

Spread Strategy

ASSIST will support the MOGCSW to promote the involvement and ownership of district stakeholders through the District Executive Committee by providing oversight of the QI work being implemented in the district. By working with Child Protection Workers, the approaches used to deliver improvements will be disseminated by the extension workers in nearby villages through the work of the Community Child Protection Workers in the communities.

Activity 2: Improve care for vulnerable children

Child protection

- **Worked with communities to ensure children are safe from any abuse and have access to essential services:** After communities conducted CSI assessments for children in the three districts of Blantyre, Lilongwe and Mangochi, child abuse emerged as a priority problem that communities needed to focus on. The QI teams worked in collaboration with various child protection stakeholders such as the District Social Welfare Offices (DSWO), Community Victim Support Units (CVSU), community policing units and local leaders to sensitize communities to build knowledge in prevention of abuse and child protection processes. During the year, the QI teams identified and handled 513 child abuse cases ranging from neglect, child marriages, child labor, sexual abuse and abduction.

⁵ Recommendations: Implementation of the standards should start with identification and training of quality improvement coaches in the communities; Formation and orientation of QI teams is significant in implementing the OVC minimum standards; Integrating QI coaching of QI teams to districts implementing the OVC standards; An on-going process of learning from the implementation sites will be crucial to facilitate learning and improvement in the lives of children; Involvement of government sectors at all levels is key to successfully implement the OVC minimum standards and improvement work; Introduction of the OVC minimum standards to the districts and communities should emphasize community ownership; Documentation of the implementation of the OVC minimum standards indicators is crucial to track changes and improvement in children's lives

- During the year, the QI teams discovered that in most communities there was limited knowledge and understanding of the Malawi constitutional laws. As a result, the QI team facilitated meetings with 91 villages to improve communities understanding of the laws that protect children rights in the three districts.
- Whilst working with children in the communities, the QI teams in Mangochi District also discovered that most children had inadequate knowledge to protect themselves and recognize any traits of child abuse in the communities and report them accordingly. The QI team facilitated life skills training of 530 children in their catchment area to equip them with knowledge on child rights and protection mechanisms available in the communities.

Early childhood development

- **Improved access to early childhood development:** In the pilot districts of Blantyre, Lilongwe and Mangochi, QI teams facilitated community mobilization activities to gather support of early childhood development (ECD) services in the communities. After the mobilization activities communities mobilized bricks, sand and quarry stones for building ECD centers. Due to these activities there has been an increase of ECD centers, from 64 to 129 in the piloting sites.
- **The QI teams linked with Save the Children and the Firelight Foundation to train 233 ECD caregivers in ECD centers and 209 committee members were trained in management and mobilization skills for the centers.** As a result, the quality of ECD activities in the community based centers has improved, resulting in a total enrolment to 7,282 children for children aged 0-6 years as compared to 2,604 in January 2013.

Food security and nutrition

- **QI teams facilitated assessments of children and discovered that most vulnerable households experienced food insecurity problems (Karonga District).**
- **The CBOs linked with various stakeholders in the communities** such as the Ministry of Agriculture and other organizations providing livelihood support in the area to build the capacity of these vulnerable households.
- **The QI teams facilitated orientation sessions for 258 vulnerable households** in crop husbandry practices concentrating on production of leguminous crops to help in diversifying the diets of these vulnerable households. The teams also linked with Ministry of Agriculture to support them in the construction of metallic and brick crops storage facilities. These storage facilities help in protecting crops from pests and the crops can be accessed by vulnerable families when in need.
- **The QI teams also linked with the Ministry of Agriculture to facilitate community based nutrition education** and demonstrations through open days on local food preparation and preservation. A total of 70 women and 19 men participated in these sessions.
- **The team also identified 40 moderately malnourished children in the communities** through linkages with the HSAs and referred them to the nearest health facilities in the area.
- **Trained 258 OVC guardians in improved crop production and diversification:** QI teams in collaboration with agriculture extension and livelihood organizations' in the area facilitated the training of vulnerable households in modern crop husbandry practices to increase their crop production particularly on leguminous crops such as soya beans, pigeon peas and groundnuts. During the year the QI teams have observed that the communities have organized themselves and build four grain banks/silos to preserve 240bags of 50kg maize harvest to be used during the hunger months by the vulnerable households.

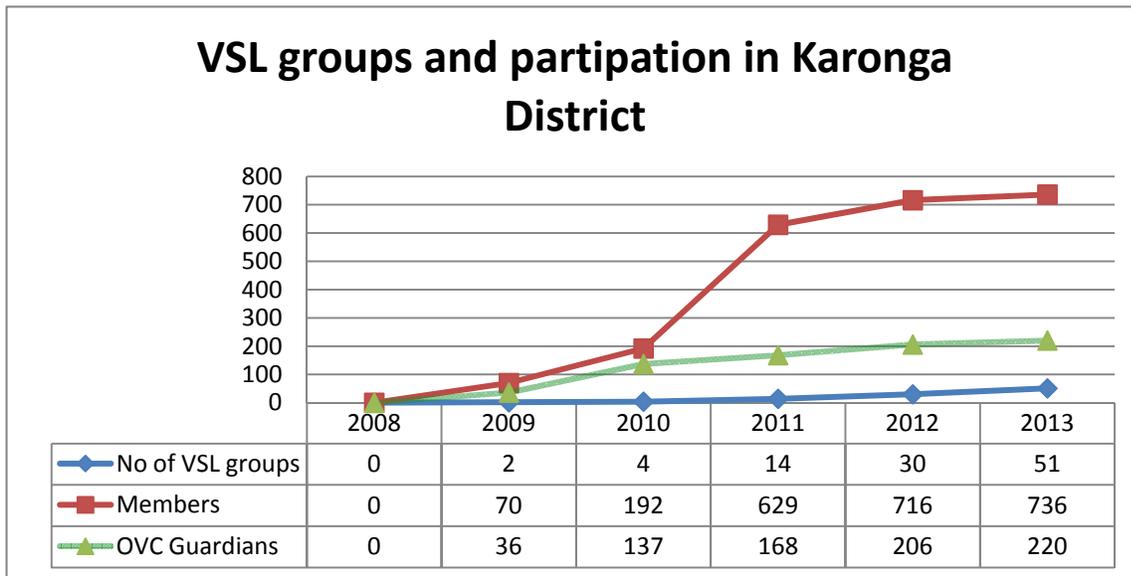
Education

- **Improved access to educational services:** At the beginning of ASSIST, the four pilot districts assessed the children using the CSI and discovered that education was a problem in the two districts of Mangochi and Blantyre. The QI teams in the districts conducted a situational analysis of why this was the case using the standards in education service area. The teams discovered that there were geographical, socio-economic and cultural factors affecting the access of children to primary and secondary education services. In Mangochi district the team discovered that 1,273 children were in dire need of scholastic materials because their families could not afford to support them due to poverty. These children were linked to various stakeholders including the

DSWO offices in the district. The total enrollment of children in primary schools in the two districts increased from 9,054 children in enrolled in primary schools in December 2012 to 13,681 children enrolled and attending primary schools.

- Improved vulnerable households' economic wellbeing:** In Karonga District, ASSIST worked with two QI teams in Mwanganya and Nyungwe catchment areas to identify needy vulnerable households to orient in household economic strengthening activities such as Village Savings and Loans and small scale business ventures. The QI teams linked with Ministry of Agriculture extension workers and Lusubilo CBO that is supported by Catholic Relief Services to implement household economic strengthening activities. Over the years, the QI teams engaged vulnerable households to participate in the formed Village Savings and Loan groups in their communities. The QI teams facilitated formation of Village Savings and Loan groups in Karonga District as shown in Figure 4 below:

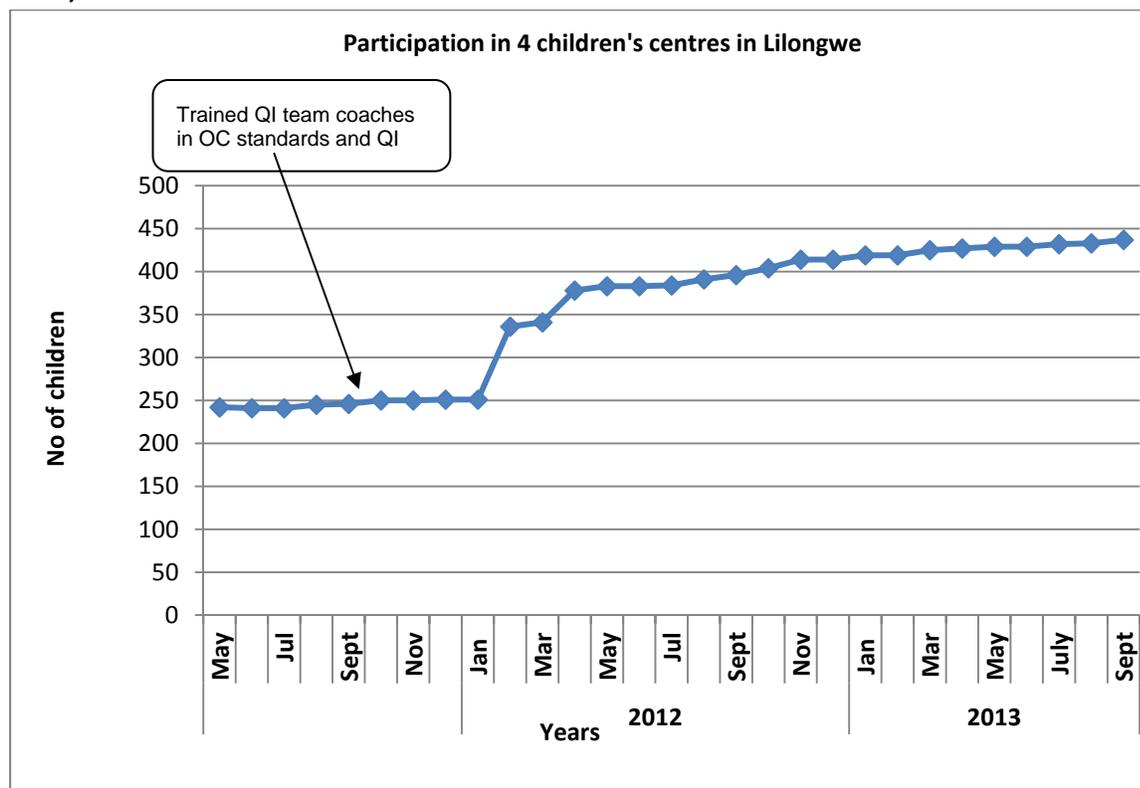
Figure 4: Karonga District, Malawi: Number of VSL groups formed and their participation (2008-2013)



Psychosocial support

- Worked with children's corner centers to improve participation of children:** During the year, Tigwilizane CBO was working with four children's corner centers to improve participation of children in various activities to improve the psychosocial wellbeing of vulnerable children in four villages in Traditional Authority Chitukula in Lilongwe District (See Figure 5).

Figure 5: Lilongwe, Malawi: Participation of children in four children's centres (May 2012-Sept 2013)



- **Trained five psychosocial support counselors:** Save the Children identified the need to train five PSS counselors at each center to support children identified as in need emotional support due to the impact of HIV and AIDS in the communities. The counselors and facilitators were also oriented on the PSS service standards to improve the quality of PSS services at the centers.
- **Mentored the QI coaches at the CBO:** ASSIST mentored two coaches from the QI team to facilitate regular QI team meetings to discuss improvement work in the four centers' activities. As a result, some improvements were observed in children's participation in the four centers.

Improvement Strategy

At the community level the QI team has linked with the relevant government extension workers in health, social welfare, education and agriculture to support teams with some technical knowledge and skills in all the service areas in the OVC service standards. This approach promotes community ownership and government involvement at the grassroots level.

Improvement in Key Indicators

Activity	Indicators	Baseline as of February 2012	Sept 2013
1. Identify and address critical barriers in the	Child protection		
	Number of cases referred to child protection service providers	214	513 ⁶

⁶ This data is from Mangochi, Blantyre and Lilongwe Districts

Activity	Indicators	Baseline as of February 2012	Sept 2013
scale up and sustaining of effective high-impact interventions provided to vulnerable children and their families in two districts in Malawi by September 2014	Number of children removed from child labor situations	Data not available	302
	Number of children trained in life skills, rights and responsibilities	Data not available	530
	Early childhood development		
	Percentage of malnutrition cases among the 0-8 year old children	36.2% ⁷	3%
	Number of ECD centres established	64	129
	No of children enrolled in ECD centres	2,604	7,282
	Food security and nutrition		
	No of OVC households oriented on food production, preparation, utilization, preservation and processing	Data not available	3,840
	Number of OVC households linked to food security programs in the area	Data not available	158
	No of demonstration plots established for training farmers	Data not available	15
	Education		
	No of children enrolled in primary schools	9,054	13,681
	Household economic strengthening		
	Number of Village and Savings & Loans (VS&L) groups formed	2	51
	Number of VS&L groups functional	2	51
Number of households hosting OVC participating in VS&L groups	36	220	
	Number of community members participating in VS&L groups	70	736
	Psychosocial support (PSS)		
	Number of children accessing PSS services	246	1,455
	Number of safe social structures ⁸ established and strengthened by type	3	26

What Are We Learning?

- Using the standards is guiding communities to identify gaps that exist in the services they provide and link with appropriate stakeholders for support of their children.
- The involvement of local leaders such as Group Village Heads in QI is helping to fast track some of the agreed actions in the communities.
- Working in teams that cut across multiple sectors and involving extension workers from different ministries is also important in helping provide holistic care to children.
- Involvement of a team to follow up improvement activities at the children's corner is helping

⁷ This data is from Blantyre District

⁸ These are community-based centres which communities establish for children to assemble during weekends to play, be taught some life skills, reproductive health messages, child rights and resilience topics so that vulnerable children can protect themselves from exploitation, abuse and violence.

service providers pay attention at what kind of services they provide to children.

- Sharing of information and data among QI team members improves service delivery of OVC services in the community. For example in Karonga District sharing information in the QI team with the Agriculture extension workers and the local leaders helped the identified nine needy OVC households in Nyungwe area to be linked to the Farm Input Subsidy program (FISP) to receive farm inputs to improve their household food security. These OVC households were later accepted as beneficiaries of the government farm inputs which included fertilizer and maize seeds. These OVC families have grown their gardens using the farm inputs received from FISP.
- The CSI assessments are assisting communities to prioritize areas that need attention by the implementing partners' and the communities themselves to effectively mobilize resources and allocate the limited resources to appropriate service areas in need.
- Using the CSI to understand what are the main problems faced by vulnerable children in communities, helps communities to look for solutions to these problems rather than passively waiting for support provided by outside groups. For example, Mangochi was not working on improving education until they did the CSI and realized that this was a major problem for the children they supported. They were able to then use the information from the CSI for advocacy with local leaders and government officials to start working on improving education.
- Availability of data helps communities to identify areas that need special attention and helps in finding appropriate solutions. In Blantyre District, the QI team at the district level discovered that 16 caregivers were trained. The QI team agreed to seek resources from Save the Children to train an addition of 49 caregivers for 14 CBCCs in the area. Save the Children facilitated the training of these caregivers and attendance of children at the CBCCs has increased.

Directions for FY14

- Focusing in two districts (Mangochi and Balaka Districts) instead of the four pilot districts to implement the OVC standards in selected Traditional Authorities in order to identify and develop a change package of services that could be scaled up in other sites.

1.7 Mali

Background

In FY09 HCI began working in Mali, applying improvement science to MCH care, with significant results. Given the still significant unmet need in Mali for adequate coverage and quality of maternal and newborn health services along with the stated interest of the MOH and USAID in strengthening maternal and newborn services, ASSIST began working in Mali in May 2013 to strengthen and expand the activities begun by HCI, both in technical content and coverage.

Program Overview

What are we trying to accomplish?	How will we know?	At what scale?
1. Improvement of Essential obstetric and newborn care (EONC) interventions at facility and community levels in Kayes Region	<ul style="list-style-type: none"> • Tangible results achieved for target improvement aims on ANC, AMTSL, ENC, Helping Babies Breathe (HBB), Pre-eclampsia/eclampsia (PEE) and Post-partum family planning (PPFP) at facility and/or community levels • District, region and national managers and stakeholders sensitized and/or competent to support QI process 	<p>Targets 1 region (1/7), 1 facilities (148/163) in 5 districts (5/7) for 1,130,366 inhabitants (out of 1,687,116)</p> <p>Type of target facilities include peripheral facilities (142), district hospitals (5) and the regional hospital</p> <p>Target districts in Kayes Region include: Bafoulabé, Diema, Kayes, Nioro, and Yelimané</p>
2. Improvement of anemia prevention and control	<ul style="list-style-type: none"> • Tangible results achieved for target improvement aims on anemia control and prevention at facility and/or community levels 	<p>Targets one region - Sikasso (1/9), 25 facilities (25/29) in 1 Bougouni district (1/7) for 525,000</p>

activities in Bougouni district (Sikasso Region)	<ul style="list-style-type: none"> District, region and national managers and stakeholders sensitized and/or competent to support QI process 	inhabitants (out of 2,625,919) Type of target facilities include peripheral facilities (24) and district hospital (1)
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Key Activities, Accomplishments, and Results

Activity 1. Improvement of EONC intervention at facility and community levels in Kayes Region

- **Conducted facility-based coaching visits for clinical refreshment on PEE screening and case management** in eight poorly performing sites in collaboration with the referral hospital's gynecologist and regional health direction. At least two providers have been trained on-site.
- **Organized district-based learning sessions** for Kayes and Diema for 123 participants including 35 women and four from MCHIP and two from the Regional Directorate. The session included a clinical refreshment on PEE screening and case management.
- **Provided all sites with data transmission tools for all targeted technical content areas (AMTSL/ENC/PEE and PFPF).**

Improvement Strategy

To reinforce ownership and sustainability, all facility-based coaching visits were performed by regional coaches (regional management and regional hospital coaches).

Activity 2. Improvement of anemia prevention and control activities in Bougouni district (Sikasso Region)

- **Together with DHMTs trained 147 providers of 25 target sites on essential norms for anemia control and prevention among pregnant women and children under five.** The providers then set up the QI teams in collaboration with community health associations and support from ASSIST.
- **Conducted coaching visit with district coaches** to all 25 target facilities to reinforce newly set up QI teams.

Improvement Strategy

Coaching visits were performed jointly with DHMT in order to create awareness and to prepare for ownership and sustainability.

- **Results: Improved percentage compliance to eclampsia and pre-eclampsia diagnostic standards.** Figures 6 and 7 below show that compliance to PEE screening and treatment standards remained below 50% for more than one year (pre-2012). This was mainly due to screening being limited only to suspected cases. In addition, the unavailability of inputs (such as urine dipsticks) also contributed to low compliance. However, with the strong involvement of the community committee (ASACO) in the purchase of essential inputs; coaching visits with refresher/on-the-job training in PEE screening and case management for providers; and peer observation of PB monitoring and treatment standards posted in the delivery room, the detection rate and case management have been maintained at over 70% since March 2012.

Figure 6: Kayes Region, Mali: Percentage compliance to eclampsia and pre-eclampsia diagnostic standards (Oct 2010 - Sept 2013)

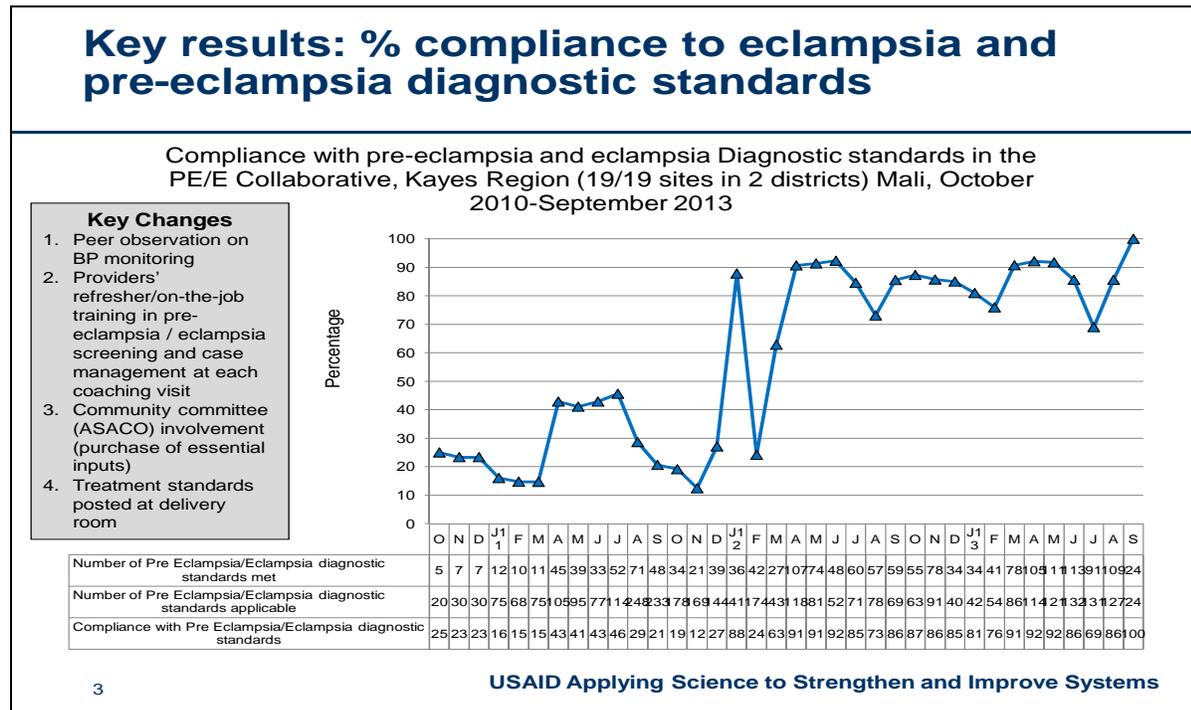
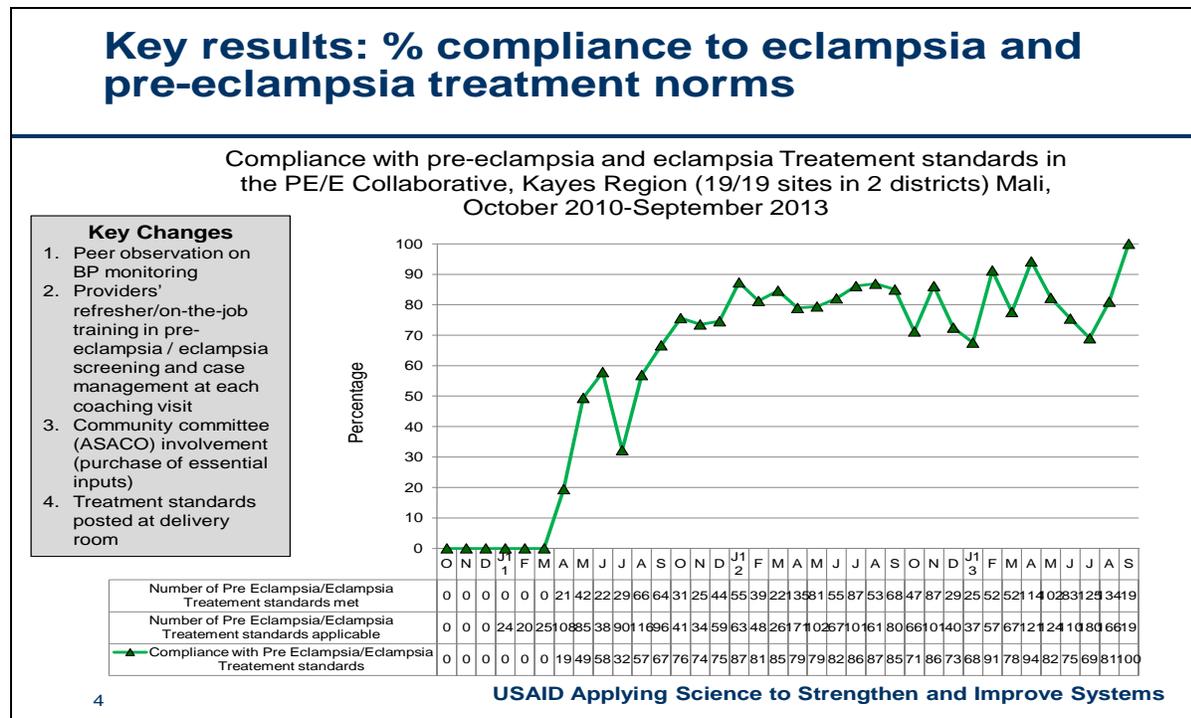


Figure 7: Kayes Region, Mali: Percentage compliance to eclampsia and pre-eclampsia treatment norms (Oct-Sept 2013)



Improvement in Key Indicators

Activity	Indicators	Baseline	Last value
Improvement of EONC intervention at facility and community levels in Kayes Region	Compliance to three key AMTSL norms	0%	100% (Sep '13)
	PPH rate	1.2%	0.2% (Sep '13)
	Compliance to ENC norms	39%	99% (Sep '13)
	Compliance to PEE diagnostic standards	25%	100% (Sep '13)
	Compliance to PEE treatment standards	0%	100% (Sep '13)
Improvement of anemia prevention and control activities in Bougouni district (Sikasso Region)	% Pregnant women for whom palor and hemoglobin are checked at ANC visits	0%	30% (Aug '13)
	% Pregnant women who received good counseling on how to prevent anemia during ANC visits	0%	32% (Aug '13)

What Are We Learning?

Given that behavior change is central to the control and prevention anemia among pregnant women and children under five, partnership with other sectors (e.g., agriculture, economy, education, public media), IPs and NGOs and full involvement of communities is needed. As a consequence, we are adapting our approaches to include: better conceptualization of our community health system approach and better situational analyses (i.e., availability of affordable micro-nutriments rich foods at local markets).

Directions for FY14

Three new EONC activities will be launched in three districts of Kayes region during FY14:

- Introduction of HBB to ongoing AMTSL/ENC component to target newborns.
- Reinforcing ANC activities to better highlight evidence base norms during the process (e.g., birth preparedness, ITP, iron and foliate intake, recognition of danger signs).
- Implementation of the WHO Safe Childbirth Checklist to improve processes around birth and postpartum.
- Implementation of a community-based collaborative using the community health system model for anemia.

1.8 Mozambique

Background

Mozambique has an estimated 1.8 million orphans (of father, mother or both), of which 510,000 are orphaned due to HIV and AIDS. In July 2013, the Government of Mozambique, supported by USAID, finalized and approved the minimum standards of care for vulnerable children. The standards were piloted in three provinces of Gaza, Zambezia, and Cabo Delgado (targeting about 6,150 children in 10 districts). The findings of the pilot demonstrated that out of seven services, household economic strengthening and PSS were the weakest services in terms of implementation. The government recommended that these two services be addressed during the roll-out process and that capacity building was needed for key actors in the process in order to better respond to the needs of children.

Starting in June 2013, ASSIST has continued to support the Ministry of Women and Social Action (MMAS) to roll out the standards throughout all 11 provinces. ASSIST has also engaged the QI task team to use QI techniques to identify, address and share best practices in the implementation of the standards.

Program Overview

What are we trying to accomplish?	How will we know?	At what scale?
1. Improve the quality of OVC services and care through distribution of national service standards in eleven provinces	<ul style="list-style-type: none"> # provinces, districts and organizations trained in implementation of the service standards # organizations implementing best practice guidelines from the standards Children show improved outcomes on indicators from following areas: health, nutrition and food security, education, shelter, protection, PSS and household economic strengthening 	Distribution of standards to eleven provinces through three regional meetings in North, South, and Central
2. Identify and address critical barriers in the scale up and sustaining of effective high-impact interventions provided to vulnerable children and their families	<ul style="list-style-type: none"> Knowledge is generated on high-impact interventions in the Mozambique context Tools developed and used to facilitate processes of mapping, referral, case management, clarification of roles and responsibilities of formal and informal actors, data collection and analysis # organizations effectively implementing adopted tools Children show improved outcomes on indicators from following areas: health, nutrition and food security, education, shelter, protection, PSS and household economic strengthening 	One district in each of two provinces, sites to be determined in collaboration with MMAS and USAID
3. Finalize the HBC standards in Mozambique	<ul style="list-style-type: none"> Government of Mozambique approves the final home-based care (HBC) standards in Mozambique 	Piloting will take place in two communities in one district in each province of Gaza, Sofala and Cabo Delgado.
4. QI technical assistance to communities for PHFS	<ul style="list-style-type: none"> Increase the retention of HIV-positive pregnant women and their exposed infants receiving PMTCT services by linking them to facilities for care 	Mozambique – eight communities in three provinces (Gaza, Sofala and Zambezia).

Key Activities, Accomplishments, and Results

Activity 1. Improve the quality of OVC services and care through distribution of national service standards in eleven provinces

- Conducted QI training for OVC, HBC and PHFS technical working teams and staff from the Ministries of Health and Social Welfare.** In August 2013, the project conducted a four-day training for 21 participants comprised of the OVC, HBC and PHFS technical working teams and staff from the Ministries of Health and MMAS. The aim of the training was to refresh the technical teams with QI tools and techniques for use as the government plans the scale up minimum standards of care for vulnerable children as well as approve and pilot the draft HBC standards. Consensus was reached on the way forward, including the following steps: 1) Conduct three regional workshops to initiate the roll out of standards in 11 provinces in Q1 FY14; 2) Develop a roll out strategy for OVC service standards; 3) Conduct mapping of available OVC organizations and resources in the provinces and districts; and 3) Support and coordinate use of tools (data collection, M&E, indicators) across organizations. Both MMAS and the project have also agreed on the need to continue to review and determine the capacities and the pace for organizations to roll out the standards at community level.

Activity 3. Draft and Pilot Home Based Care Standards

- **The MOH with technical assistance from USAID ASSIST drafted HBC standards document for the Government of Mozambique.** The HBC draft standards document has received its final comments from the HIV technical team from the USAID Mission in Mozambique. Two critical issues were raised: 1) Regarding access to treatment and care, there is a need to take into account the creation of community based structures such as support groups for people living with HIV/AIDS (PLWHA); 2) The standards need to incorporate actions that promote retention of patients in care and treatment, a major challenge in all the HIV support and care programs running in the country to date. The HBC TWG will soon be reconvening to address and incorporate these issues raised before final submission to the Ministry in the next quarter.

Activity 4. Partnership for HIV Free Survival

- **Agreed on budgets and the scope of work.**

Directions for FY14

OVC

- ASSIST will support multiple levels of stakeholder teams – national, provincial, district and community – in disseminating the service standards and to use QI approaches to identify best practices in the protection and care of vulnerable children and their families.

HBC

- Support the Government of Mozambique and PEPFAR in finalizing the standards.
- Define quality using service standards; pilot the standards; gather evidence on implementation of the standards; develop a training strategy; and work with the MOH to develop a QI strategy.
- PHFS
- Conduct QI training for district and provincial levels coaches; learning sessions in each province to facilitate shared learning; coaching visits with Government of Mozambique staff to support improvement teams follow up of post natal mothers and link them and their infants with health facilities.
- Work with HealthQual personnel to develop a change package that will incorporate results of the improvement work in communities and health facilities, and develop a scale-up strategy and plan for the second phase.
- Build on existing global knowledge about postnatal PMTCT care and infant feeding by contributing to activities such as national, provincial and district QI trainings, provide coaching support for facilities, and learning sessions for facilities that will be organized by other IPs.

1.9 Nigeria

Background

The Nigerian Federal Ministry of Women Affairs and Social Development (FMWASD) in coordination with the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) Nigeria, has been engaged in the initiative to improve quality of vulnerable children (VC) services by developing the national VC service standards. Since FY11, HCI has worked with the FMWASD to support the institutional strengthening of the Ministry of Women Affairs and Social Development (MWASD) at the federal, state, and local government levels to develop and pilot standards for VC services using quality improvement methodologies.

In FY13, the USAID ASSIST Project piloted the final draft service standards using improvement science in 11 states, resulting in the adoption of the national service standards and improvement methodologies as the nationally accepted sustainable approach for VC programming in Nigeria. Henceforth all USAID-supported VC programs will be required by the Government of Nigeria to use the national service standards along with improvement methodologies for VC programs.

In April 2013, USAID Nigeria made two Umbrella Grants Mechanism (UGM) awards to two lead implementing partners (IPs) (Catholic Relief Service (CRS) and Save the Children International (SCI)) to ensure high quality delivery of the standards in 10 states of Nigeria. selected states in Nigeria:

CRS is implementing the SMILE⁹ project and SCI is implementing the STEER¹⁰ project in close cooperation with the FMWASD. For FY14, the USAID Mission in Nigeria has requested that the USAID ASSIST Project to support the two lead IPs to apply improvement methods in the implementation of the UGM awards.

Program Overview

What are we trying to accomplish?	How will we know?	At what scale?
1. To build the capacity of Federal and State Ministries of Women Affairs and Social Development in piloting draft service standard for vulnerable children in Nigeria	<ul style="list-style-type: none"> Federal and State Ministries of Women Affairs and Social Development take the lead in piloting draft service standards for vulnerable children 	National 11 State Ministries of Women Affairs and Social Development Lagos, Ekiti, Cross River, Akwa Ibom, Enugu, Ebonyi, Kaduna, Kano, Taraba, Bauchi, Benue, and Federal Capital Territory 27 local government areas
2. To gather evidence on the pilot through the use of improvement science	<ul style="list-style-type: none"> Draft service standard document revised with evidence gathered and feedback incorporated 	31 community improvement teams, 31 community-based organizations (CBOs), 9 implementing partners
3. To integrate draft vulnerable children service standards into National Priority Agenda (NPA) and M&E Plan	<ul style="list-style-type: none"> Statement of declaration /commitment to use standard based and quality improvement approach integrated into registration of CBOs with the Federal Ministry of Women Affairs and Social Development 	National
4. To institutionalize quality improvement through piloting and creating communities of learning across state holders	<ul style="list-style-type: none"> Establishment of Quality Improvement Teams/Units in the office of Federal and State MWASD and incorporation of quality improvement activities to the official duties of OVC desk officers 	National, state, local government, and community levels
5. To communicate standards to partners and other vulnerable children stakeholders	<ul style="list-style-type: none"> Service standard for vulnerable children documented, finalized and launched 	National, state, local government, and community levels

Key Activities, Accomplishments, and Results

Activity 1: Improve quality of vulnerable children services by developing the national vulnerable children service standards

- **Finished 2nd learning session** in all 11 states using the learning session guide with the knowledge management strategy.
- **Held 3rd learning session in all the six geo political zones** of Nigeria (North Central, North East, North West, South- South, South East and South West) with participation of Directors of child development, Orphans and Vulnerable Children Desk Officers from 36 states, MWASD, FMWASD, USAID IPs, representatives of CBOs and community QI teams in pilot sites.
- **FMWASD took the lead in the piloting of the services standard in all the states.**
- **Conducted harvest meeting in the six geo political zones** (North Central, North East, North

⁹ Sustainable Mechanisms for Improving Livelihoods & Household Empowerment (SMILE)

¹⁰ Systems Transformed for Empowered Action and Enabling Responses for Vulnerable Children and Families (STEER)

West, South - South, South East and South West).

- **Organized monthly state quality improvement meetings with MWASD.**
- **Coached community quality improvement teams between learning sessions.**
- **Held standards review meeting in the six geo political zones of Nigeria** (vulnerable children service standard review meeting). Standards review meetings were held in the six geo political zones of Nigeria (North Central, North East, North West, South -South, South East and South West). The participants were made up of Directors, Orphans and Vulnerable Children Desk Officers from 36 States Ministry of Women Affairs and Social Development with Federal Ministry of Women Affairs six man Quality Improvement team, Representatives from FHI 360, Creative Associates international , AIDS Prevention Initiative Nigeria, Institute of Human Virology, Hope Worldwide Nigeria, Association of OVC NGO in Nigeria (AONN), Management Science for Health, Save the Children International, Association of Reproductive Health PACT, representatives of CBOs and community quality improvement teams. The review meeting assessed all the essential actions and guidelines of the vulnerable children services using the following criteria: Understandable, Feasible, Relevant/Appropriate and Effective
- **Finalized service standard:** The National standard for improving the Quality of Vulnerable Children Service is at the final stage ready for launching as soon as the finalization committee reviews the document and approves it. The following activities were done to develop supporting materials for the launch of the final service standards:
- **Drafted toolkit to communicate improvement and standard-based approaches for vulnerable children.**
 - The contents in the toolkit are:
 - National standards for improving the Quality of Vulnerable Children Service
 - A guide for developing Improvement Measurement Plans for Vulnerable Children Programs in Nigeria
 - Improvement Journal for Vulnerable Children Programs in Nigeria
 - USAID Care that Counts: An E- learning Course for Quality Improvement (QI) in programs for Vulnerable Children
 - Cartoon comic stories: The Improvement Story
 - Improvement Journal for Vulnerable Children Programs in Nigeria: This will be used by the community improvement teams
 - Maturity index for monitoring improvement teams: This will be used by the CBOs to monitor progress of the community improvement team maturity as they work through different stages of improvement, service provision and care steps. The purpose is to monitor progress in team maturity as they work through different stage of improvement and care steps.

Activity 2: Gather evidence on the pilot by using improvement science

- **The draft service standard was revised with evidence gathered and feedback provided.**

Activity 3: Integrate draft vulnerable children service standards into National Priority Agenda and M&E Plan

- **Held pre-validation meeting of service standards:** Pre validation of service standard was held in June 2013 at the FMWASD. The objective was for the National Quality Improvement taskforce members to: a) take a critical look at the service standards viz a viz the comments made during the harvest meetings/ standard review meeting; b) come up with recommendations on corrections made and incorporate the same into the service standard.
- **Held one-day validation meeting aimed at finalizing the draft National Orphans and Vulnerable Children Service Standard:** Held meeting in July with National Quality Improvement Task Force (i.e., management staff from Save the Children International, Catholic Relief Services, FHI 360, Management Sciences for Health, USAID MARKETS, SPRING, Association of OVC NGO In Nigeria, National Action Control of AIDS (NACA) Hope World Wide Nigeria, AIDS Prevention Initiative Nigeria with Federal Ministry of Women Affairs Six-Man Quality Improvement Team and Director of child from 36 states). At the end of the meeting, a statement of declaration/commitment to use a standards-based improvement approach for the registration of civil society organizations within the Ministry Women Affairs Social Development.

- The outcomes of the meeting were:
 - Vulnerable children services standards document finalized
 - Consensus reached by the National Quality Improvement Taskforce on the Service Standards
 - Service Standards acceptable as National Document
 - Setting up of finalization committee

Activity 4: Institutionalize quality improvement through piloting and creating communities of learning across stake holders

- **Established ASSIST offices** in Ebonyi, Ekiti and Akwa Ibom State MWASD
- **Held inauguration of national quality improvement task force team**
- **Incorporated quality improvement activities into the official duties of MWASD OVC desk officers**
- **Planned for scale up by working with two organizations that won the Umbrella Grant Mechanism (UGM) on Vulnerable Children in Nigeria** to provide them with an implementation science approach.

Activity 5: Communicate standards to partners and other vulnerable children stakeholders

This activity was shifted to the FY14 work plan. The communication of standards will use the toolkit developed in FY13.

What Are We Learning?

- What do the CBOs and quality improvement teams do to facilitate the ability to implement these standard and best practices? They documented improvement changes of the pilot by using empirical data and run charts; they collaborated with other line ministries, e.g., Education and Agriculture; and they conducted bi-weekly community quality improvement review meetings.
- Does implementing the standards improve the quality of programs for vulnerable children? Yes, it increases community ownership and participation, it leverages additional resources from the community for vulnerable children, it increases monitoring of vulnerable children activities by the state, local government and community, and it orients community quality improvement teams to take independent actions that lead to improvements across the vulnerable children service areas.

Directions for FY14

- Conduct improvement training for 15 members of STEER/SMILE Management
- Identify, form and train members of State/LGA, improvement coaches, and community quality improvement teams in 10 states
- Conduct interface meetings with UGM IPs to share knowledge on what work and what did not work and identify opportunities for improving the work
- Conduct learning sessions
- Develop case studies and success stories
- Conduct meetings with the UGM IPs on spread mechanism
- Develop an spread plan for FY15 and beyond
- Develop improvement training manual
- Develop a step by step guide
- Develop a case study on the piloting process

1.10 South Africa

Background

Since 2000, the QAP and HCI projects have worked in South Africa, initially improving treatment outcomes in key health areas (TB, maternal and peri-natal health), and then focusing on improving quality of HIV and AIDS programs.

In the middle of FY13, HCI project staff started the transition of activities into the USAID ASSIST project in South Africa. As of October 1, 2013, all HCI South Africa activities have transferred to the ASSIST project's portfolio. As a Specialized Provincial PEPFAR Partner for Quality, the ASSIST staff has focused on strategic activities, as improvement initiatives are targeted at provincial and district

levels rather than at the facility and community levels. The scope of practice has also expanded considerably to include health system strengthening (HSS). HSS activities have included the building of Department of Health (DOH) staff capacity and support in the development and implementation of key health policies and guidelines in five provinces: Eastern Cape, KwaZulu Natal, Limpopo, Mpumalanga, and North West.

South Africa Program Overview

What are we trying to accomplish?	How will we know?	At what scale?
1. Build capacity at all levels in strategic planning, supervision, program review, training and mentorship, development of clinical skills, policy development.	<ul style="list-style-type: none"> Number of people trained/mentored Number/frequency of participation in program review meetings Number of policies/plans created 	Geographic focus: 5 out of 9 provinces, (56% of all Primary Health Care (PHC) facilities in 9 provinces) Number / percent districts covered by ASSIST: 30 of 52 (58%)
2. Development and implementation of QI plans and provision of assistance with documentation of QI efforts	<ul style="list-style-type: none"> Number of QI plans developed/implemented Number/frequency of technical assistance provided in documenting QI efforts 	Number of total population covered by ASSIST: 5 million Number of HIV patients covered: 850,000

Key Activities, Accomplishments, and Results

Activity 1: Build capacity at all levels in strategic planning, supervision, program review, training and mentorship, development of clinical skills, policy development

- **Strengthened review and reporting of performance in HCT, PMTCT, and ART**
 - *Eastern Cape:* In the Q4 of FY13, ASSIST staff trained and mentored six District Information Officers in operations research (OR) Tambo District on Tier.net—a web-based system that facilitates ART cohort reporting, data capture and use of new ART registers.
 - *Limpopo:* In Q4 of FY13, ASSIST staff trained 30 individuals (identified as Focal Persons) on HBC in Sekhukhune District.
 - *North West:* In Q4 of FY13, ASSIST staff trained 32 DOH staff on PMTCT QI.
 - *Mpumalanga:* In Q4 of FY13, ASSIST staff trained 29 data collectors (including 12 field workers) on the use of the PHC supervision questionnaire.
- **Strengthened family planning (FP) implementation as a strategy to reduce maternal morbidity and mortality**
 - *KwaZulu Natal:* While the ASSIST portfolio mostly covers activities focusing on HIV/AIDS prevention and care, a deliverable on increasing FP implementation has been undertaken in HCI and continued through the ASSIST. In order to understand FP attitudes, belief and practices in KwaZulu Natal, a rapid assessment was conducted in Uthungulu. The report found that 64% (254 out of 400) respondents reported that they have visited a health facility in the last three months for FP. Only 12% (four out of 33) in the age group 14 – 18 visited a health facility for FP. The age group 19 – 25 utilized FP services the most with 71% (99 of 140) reported to have visited a health facility for FP in the last 3 months. Recommendations in the report included that improvement was needed in accessibility of service, improved health care worker attitudes and performance and availability of different methods and provision of more information on FP methods to reduce fear of side effects. The ASSIST team has continued the work of HCI in this area consistent with the recommendations from Uthungulu. In Q3 of FY13, 10 health care workers were trained on inter-uterine contraceptive device (IUCD) insertion. Seventeen facilities introduced new IUCD clinical guidelines along with a tracking tool for monitoring IUCD training and insertions. In the fourth quarter of FY13, staff motivated 729 clients on the importance of FP and use of IUCD during clinic visits and youth gathering events. Insertion of 451 new IUCD insertions was done by DOH staff, who were trained by ASSIST staff. Health care workers were trained (163) on the National Fertility and FP Guidelines, including 19 Team Leaders.

Improvement Strategy

Baseline assessment, QA/QI training, data training, use of improvement methodology, community mobilization through presentations at “Sukuma Sakhe” ward meetings.

Spread Strategy

Presentation of findings within different fora, including national and international conferences, advocacy for FP work within different districts in KwaZulu Natal province and different provinces in South Africa.

Activity 2: Development and implementation of QI plans and provision of assistance with documentation of QI efforts

- **Capacity built in National Core Standards for Health Establishments (NCS) QI** – this is now a national program implemented by all 52 districts in all nine provinces. Developed protocol to assess NCS compliance and impact nationwide.
- **Provided inputs to the National DOH on competencies required for clinic supervisors and facility managers for the purpose of policy development.**
 - All district hospitals have: QI plans and infection prevention and control (IPC) plans; maternal and neonatal mortality meetings, monitor out-patient department waiting time quarterly and perform Patient Satisfaction Survey annually.
- **Provided support to National PMTCT program with training of Provincial and District staff on QI methodology and application of technology in: MP, Limpopo and North West.**
- **Provided feedback to National OSC on progress and challenges in provinces on implementation of NCS.**
- **Provided technical assistance with development of Provincial and District QA/QI Operational plans for 2013-2014, as well as QI implementation plans (Limpopo and Mpumalanga provinces).**
- **Participated in a client satisfaction survey and in the NCS assessments conducted in key facilities in Mpumalanga province.** Reports to be shared in the next quarter.
- **Developed plan for evaluation of primary health clinic in Mpumalanga.**

Improvement Strategy

Baseline assessment, QA/QI training, use of improvement methodology, development and revision of national core standards, assessment of standards, ongoing implementation.

Spread Strategy

Presentation of assessment findings within different fora, including national and international conferences, advocacy for NCS work within different provinces in South Africa.

What are we learning?

- Involvement of communities is essential to improve access and uptake of services.
- Participation between DOH and all development partners ensure efficiency and effectiveness of improvement strategies. A fine balance should be sustained between building capacity and doing work for a province as responsibility is easily shifted to partners. This results in less commitment from government and little or no transfer of skills from partners to government staff.
- Targeting and involvement of National and Provincial management is essential for sustainability and institutionalization (also important for National scale-up of interventions).
- Continuous capacity building and mentorship for QA results in sustainability and institutionalization – NCS, National PMTCT QA program.

Directions for FY14

- Focus on programmatic evaluations, assessment and operational research in consultation with provinces.
- Develop, implement and link the KM strategy with project activities.
- Develop PHC Clinic Supervision Policy and Capacity development framework for PHC supervisors and Facility Managers.

1.11 Swaziland

Background

Tuberculosis (TB) is one of the major public health problems currently confronting the Kingdom of Swaziland. Current MOH statistics show that tuberculosis accounts for about 10% of in-patient morbidity in the country and is responsible for 20% of in-patient deaths. To compound this, an estimated 80% of TB infected patients are co-infected with HIV. The high TB/HIV co-infection rates adversely affect the case detection as well as the treatment outcomes.

The USAID ASSIST project seeks to use the modern QI approaches to: expand the coverage of integrated TB/HIV diagnostics and treatment services; improve TB treatment outcomes as well as quality of TB, TB/HIV and MDR-TB services in Swaziland; strengthen health systems to better meet the needs of the underserved populations especially women and children and the most at risk populations; institutionalize modern QI approaches in the health care system in order to improve efficiency and reduce costs of poor quality service delivery; and improve health worker capacity, motivation and retention. ASSIST builds on the accomplishments of HCI, which made significant progress in increasing TB treatment enrolment and treatment success (through support for decentralization of TB services to PHC clinics and expanding linkages between communities and facilities, and providing technical expertise, assistance and financial resources to strengthen the integration and decentralization of TB, TB/HIV, and MDR-TB services. HCI also increased quality of adult and paediatric HIV and AIDS treatment/ARV services for TB patients by introducing ART in TB clinics and worked to improve programmatic and clinical MDR-TB case management, established and scaled up community-based MDR-TB model of care in Manzini and Hhohho regions in order to increase coverage and reduce costs of MDR-TB care.

In FY13, ASSIST worked with the MOH through the National Tuberculosis Control Program (NTCP), the Swaziland National AIDS Program (SNAP) and the Swaziland Health Laboratory Service (SHLS) to: apply lessons learned from established HIV/AIDS and TB QI activities; adapt integrated service delivery models and algorithms for health facilities and providers in Swaziland; foster improvements in a range of health care processes through the application of modern improvement methods by host country providers and managers; improve treatment outcomes as well as expand coverage and quality of TB, TB/HIV and MDR-TB services; and strengthen health systems to better meet the needs of underserved populations, especially women and most at risk populations.

Program Overview

What are we trying to accomplish?	How will we know?	At what scale?
1. Support MOH and implementing partners to institutionalize modern QI approaches	<ul style="list-style-type: none"> • National QA/QI strategic plan and standards available • Number and % of health facilities with functional QI teams • Number and % of health care workers trained on QI and quality management 	National, Regional, and Facility
2. Contribute to HSS through building capacity of model TB/HIV Clinics and 2 Centers of Excellence for TB care and treatment	<ul style="list-style-type: none"> • Number of facilities receiving at least 80% of the planned joint clinical mentoring and support supervision visits • Number of facilities with standards of care and algorithms for referrals and linkages in place 	2 regions out of 4 3 primary health facilities 5 hospitals 12 out of 20 facilities in sub-region
3. Strengthen TB DOTS: Pursue High quality DOTS Expansion including MDR-TB	<ul style="list-style-type: none"> • Case finding for TB • TB Treatment success rate • Case Detection and enrollment on MDR-TB treatment regimen • Six months treatment interim outcomes for MDR-TB • Treatment success rate for MDR-TB 	National: support provided to the MOH-NTCP Regional: 2 regions out of 4

What are we trying to accomplish?	How will we know?	At what scale?
4. Strengthen MOH capacity and its partners to implement infection control	<ul style="list-style-type: none"> • # of facilities implementing the National Standards for infection control practice. • # of facilities with IPC plans • # of HCW contracting TB 	National: support provided to the MoH-NTCP Regional: 3 regions out of 4 Facility: 34 facilities
5. Implement integrated TB/HIV prevention, care and treatment activities	<ul style="list-style-type: none"> • Proportion of HIV positive patients who have been screened for TB disaggregated by sex and age • Proportion of TB/HIV co-infected patients receiving co-trimoxazole (CPT) • Proportion of TB/HIV co-infected patients receiving ART 	National Regional Facility
6. Enable and promote research to improve paediatric TB diagnosis		160 doctors 6300 nurses and midwives

Key Activities, Accomplishments, and Results

Activity 1. Support MOH and IPs to institutionalize modern QI approaches

- **Developed QI/QA strategic documents:** In FY13, ASSIST participated in the national QA/QI Technical Working Group. In collaboration with the national QA stakeholders, ASSIST participated in the development of the following QA strategic documents: National HIV QA/QI work plan, National QA/QI training manual, Customer Care Training Manual and assisted the Nazarene health institution to develop the incident management manual. In addition, the project assisted in the dissemination of the national QA/QI strategic plan and QA standards documents for health facilities have been developed and printed.
- **Provided capacity building of the national QA program:** The project provided technical assistance to MOH public health programs to plan, lead and manage the roll out of QA/QI interventions. Through advocacy and lobbying, the MOH directorate elected the deputy director for health services to oversee the QI/QA office. This appointment will provide guidance and oversight for the implementation of QA/QI from national down to facility level and engagement of Regional Health Management Teams (RHMTs) and regional QI specialists. One hundred and five (105) Members of the RHMTs from Manzini (28), Hhohho (34), Lubombo (17) and Shiselweni (26) were oriented on the Hospital and Health Center Standards.
- **Built the capacity of health care workers and mentors:** Through collaborative learning sessions with facility-based QI teams and MOH officials, facility-level coaching, and clinical mentorship, the project supported efforts at all levels to improve the effectiveness, safety, accessibility, equity of health service delivery, and foster a patient-centered approach through the use of QI approaches.

Improvement Strategy

In order to institutionalize improvement approaches, activities were conducted to improve capacity of the national QA program and other MOH public health programs, build the capacity of health care workers and mentors at all levels and improve performance measurement, documentation and use of data for improvement at national, regional and health facility.

Spread Strategy

ASSIST helped stakeholders and facilities to incorporate QA/QI activities into their work plans and budgets allocated to these activities.

- **Improved performance measurement, documentation and use of data for improvement at national, regional and health facility:** Improvements were noted in the clinical service provision at several facilities implementing QI projects. Four of the TB/HIV comprehensive centers of care

showed a remarkable increase in ART uptake – from 70% to 88% from baseline (September 2012) to September 2013 at the Raleigh Fitkin Memorial hospital (see Figure 8); and from 62% to 81% in four supported TB/HIV comprehensive care centers (see Figure 9).

Figure 8: Manzini, Swaziland: ART uptake in Raleigh Fitkin Memorial hospital (Sept 2012-2013)

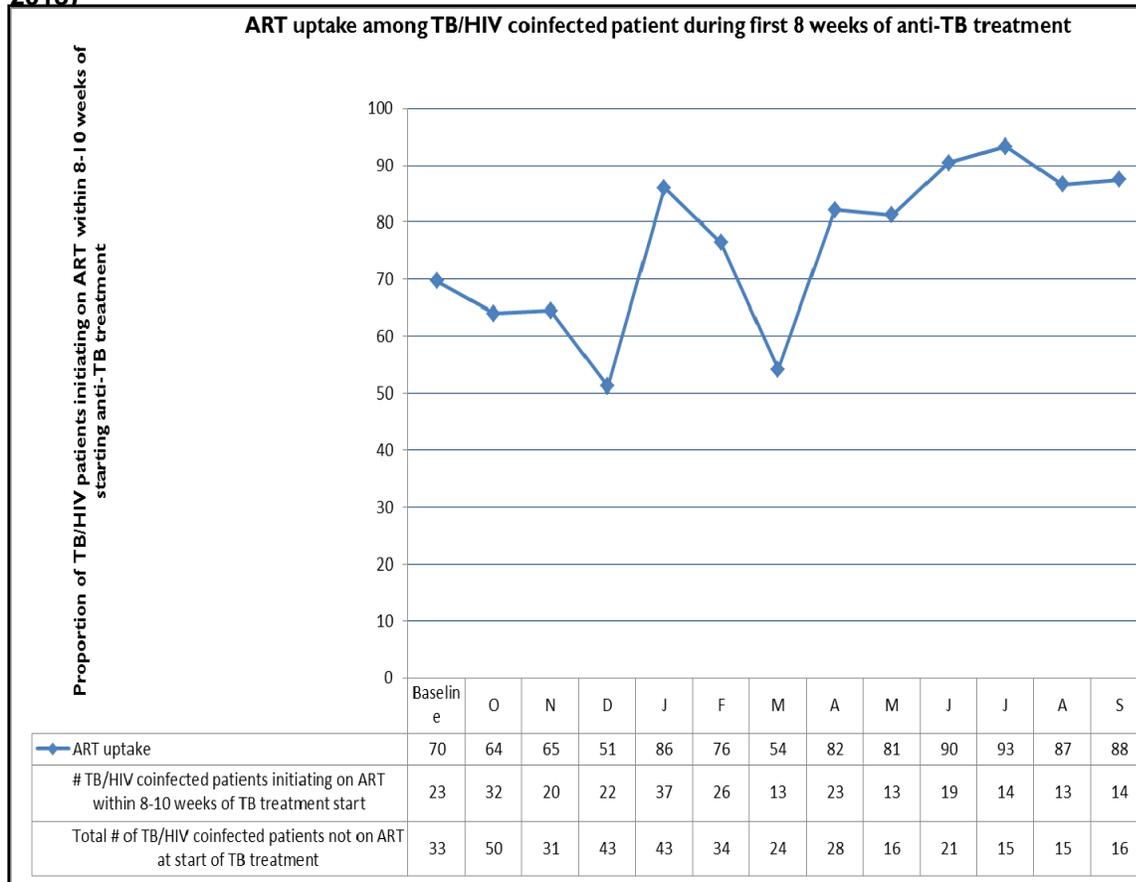
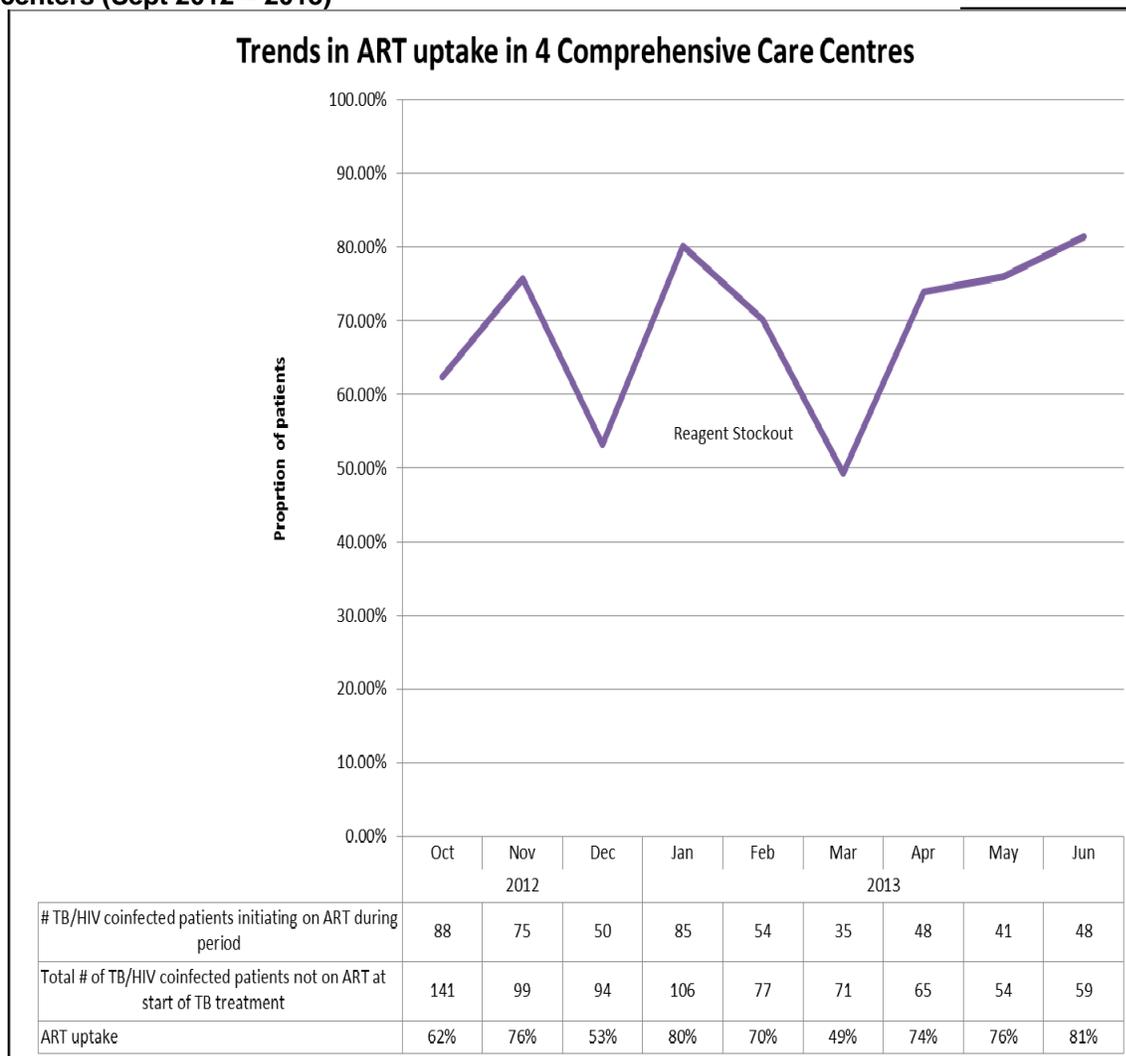


Figure 9: Swaziland: ART uptake in four TB/HIV comprehensive care centers (Sept 2012 – 2013)



Activity 2. Contribute to HSS through building capacity of demonstration sites: three model PHC Clinics, five Comprehensive TB/HIV care Clinics and two centers of excellence for TB care and treatment in Hhohho and Manzini regions

Increase universal access and availability of comprehensive, quality TB/HIV, MDR-TB, infection control at regional and PHC clinics in line with the Swaziland Essential Health Care Package.

Model clinics:

- **Introduced model clinics and comprehensive quality TB/HIV, MDR-TB, and infection control services in line with Swaziland Essential Health Care Package:** Model clinics are primary health clinics that were supported by the ASSIST project to implement the entire continuum of HIV/TB care (with the eventual goal of implementing the Essential Health Care Package) through: Process and practice improvements; minor infrastructural renovations; M&E and documentation of the processes. The model clinics include Ngowane, Horo and Ezulwini satellite primary health clinics.
 - In the second quarter of FY13, patient appointment and follow up registers were introduced to six TB facilities. In the third quarter of FY13, the concept of model clinics was introduced to the RHMT. An assessment was done to determine the current services offered and the infrastructural needs of the chosen model clinics. In the fourth quarter of FY13, work plans

were developed in all model clinics. Work plans included the integration of TB, TB/HIV, MDR-TB, IPC and QI activities in the clinics' service delivery package. The service delivery at the clinics will be implemented to the level recommended by the Essential Health care package.

Comprehensive TB/HIV Care Clinics:

- **Five TB clinics at hospitals and centres (Mbabane Government, Raleigh Fitkin Memorial, Pigg's Peak, Emkhuzweni and Dvokolwako) provide comprehensive and integrated TB/HIV care and treatment.** QI team journals and databases are being used to track interventions like Directly Observed Therapy (DOTS) supervision, early ART initiation (see Figures 8 and 9 above).

Centers of Excellence:

- **Supported the creation of centers of excellence for TB, TB/HIV and MDR-TB to support communities of practice for TB/HIV and MDR-TB management.** A center of excellence is a health facility that provides leadership, best practices, research, support and/or training for TB and MDR-TB management. Two health facilities have been targeted as centers of excellence: National TB Hospital and TB Centre. In second quarter of FY13, facility staff (63 nurses and five doctors) were provided with technical support to develop standard operating procedures for service delivery, TB drug management, TB data management, outreach visits and contact tracing in the community. As part of the QI projects for the center of excellence, an audiology department was established to monitor adverse ototoxicity among MDR-TB patients. The Audiology department is fully functional with standard operating procedures (SOPs) in place for referral of patients and their follow up. Pamphlets and brochures were developed to provide information for both patients and health care workers and how they can access the services.
- **Enhanced the institutional capacity of RHMT to ensure efficient performance of service delivery at the region.** In Q4 ASSIST conducted 18 joint clinical mentoring visits to 15 facilities in the Hhohho region. The joint clinical mentoring visits were conducted in conjunction with the regional health management team clinical mentors and other implementing partners. ASSIST provided logistics and transportation to facilitate the mentoring visits. Training needs were identified during the mentoring sessions and five onsite trainings were conducted on TB screening, clinical management of TB and TB/HIV collaborative activities. Informational material was developed to promote service delivery.
- **Strengthened TB/HIV, MDR-TB referral systems and bridge the continuum of care between community and primary, secondary and tertiary level care:** Strengthened ongoing collaboration with the Luke Commission, a community based organization. The Luke Commission facilitates TB screening and linkage to TB care and treatment services. Referral tools from the community to the facilities have been provided for their use.
- **Strengthened KM, M&E and Research at the supported facilities** With the support of ASSIST seconded health information officers, the Hhohho region conducted the regional semi-annual review of performance (RESAR) for TB, HIV and MNCH. The health information officers assisted with the data collection and verification and development of the various data presentations from the facilities participating in the RESAR.

Improvement Strategy

The RHMTs and the National Essential Healthcare package coordinator have been involved and have taken ownership for these activities.

Spread Strategy

Through ASSIST advocacy, the regions have included the scale up of the Essential Healthcare package to primary health clinics in the regional work plans and have allocated clinic supervisors to oversee the scale up strategy.

Activity 3. Strengthen TB DOTS: Pursue High Quality DOTS Expansion for TB & MDR-TB

- **Scaled up TB and MDR-TB case finding in health facilities:**
 - Over the period, a total of 7,050 patients were registered for TB care and treatment. Pediatric cases accounted for 668 (9.4%). Sputum Smear positive cases accounted for 3057 (44%) while Extra Pulmonary TB cases accounted for 15% (996).

- The TB treatment success rates noted over the period has improved in the general TB population from 72% to 77% (see Figure 10 below) and in the TB/HIV population from 72% to 74%. The default rates in the general population and in the TB/HIV population is at 6%. The failure rates in the general population are 5% compared to 6% in the TB/HIV population.
- Over the reporting period, the MDR-TB suspects screened by culture and drug susceptibility testing were 3,884 of which a total of 184 were diagnosed with MDR-TB. Of those diagnosed, 126 (69%) were enrolled for treatment. Patients who are not yet initiated on treatment are traced using the adherence officers and during the mapping process once the results are available to improve treatment enrollment.
- Provided resources to support the printing of the national TB and MDR-TB treatment guidelines. Job aids have been developed and printed for the health care workers to ensure rapid reference to the new guidelines.
- Through ongoing support for cough monitors/officers and the printing of the revised TB screening tool, the national TB screening efforts continue to improve. The TB screening occurs at all entry points in the health facilities but is not disaggregated by HIV status.

Figure 10: Swaziland: National TB treatment success rates (Q1 FY8-Q4 FY13)

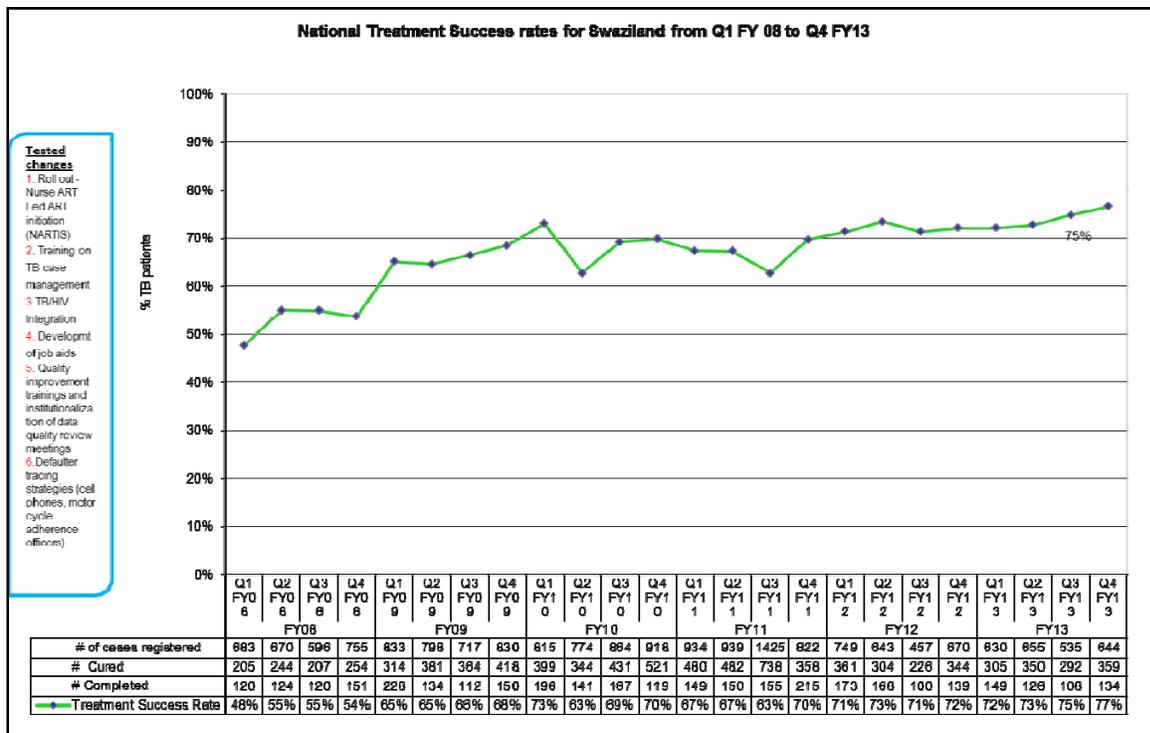
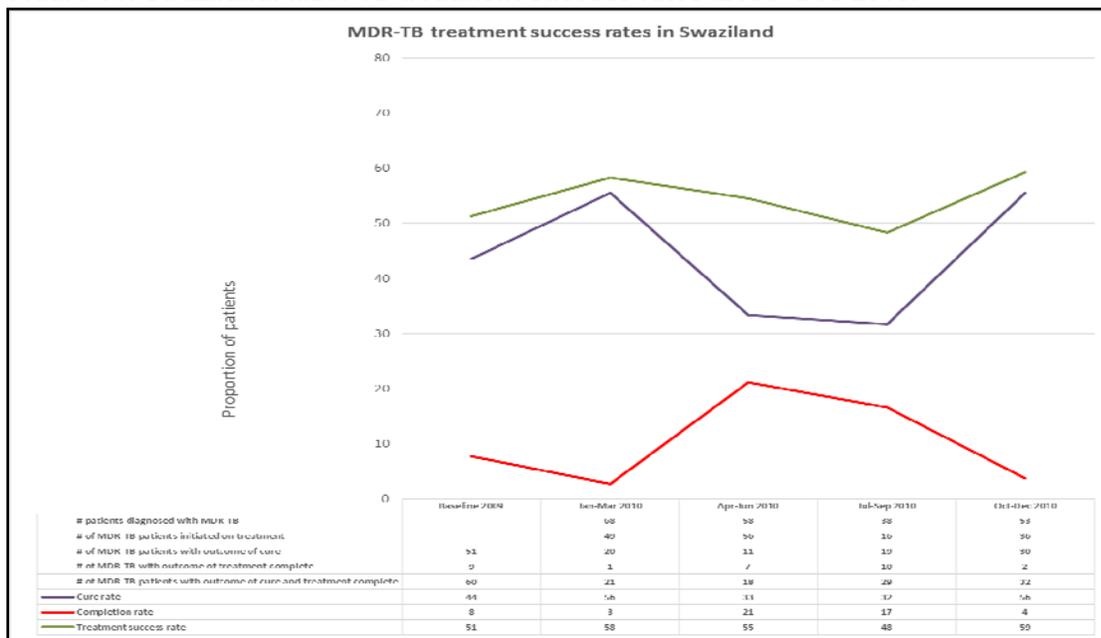
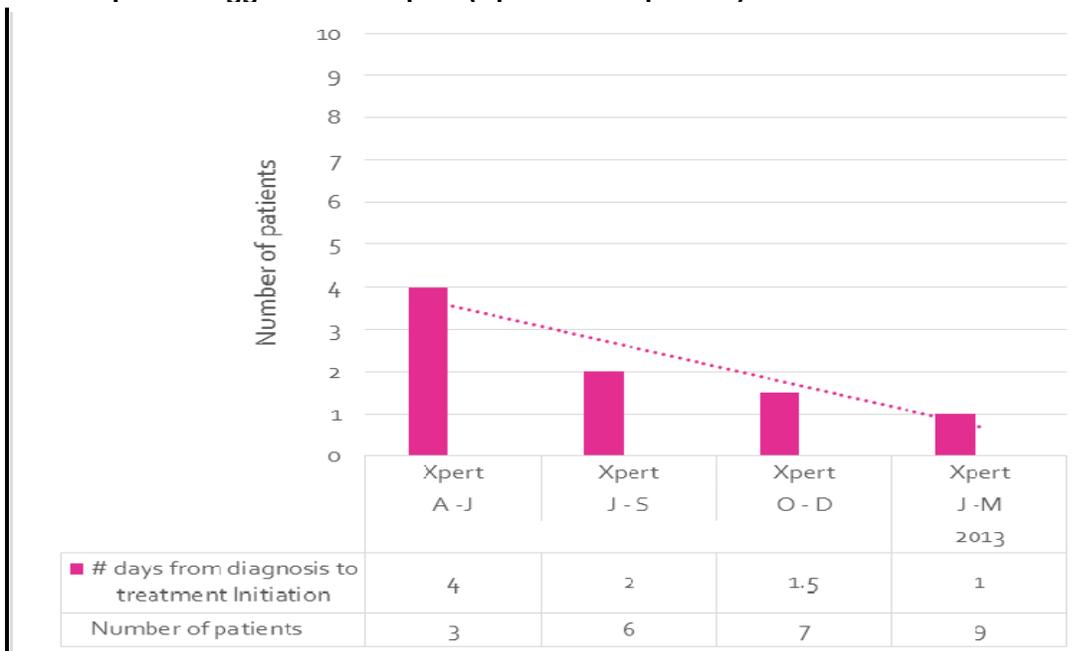


Figure 11: Swaziland: MDR-TB treatment success rates (2009- Dec 2010)



- In collaboration with the Swaziland Health Laboratory service supported the introduction of rapid diagnostics like the GeneXpert MTB and Line Probe Assay.** As of the fourth quarter in FY13, 22 GeneXpert machines have been installed in country—all facilities have access to them either onsite or by sputum referral. The turnaround times have been reduced and now patients receive the results of their sputum much faster. Job aids have been developed for facilities to increase utility of the GeneXpert. Figure 12 below shows the reduction in turnaround times from TB diagnosis to treatment initiation since the introduction of the GeneXpert at Pigg's Peak Hospital as of third quarter in FY13.

Figure 12: Swaziland: Trends in time to initiation of MDR-TB treatment using the GeneXpert at Pigg's Peak Hospital (April 2012-Sept 2013)

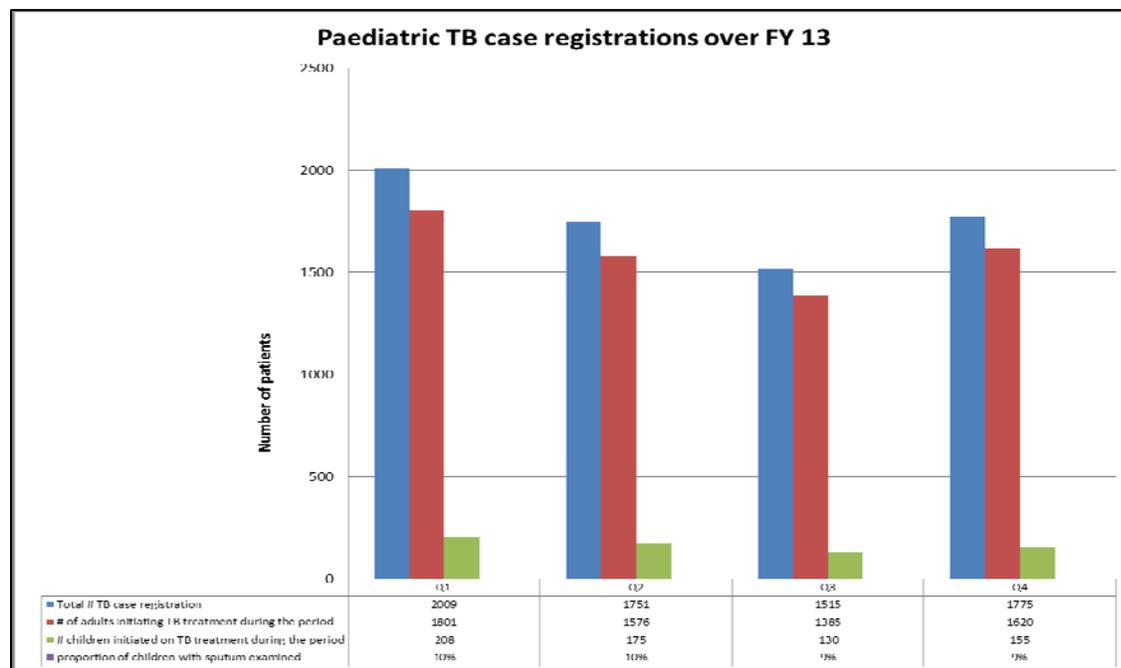


- Worked to improve TB case detection among key groups including vulnerable populations (i.e., children and health care workers).

Paediatric TB:

- Supported the formation of the pediatric TB TWG and provided resources for the first working group meeting to be held. Terms of reference for the TWG members have been circulated. A pediatric TB and MDR-TB situational analysis has been conducted and the data is currently being analyzed. An analysis of availability of pediatric friendly MDR-TB drugs was also conducted and the report shared amongst the TWG members.

Figure 13: Swaziland: Trends in Pediatric TB case registrations (FY13 Q1-Q4)



Prisons:

- TB screening was conducted in eight of the 12 prisons and anti-TB treatment provided at the nearest health facility for those diagnosed with tuberculosis. A TB clinic at Matsapha correctional services is receiving ongoing support and resources to become the main TB referral clinic for all the prisons.

Miners:

- TB screening among the miners was conducted during health awareness days in the mining communities. Ongoing efforts are in place to ensure all mining communities are mapped so that interventions can be put in place to address the high TB rates. Currently a total of 109 miners have been mapped.

Health care workers:

- Supported through technical and financial assistance a pilot project on TB screening, diagnosis and linkage to care for health care workers in 16 health facilities from October 2012 to September 2013. The pilot project is part of a prospective TB surveillance program within the MOH run by the Wellness Center (a local NGO catering to the health of health care workers). Between October 2012 and June 2013, out of 5,992 health care workers in 14 health facilities, 2,984 received TB screening (50%), and 26 were diagnosed with tuberculosis and put on treatment.
- Improved case holding and treatment outcomes for TB and MDR-TB: ASSIST supported the National TB control Program to adapt and implement the community TB DOTS strategy. The

community treatment supporter DOTS card was revised, printed and distributed to all TB diagnostic sites. All hospitals and health centre adherence officers are supported with cell phones and airtime to provide facility based patient follow-up. These officers are equipped with motor-bikes and in the event that a patient fails to return to the clinic after the phone call, the adherence officer will do a home follow-up. This has helped reduce the defaulter rates in the hospital and health center TB clinics. ASSIST has continued to support mapping of the DR-TB patients. ASSIST provided technical assistance and trained 18 TB adherence officers on how to conduct mapping of MDR-TB patients and TB treatment supporters using GIS equipment (the 4 GPS receivers procured by HCI and 10 GPS receivers procured through the World Health Organization) for use during the mapping exercises.

- **Supported community MDR-TB:** To improve retention on treatment, community MDR-TB care is provided with the support of the community based care office at the National TB hospital. The project supports the community MDR-TB care at both Pigg's Peak hospital and the National TB hospital.

Improvement Strategy

Conducting clinical mentoring and supportive supervision with the National TB control program regional TB coordinators and co-facilitating at regional TB clinical management trainings has improved the provision of support to the facilities and also ensures that the TB control program has ownership of the process.

Spread Strategy

Conducting regional collaborative quarterly review meetings and sharing of best practices between the facilities has ensured that TB diagnostic clinics are implementing QI plans using their own initiative.

- **Conducted advocacy, communication and social mobilization activities:**

- **Community Engagement:** Following a four day workshop on TB held for community leaders in Hhohho region, community sensitization meetings on TB have been conducted in seven communities, aimed at empowering community leaders on TB, TB/HIV and MDR-TB and their role in TB community care and assisting TB patients in their catchment areas.
- **Health Education:** TB health education was conducted at one pre-school for 15 children and one primary school for 840 children. Children friendly information, education and counselling materials were also disseminated on TB disease/facts with an emphasis on identification of symptoms and preventive measures.
- **Supported community based TB screening:** ASSIST, in collaboration with The Luke Commission (an NGO providing health services at community level through an outreach program), has integrated TB screening into their community health care delivery operations by providing TB screening in communities they serve. During the reporting period ASSIST trained 16 Cough Monitors on Susceptible TB, TB/HIV Co infection, and DR TB. ASSIST facilitated the Luke Commission to provide referrals for TB treatment at health facilities. Referral tools from the community to the facilities have been provided for their use. As a result, dramatic increases have been seen between 2010 and 2013 in the numbers of patients treated for TB (from 19,553 to 116,680), screened for TB (from 4,567 to 23,229), and tracked for TB-HIV referrals (from 892 to 4,187).

Improvement Strategy

Conducting clinical mentoring and supportive supervision with the National TB control program regional TB coordinators and co-facilitating at regional TB clinical management trainings has improved the provision of support to the facilities and also ensures that the TB control program has ownership of the process.

Spread Strategy

Conducting regional collaborative quarterly review meetings and sharing of best practices between the facilities has ensured that TB diagnostic clinics are implementing QI plans using their own initiative.

Activity 4. Strengthen MOH capacity and partners to implement infection control

- **Provided support to IPC TWG:** ASSIST provided support for the IPC TWG to conduct their quarterly meetings. The IPC TWG completed the development of annual work plans. The project provided technical assistance and resources for a three day workshop to review, adapt and finalize the national IPC curriculum and training manual; the documents will be used to standardize IPC training and implementation at all levels. Using the new curriculum, 32 HCWs have been trained.
- **Conducted TB infection control risk assessments:** Eight TB infection control facility assessments were conducted; gaps that were identified are being addressed. Thirteen health facility IPC focal points were trained and supported. IPC committees were re-established in two facilities (TB hospital and Piggs Peak hospital). IPC plans have been developed for two facilities (Good Shepherd Hospital and Raleigh Fitkin Memorial Hospital) The FAST (Finding cases quickly, Active case finding, Separating Safely and effective Treatment) strategy which aims to reduce TB transmission in facilities has been adapted and supported in three facilities (TB center, Pigg's Peak Hospital and Raleigh Fitkin Memorial Hospital). IEC materials and job aids were developed and disseminated to health care workers in these facilities.
- **Developed Infection Prevention Control (IPC) curriculum and training:** In the second quarter of FY13, the ASSIST team held a three-day workshop to review and adapt the national IPC curriculum and training manual for standardization of IPC training and implementation at all levels. In the fourth quarter of FY13, the ASSIST team supported the completion of the IPC training manual for HCWs. Job aids were also developed for this purpose.
- **Strengthened infection prevention and control practices in model clinics in areas of high risk for TB transmission:**
 - Conducted N95 Respirator fit testing exercise at the National TB hospital; 85 health care workers participated in this exercise. The exercise helped to establish the proportions of mask sizes needed. These proportions are being used to inform the procurement of the N95 masks.
 - TB risk assessments were conducted in two facilities (Horo Clinic and Maloma Colliery Clinic) and the gaps identified were: lack of IPC structure/protocols, poor triage of TB patients and suspects and compromised ventilation.
 - Follow up mentoring on developing a TB infection control plan to address gaps identified during the TB risk assessments.

Improvement Strategy

Working in collaboration with MOH counterparts and NGOs ensures there is skills transfer and improved coordination for the activities ensuring sustainability and ownership by the MOH.

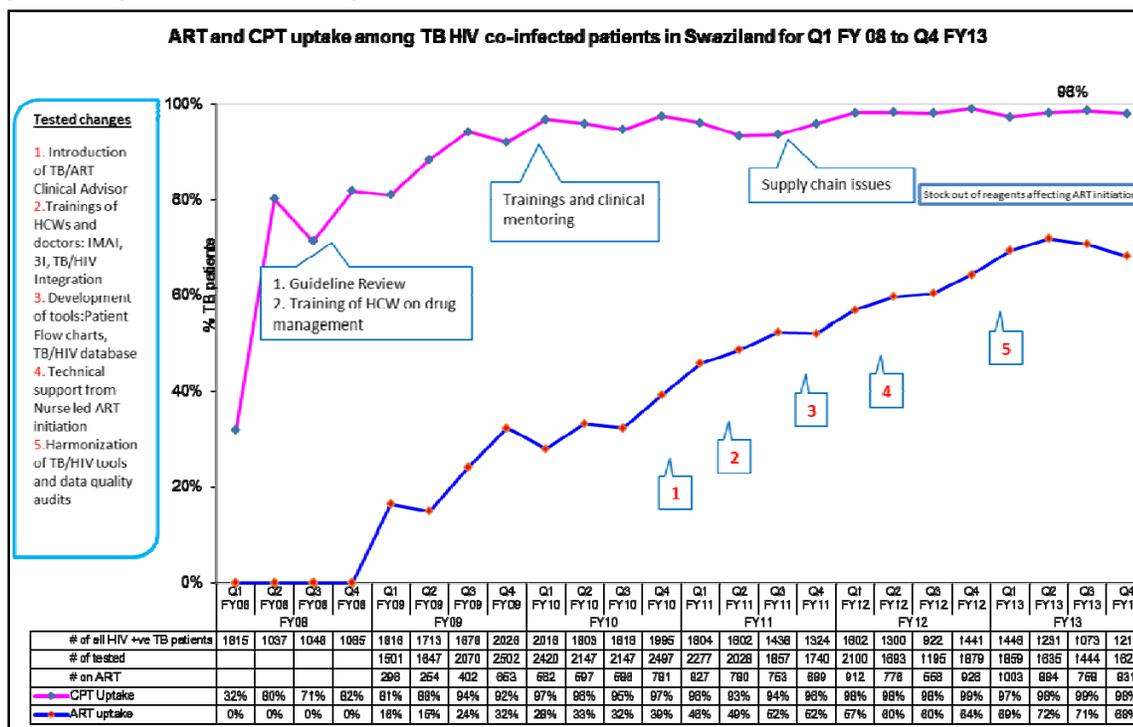
Spread Strategy

The project advocated for the development of a national Infection control work plan and regions were supported to include infection control activities in their work plans to ensure that facilities are implementing infection control.

Activity 5. TB/HIV Integration: coordination, decrease burden of TB in HIV patients, decrease burden of HIV in TB patients

- **Supported the MOH TB and AIDS programs to coordinate and oversee implementation of the TB/HIV collaborative activities:** Supported the National TB/HIV coordinating committee (TB/HIV NCC) to hold the quarterly working group meeting. The main focus of the meeting was to deliberate on integration of TB/HIV activities in facilities and the implementation of Isoniazid Preventive Therapy.
- **Conducted clinical mentoring and supportive supervision to TB/HIV clinics** to increase HTC and CPT uptake among adult and pediatric populations in TB clinical settings;
 - The project supported HIV testing in TB clinical setting. A total of 7,050 TB cases of which 4,969 (70.4%) were HIV positive patients were recorded in the reporting period, 4,866 (98%) were initiated on CPT (See Figure 14 below). There has been a proportionate decline in the number of TB/HIV co-infected cases. Facilities received clinical mentorship and supportive supervision to ensure that all TB/HIV co-infected patients received CPT.

Figure 14: Swaziland: National Trends in ART and CPT uptake among TB/HIV co-infected patients (FY08 Q1- FY13 Q4)



- **There has been a steady increase in the ART uptake among TB/HIV clinics. Over the reporting period, 3,476 (70%) of TB/HIV co-infected patients received ART (see Figure 14), of these, 2,236 were previously on ART while 1,240 TB/HIV co-infected patients started on ART during the reporting period. However at the end of Q4 FY13, the ART uptake declined to 68% due to recurrent shortages of creatinine reagents that affect the ART initiation especially in sites that have a NARTIS trained nurse with no doctor support. However at supported sites, the health care workers were encouraged to initiate ART despite the absence of creatinine reagent as this is not a prohibiting factor to initiate a tenofovir based regimen. A review of the data in five Comprehensive TB/HIV Care Centers showed that within the first eight weeks of anti-tuberculosis treatment initiation, 81% of those who were not on ART had been initiated on ART.**
 - TB screening is being conducted in HIV clinics as well as the outpatient departments and inpatient wards. The data from the ART clinics shows that in the reporting period, 51,703 of 81,000 registered patients were screened at least once during the reporting period.
- **Isoniazid preventive therapy (IPT) has been rolled out to seven hospitals (Pigg’s Peak, Mbabane Government, Raleigh Fitkin Memorial, Good Shepherd, Hlatikhulu, Mankayane and National Psychiatric Hospital); five health centres (Dvokolwako, Emkhuzweni, Sithobela, Nhlanguano and Matsanjani); 23 primary health clinics in Shiselweni region and two NGOs (AHF Lamvelase and Cabrini Ministries). All of these facilities have received formal offsite training and follow up onsite training.**
 - In the reporting period, 659 eligible HIV positive patients were initiated on IPT. During the same period, 165 patients completed their IPT regimen. However, the initiation of patients on IPT has been interrupted due to irregular supplies of isoniazid and weak data collecting systems.
 - To address these challenges, the implementation framework has been developed and will be shared with stakeholders. The HIV and TB recording and reporting tools have been revised to capture IPT data at the facility level.
 - An “IPT indaba” was held, all stakeholders were invited to deliberate on way forward as well as get buy in from the stakeholders. Since the Indaba, the HIV and TB recording and

reporting tools have been revised to capture IPT data at the facility level, IEC materials are being developed.

- **Worked to increase ART uptake among the TB/HIV co-infected adults and children in accordance with the National treatment guidelines.**
 - **National:** All ASSIST supported facilities received clinical mentoring and support for their QI plans to ensure all TB/HIV co-infected patients are initiated on ART. In the five comprehensive centers of care and two centers of excellence, the early ART (within eight weeks) uptake is at 81%. The national ART uptake (early and late) among TB/HIV co-infected patients declined to 68%. The ART uptake was affected by the stock out of reagents for creatinine which is needed at baseline for ART initiation and nurses trained in NARTIS hesitant to initiate without these results.
- **To improve implementation of the three I's in HIV care settings and for vulnerable populations at risk (miners, diabetics, incarcerated) initiated the discussion on implementation of IPT in the country.** The implementation framework has been developed and will be shared with stakeholders. The HIV recording and reporting tools have been revised to capture IPT data at the facility level. An onsite training for IPT was conducted at the National Psychiatric Hospital for 35 health care workers. A total of 30 health facilities are providing IPT, however the data reporting has been a challenge as the current tools in the TB or HIV clinics did not accommodate IPT data collection.

Improvement Strategy

In conjunction with the National AIDS Program, ASSIST developed the IPT implementation plan and started the revision of the policy on TB/HIV collaborative activities. The National AIDS program and the National TB control program are providing oversight for the implementation of the TB/HIV collaborative activities and this ensures sustainability and ownership for the improvement strategy.

Spread Strategy

ASSIST provided technical assistance to the TB/HIV NCC to develop the decentralization plan for integration of TB/HIV activities as well as provide assistance in monitoring the decentralization plan. The implementation of the decentralization plan ensures that the facilities systematically strengthened to provide integrated TB/HIV services.

Activity 6. Enable and promote research to improve pediatric TB diagnosis

- **Conducted priority operational research studies for TB including MDR-TB, TB/HIV**
 - A protocol on improving pediatric TB diagnosis using various sputum retrieval methods and diagnostics has been developed. Institutional Review Board (IRB) approval has been obtained and the study is being piloted in one facility prior to full implementation.
 - A pediatric TB and MDR-TB situational analysis has been conducted. The data has been collected and is currently being analyzed. A total of 16 facilities participated in the situational analysis.

Improvement Strategy

ASSIST supported the MOH in various research-related improvement activities that include development of a Research Strategic Plan and Research Policy for Health and documents will provide guidance on the research objectives of the MOH and supporting and conducting a training for members of the Swaziland Scientific and Ethics Committee. This Support for the MOH research unit and the ethics committee members ensures skills capacity building and will result in enhancing the quality, coverage, effectiveness of the health systems or programs in which research is being conducted.

Spread Strategy

ASSIST project provided support in the training on data analysis and the use of STATA software to analyze data from ongoing operational research projects. Continued support to the MOH through the participation of ASSIST staff on the research TWG ensures that technical support is provided to the MOH research office.

Improvement in Key Indicators

Activity	Indicators	Baseline (September 2012)	Q4 (July – September 2013)
1. Support MOH and IPs to institutionalize modern QI approaches	Number of health facilities participating in collaborative and feedback meetings	40	68
	Number of health care workers trained on QI and quality management	40	65
	Number of health facilities (%) documenting performance of key QI indicators supported by QA program	7	25
2. Contribute to HSS through building capacity of three model Clinics, five demonstration clinics and two centers of excellence for TB care and treatment in Hhohho and Manzini regions.	Number of facilities providing comprehensive TB/HIV care and treatment	69	74
	Proportion of facilities receiving at least 80% of the planned joint clinical mentoring and support supervision visits	NA	15 (38%)
	Number of facilities with standards of care and algorithms for referrals and linkages in place	NA	8
3. Strengthen TB DOTS: Pursue High quality DOTS Expansion including MDR-TB.	TB case finding	2,074	1,873
	MDR-TB case finding	20	37
	MDR-TB treatment enrolment	16/20 (80%)	28/37 (76%)
	Six Month Interim MDR-TB Outcomes	54.2%	68%
	TB treatment success rates	72%	76%

What Are We Learning?

- Onsite trainings are very instrumental in ensuring sustained improved QI projects.
- Attending the facility multi-disciplinary team meetings helps improve the planning for prompt onsite trainings for new nurses in the TB/HIV units.
- Motivated staff can help sustain improvements gained in a unit even when they are moved from the unit.
- Regular facility data reviews and involvement of all clinic staff in the QI plans improves performance of indicators and sustainability of the projects.
- Strengthened relationships with the facility management are crucial in ensuring that during change over not all the nurses are moved from the unit.

Directions for FY14

- Conduct trainings build the capacity of health care workers and mentors (MOH and IP) to health care QI
- In collaboration with MOH and IPs, conduct QI coaching to regional and health faculty teams
- Develop and disseminate QI job aids and IEC materials for health care workers and patients
- Review and adapt TB and non-communicable disease (NCD) collaborative policy guidelines using TB and DM as an entry point
- Equip TB hospitals' management with management and leadership skills and build capacity of the TB hospital tripartite management structure to function efficiently and effectively
- Print and disseminate TB and MDR-TB guidelines and policies

- Conduct clinical mentoring to improve active case finding, IPT and early ART initiation
- Improve the surveillance, documentation, recording and programmatic reporting for X/MDR-TB
- Conduct training on TB/HIV and MDR-TB management
- Plan and facilitate decentralization of MDR-TB initiation sites to increase access and retention in MDR-TB diagnostics and treatment services
- Conduct baseline TB infection control assessments for high volume facilities, development of infection control plans and implementation to minimize TB transmission
- Provide resources and technical assistance to the NTCP to develop, print advocacy, communication and social mobilization strategy
- Conduct community dialogues on TB, TB/HIV and MDR-TB to inform interventions
- Adapt and implement patients' charter for MDR-TB patients

1.12 Tanzania

Background

In 2008, HCI began working in Tanzania supporting the Ministry of Health and Social Welfare (MOHSW), IPs, and RHMTs and council health management teams (CHMT) to scale up PMTCT QI efforts; improve the quality of infant feeding (IF) in the context of PMTCT; and to design and manage a national QI program for ART. In addition, HCI provided support to the Department of Social Welfare (DSW) of the MOHSW serving most vulnerable children (MVC) to improve the quality of MVC services; started an improvement collaborative in the Bagamoyo district to improve the welfare of MVC and caregivers; and supported the MOHSW and IPs to develop Standard Operating Procedures (SOP) for the HBC program.

Starting in October 2012, ASSIST began building on the gains from HCI to support MOHSW and implementing partners to scale up activities to additional regions not covered under HCI.

Program Overview

What are we trying to accomplish?	How will we know?	At what scale?
1. Support MOHSW and PMTCT implementing partners to scale up programs providing women and their families improved access to quality care along the PMTCT cascade	<ul style="list-style-type: none"> • % pregnant women who book ANC at 14th week of pregnancy • % HIV positive pregnant women who receive ARVs • % HIV positive screened for TB at Reproductive and Child Health centers (RCH) • % Non pregnant women accessing FP tested for HIV 	12/26 regions; 73/80 districts of the focus regions and 237 facilities/1830 PMTCT sites in these districts
2. Support MOHSW and HIV Free Survival Partners towards elimination of HIV infection in children and reducing deaths among HIV-infected mothers through nutritional services for mothers, infants, and young children and health system strengthening of the postnatal continuum of PMTCT care	<ul style="list-style-type: none"> • % mother-infant pair retention rate to postnatal care • % of mother-infant pair adherence to package of postnatal care services 	Improvement collaboratives started in 10 sites in one district each for Tabora, Mbeya and Iringa regions
3. Support MOHSW and IPs to scale up sustainable improvements in coverage, retention and outcomes for patients on ART	<ul style="list-style-type: none"> • % eligible PLHIV attending care and treatment centers (CTC) receiving FP methods • %PLHIV (pre ART or ART) diagnosed with TB treated with anti TB drugs • % patients with follow-up CD4 at 	205 Health facilities in 12/26 regions with 400 facilities offering CTC services

What are we trying to accomplish?	How will we know?	At what scale?
	six months <ul style="list-style-type: none"> • % patients alive and on treatment 12 months after ART treatment initiation • % ART patients keeping appointment 	
4. Support MOHSW, MVC IPs and local structures to strengthen Quality of care, support and protection to vulnerable children	<ul style="list-style-type: none"> • # of vulnerable children referred and linked with different community, health and other services 	All 22 wards in Bagamoyo districts have been covered with 125 QITs; Community QI teams established in 11 wards in Kigoma and integration of OVC and HBC in three wards in Muheza.
5. Work with MOHSW and stakeholders to improve the quality of community-level HBC	<ul style="list-style-type: none"> • # of clients accessing a broader range of HBC services as guided by the SOP • # of regions and implementing partners applying SOP 	Home Based Care SOPs piloted in 16 out of 24 wards in Tanga city HBC QI training conducted in 13 out of 26 regions.

Key Activities, Accomplishments, and Results

Activity 1. Support MOHSW and PMTCT implementing partners to scale up programs providing women and their families improved access to HIV prevention, testing, care, treatment and support through QI approaches along the PMTCT cascade

- **Conducted baseline assessments:**
 - *Tabora and Arusha regions:* In the second quarter of FY13, USAID ASSIST conducted a situational analysis in the new regions of Tabora and Arusha in partnership with R/CHMTs and the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF). Planning meetings were conducted with members of the RHMT by introducing them to the activities supported by ASSIST and to QI methodologies. Joint site visits by ASSIST, EGPAF and R/CHMT staff were made to carry out the assessment in seven hospitals, four health centers and three dispensaries in the six districts of Tabora Region and in nine hospitals and six health centers in the Arusha Region. To identify implementation gaps, baseline data was collected from November 2012 to January 2013 for twelve PMTCT and four ART indicators.
 - Most of the sites visited during this assessment did not have QI teams or activities. Some health facilities did not have any data on family planning for HIV positive clients, caretakers receiving DNA Polymerase chain reaction (PCR) results for HIV-exposed infants, and six-month follow-up for CD4 tests. The plan to initiate collaborative improvement activities was implemented jointly with EGPAF so as to streamline QI activities and strengthen services for ART and PMTCT in these regions.
 - *Iringa region:* Using district funds, CHMTs conducted baseline assessment of the quality of care for PMTCT services in their districts covering 65 out of the 66 facilities offering such services in the four districts. Among the service gaps identified were: inadequate documentation, poor access to CTCs, and inadequate CD4 monitoring, inadequate family and community support for PMTCT and various organizational bottlenecks like inadequate supplies and relevant commodities.
- **Conducted stakeholder meeting for scaling up ART/PMTCT QI efforts:**
 - *Iringa region:* USAID ASSIST supported MOHSW, TUNAJALI Deloitte, the ART/ PMTCT IPs, RHMTs and CHMTs to conduct a stakeholders meeting for scaling up ART/PMTCT QI efforts in the region. The meeting brought together 51 representatives from: MOHSW – Tanzania Food and Nutrition Center, NACP PMTCT, IPs, RHMT, CHMTs from the four districts and representatives from the referral regional hospital. Status of QI implementation in the 11

demonstration sites was shared. Gaps reported by participants were: inadequate knowledge on early infant diagnosis and QI content; frequent stock outs of reagents and test kits, inadequacies in patient follow up especially, CD4 follow up, tests and late response to maintenance and repair of the CD4 machine. 66 health facilities (7 hospitals, 21 health centers, 36 dispensaries and two stand alone CTCs) were identified for scale up.

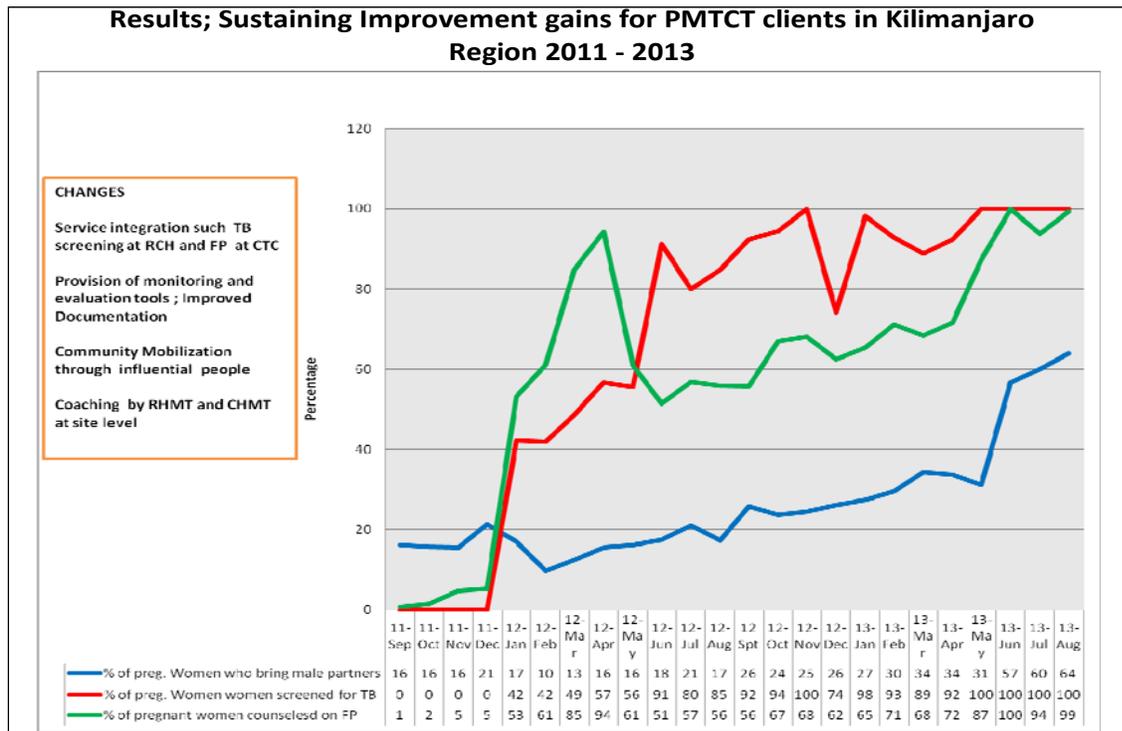
- **Formed QI teams:**

- *Tabora and Arusha:* Following the baseline assessment, learning sessions were held in Tabora, and Arusha; participants were introduced to QI principles, dimensions of quality, clients' rights and providers' needs, steps in QI and application of the QI model to strengthen ART-PMTCT services, and the use of Standard Evaluation System (SES) for documentation of QI work. QI teams were formed at facility, district and regional levels. Teams developed improvement changes, tested them and will share experience during the subsequent learning session for internal spread of best practices.

- **Conducted coaching and mentoring visits:**

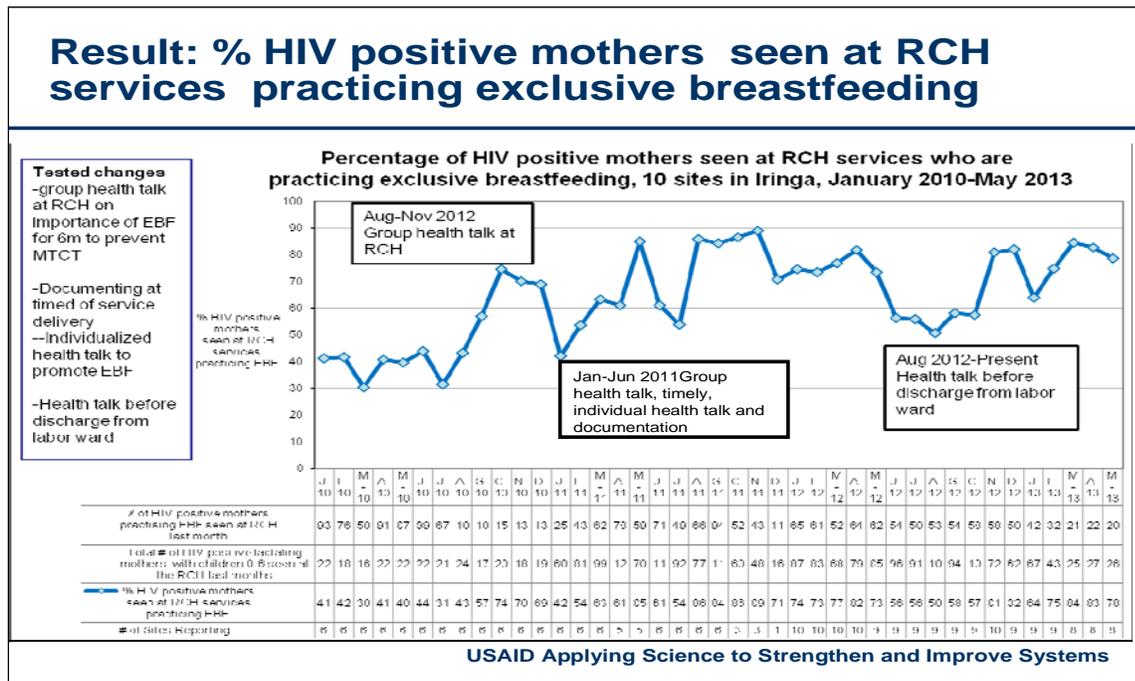
- *Arusha:* ASSIST, in collaboration with EGPAF, RHMT and CHMTs, conducted coaching and mentoring visits to 16 QI sites in the Arusha Region and mentored 89 QI team members. During the coaching visits it was found that in some facilities some of staff trained in improvement had been transferred, therefore intense coaching was conducted to revive the improvement teams and begin testing planned changes.
- *Iringa:* Coaching was conducted for three demonstration sites working with community groups to improve: ANC booking by 14 weeks; exclusive breastfeeding for 6 months; men escorting their female partners; testing for HIV; and follow up for children under age five. A sharing meeting for the six community coaches from these sites was held where coaches reported improved communication between facility and community members when attending the facility. Subsequently, community coaches were supported to lead QI meeting for Community QI teams, where a total of 108 participants attended. Community QI teams agreed to put advocacy posters at worship houses market place and local government offices. Client tracking cards were introduced to facilitate identification and counting of pregnant women and male partners, referred from the community group. A total of 51 service providers from 11 Assuring Infants and Mothers Get All PMTCT Services (AIMGAPS) sites were supported to identify and document tested changes and their outcomes as recorded in their SES. Among the tested changes were: same day enrollment to PMTCT care; on the job training on documentation in PMTCT registers; CD 4 sample collection at RCH; prioritizing HIV + pregnant women for CD4 testing; on the job and peer mentoring on Dried Blood Sample (DBS) collection; daily enrollment of HIV positive pregnant women to CTC irrespective of CTC clinic day; documentation of ANC number in CTC register for easier identification of pregnant women enrolled to CTC; and cross checking of undocumented visits in dispensing registers and mother ANC card and document in PMTCT care register.
- *Kilimanjaro:* ASSIST supported the 14 collaborative sites to integrate PMTCT and RCH in the Kilimanjaro region. Learning sessions were held in 12 out of 13 hospitals in Kilimanjaro implementing PMTCT QI activities. A total of 65 participants attended the training, including doctors, nursing officers, laboratory technicians, pharmacists, nurse midwives and enrolled nurses from RCH, CTC and labor wards. Coaching and mentoring visits were held with 14 QI sites and 79 QI team members. Substantial improvement was achieved (see Figure 15). The proportion of pregnant women booking for ANC by 14 weeks increased from 9% in September 2011 to 35% in May 2013 and the proportion of HIV positive women 15-49 years counselled on FP at CTC rose from 13% in September 2011 to 99% in August 2013. Furthermore, the percentage of pregnant women who were accompanied by their male partners to participate in RCH services increased from 16% in September 2011 to 64% by August 2013. All HIV positive pregnant women are now screened for TB at RCH in all facilities participating in the improvement collaborative. Regional IPs, RHMTs and CHMTs continue to lead the coaching visits.

Figure 15: Kilimanjaro Region, Tanzania: Sustained Improvement of Selected Elements of PMTCT Care (Sept 2011 – Aug 2013)



- **Held learning sessions:**
 - *Iringa region:* ASSIST held an orientation and preparatory meeting with nine R/CHMTs and one Zonal Reproductive and Child health Coordinator to build their skills on conducting the learning session. The learning session was conducted for two out of the four districts that finalized baseline assessment. The first learning session brought together 83 service providers from 37 sites (four hospitals, six health centers, 18 dispensaries and two stand alone CTC sites) Two RHMT and six CHMT members took the lead in facilitating the learning session assisted by four selected QI mentors among service providers. The Zonal Reproductive and Child Health Coordinator also participated to learn more about QI. Baseline assessment results were shared and participants were introduced to QI terminologies, dimensions of quality, principles of quality, steps in QI and the QI model. QI teams were strengthened for the demonstration sites and formed for the 53 new facilities. Participants developed work plans to address performance gaps identified and agree on necessary metrics to monitor progress.

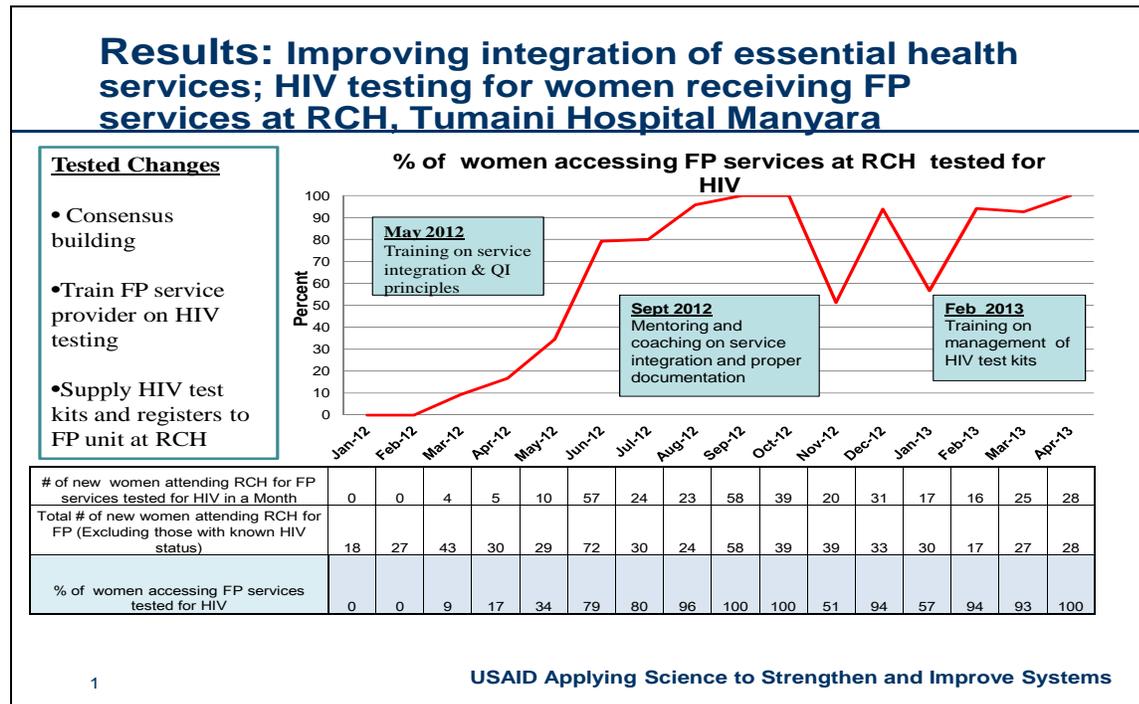
Figure 16: Iringa Region, Tanzania: Percentage of HIV positive mothers seen at RHC services who are practicing exclusive breastfeeding at 10 sites (Jan 2010-May 2013)



- *Manyara*: During FY13, two learning sessions were held in collaboration with CHMTs and RHMTs. Participation of CHMTs and RHMTs improved their coordination and supervisory competencies. Participants were trained on QI principles and improvement models and they shared experience on how to use QI approaches to improve integration of PMTCT and RCH services.
- **Three new components of the minimum package for the PMTCT and RCH integration were introduced; indicators to monitor progress were developed; and improvements were observed.** Improvements were observed in: partner testing for HIV increased from 8% in January 2012 to 18% in December 2012; HIV positive pregnant women at RCH screened for active TB increased from 73% in January 2012 to 100% in December 2012; and PLHIV receiving FP increased from 6% in January 2012 to 100% in April 2013. Changes that resulted into improvement of FP uptake among PLHIV were documented and some health care workers were interviewed in a process to write a success story in this area¹¹. Integration of HIV testing services to women attending FP clinics was seen in Tumaini Hospital, from 0% in January 2012 to 100% in April 2013 (see Figure 17 below).

¹¹ Success Story: Making Family Planning More Convenient to Clients, Improves Service Uptake in Manyara Region, Tanzania. (to be published on URC website)

Figure 17: Tumani Hospital Manyara, Tanzania: Percentage of women accessing FP services at RCHs who are tested for HIV (Jan 2012-April 2013)



- *Morogoro*: ASSIST provided support to CHMT and RHMT in scaling up QI trainings into four districts with coverage of 30 new PMTCT sites. QI teams were formed and members developed facility QI work plans to address priority PMTCT quality gaps such as male partner testing, follow up of exposed children to ensure timely uptake of Cotrimoxazole and receiving DNA PCR results.
- *Mtwara*: 65 health care workers from eight collaborative sites in five districts attended a second learning session on use of QI approaches to improve HR performance. The session was co-facilitated by RHMT and ASSIST. Two program officers from EGPAF also attended this learning session. Participants shared experience on improvement changes that improved HR productivity and ART and PMTCT service outcomes. Participants revised their job description to better align their tasks and roles with program goals. They also identified competency gaps and developed action plan to address them. Teams developed work plans for the next action plan and developed a system to ensure that there is regular performance feedback within team members and their supervisors.
- *Shinyanga*: ASSIST led joint QI coaching and mentoring visits to 10 sites testing changes to

Addressing gender-related issues

In Shinyanga and Morogoro opinion from participants to QI training and coaching was solicited on how to best encourage males to participate in RCH services. From the responses a key strategy developed was to educate men and the community at large about the importance of being involved in RCH services. Proposed interventions included:

- Community social groups and influential leaders provide messages (about the importance of participating in RCH services) to men and communities.
- Service providers at facility levels were identified to provide messages at facility level targeting male and RCH clients on the importance of testing among both males and females.
- These ideas are being implemented in Shinyanga, Morogoro, Arusha, Kilimanjaro and Iringa.

address PMTCT challenges. Through a request from the CHMT and IP, an additional 14 sites were added where ASSIST facilitated QI training to service providers from these health facilities. Priority PMTCT areas were identified and QI teams developed plans to narrow the existing gaps. These areas include enrolment of HIV positive pregnant mothers into CTC and male partner participation in RCH.

Improvement Strategy

In Iringa spread sites, most of the first learning session in the two districts was conducted by CHMTs. In both districts two QI champions were identified as mentors. They attended an orientation session with CHMTs and facilitate some learning sessions. These mentors will be supported by their districts to conduct mentoring for identified new spread sites. This approach will ensure continuous support to site teams as the CHMT who are normally responsible are usually busy attending to other matters.

Spread Strategy

Districts and regional IPs were urged to work on supporting spreading of best practices to other facilities.

Activity 2. To support MOHSW and HIV Free Survival Partners towards elimination of HIV infection in children and reducing deaths among HIV-Infected mothers through nutritional services for mothers, infants and young children and health systems strengthening of the postnatal continuum of PMTCT care

- **Completed national protocol for PHFS:** Worked with IPs to develop national PHFS protocol.
- **Developed M&E framework for project.** Developed the M&E framework of the project and the related QI framework.
- **Conducted baseline assessment in three demonstration districts of PHFS:** Worked with MOHSW, IPs and health workers in Nzega, Mbeya Urban and Mufindi districts to collect baseline data.
- **Conducted learning sessions:** Worked with IPs (Deloitte-Tunajali in Mufindi district of Iringa, EGPAF in Nzega district in Tabora and Baylor in Mbeya Urban district) to provide technical assistance for conducting learning sessions in 30 sites in these districts. During the learning sessions participants were trained on QI principles, dimensions of quality, clients' rights and providers' needs, steps in QI and application of the QI Model to strengthen ART/PMTCT services. Participants were also trained on the use of the QI team journal for documentation of improvement work. Findings from the baseline assessment were presented, areas that needed improvement were discussed and consensus was reached on selection of priority improvement areas. Indicators for monitoring of the priority areas were also selected and agreed upon.
- **Participated in all National and Regional Steering Committee and M&E sub-group meetings and PHFS Webinar calls:** Monthly national progress meetings, multicounty webinars and sharing meetings coordinated the partnership and harmonized implementation. Two meetings were held in Uganda and one in South Africa.

Improvement Strategy

The PHFS strategy is led by the MOHSW and Tanzania Food and Nutrition Centre and incorporates three regional IPs (EGPAF, Baylor and Deloitte Tunajali) and four technical partners (FHI 360/FANTA, Jhpiego and ASSIST). These national partners are working with the district and regional teams (CHMT and RHMT) to support health care workers at the selected health facilities. There are learning platforms planned at the level of the health facilities, districts, and national level and between countries to ensure that lessons learned are shared for improvement.

Spread Strategy

The activity plans to use improvement methods to ensure that health care workers at the level of health facilities have clear objectives for improvement that will be achieved through a change package of interventions and PHFS being led by the MOHSW who are at the same leading the country into adoption of PMTCT Option B+, which will therefore ensure scale-up after the initial period of implementation.

Activity 3. To support MOHSW and IPs to scale up QI activities for ART services to achieve sustainable improvements in patients coverage, retention and clinical outcomes

- **Oriented CHMT, RHMT and health care workers on QI:**
 - *Dodoma region:* ASSIST supported MOHSW, RHMT, CHMT, and IPs in the Dodoma region to initiate QI activities in six district hospitals, three high volume health centers and one referral hospital. A total of 60 health care workers, 48 CHMT and nine RHMT were oriented on improvement model that was used in implementing QI activities in the region to identify performance gaps in ART and PMTCT services. Teams were taught how to analyze systems and redesign process performance to increase client outcomes in CTC and RCH. As the country proceeded to PMTCT Option B+, USAID ASSIST advocated for integration of RCH and CTC in facilities with CTC to eliminate mother to child transmission of HIV to all mothers and children in the region. In addition, USAID ASSIST supported teams to select indicators for baseline data collection and continuous monitoring performance in implementation of QI activities in the region. To improve human performance, ASSIST empowered Dodoma R/CHMTs on QI methods and techniques to support teams during supervision to build competencies in meeting both clients' health care workers expectations. We also supported CHMTs to reform QI teams in all participating health facilities, roles and responsibilities for team members and a focal person were clearly defined.
 - *Tabora:* A one day orientation meeting was conducted to five RHMT and IP (EGPAF) whereby a brief overview of QI methodologies and selection of initial health facilities for QI implementation was done.
- **Conducted baseline assessments:**
 - *Lindi:* CHMT in Lindi's districts have conducted baseline assessment in 14 new sites and have prepared improvement work plans for the priority areas.
 - *Morogoro:* 30 new sites were engaged in improvement activities
 - *Tabora:* All six districts were involved and collection of baseline data was done in 14 sites to ready them for implementation of QI.
 - *Arusha:* ASSIST and EGPAF conducted a baseline assessment of 14 facilities in Arusha. The assessment revealed late ANC booking, low male partner testing for HIV at ANC; low FP uptake among HIV+ women and low rates of treatment for co-infection of TB. Others were HIV exposed infants (HEI) receiving ARV prophylaxis were very few; ART initiation for HIV infected children below two years was low. Improvement work was initiated with 16 improvement teams in six districts across the region. The main technical areas of focus were: improving access, retention and wellbeing for PLHIV
- **Conducted learning sessions:** Supported ART IPs, the RHMTs and CHMTs to conduct the first learning session in Shinyanga, Morogoro and Dodoma regions.
 - *Shinyanga:* 24 health care workers from 14 improvement teams and four staff from regional IPs participated.
 - *Morogoro region:* 30 new sites were reached with involvement of 85 health care workers
 - *Dodoma region:* a learning session with 70 participants was conducted for nine improvement teams providing CTC and RCH services. Team leaders were selected and they developed plans according to priority indicators to monitor Improvement and record performance in the first action period.
 - *Tabora:* A total of 63 Health care providers from 14 health facilities were trained on QI principles and improvement models and QI teams were formed accordingly. Health facilities were provided with QI files for record keeping, including tools such as the SES journal, a framework of writing meeting minutes and a QI training package for reference.
 - *Arusha:* The first learning session was conducted with 56 health care workers from 16 high volume facilities, four RHMTs, 14 CHMTs and seven program officers from EGPAF making a total of 81 participants.
- **Provided support to CHMTs and RHMTs in conducting coaching and mentoring visits:**
 - In *Shinyanga*, six sites out of 10 initial collaborative sites in six districts where QI teams are implementing changes to address ART quality gaps, preliminary results indicate improvement in PLWH who are keeping appointment for CTC services and adherence counseling done to ART patients. Several meetings were conducted by ASSIST coaches in collaboration with

the IP and R/CHMT in efforts to increase availability of ARV and test kits at the site level. This scarcity is a result of distance between sites and transport issues. The regional IP will be taking supplies whenever they go the sites.

- *Morogoro region*: Five sites in two districts. QI teams were assisted in: description of numerators, denominators and identification of source of data for new priority areas, formulation of changes, plotting and annotating change in run charts.
- The USAID ASSIST team, in collaboration with RHMT and IPs in Morogoro region, supported QI teams to develop change ideas for improving comprehensive follow up of HIV exposed children, PCR testing and HTC for male partners at RHC. Teams were also supported to improve their knowledge on numerators, denominators and their data sources for focus indicators. Changes have been tested such as: data auditing to identify lost to follow up clients and conducted physical/phone contact to bring them back to care; family planning for CTC clients focusing on HIV positive women age 15-49 and timely HIV testing among HEI.
- **Supported RHMT, CHMT and health facility staff to analyze processes of ART and PMTCT care** to address health system gaps and linkages such as challenges in managing commodities, data quality, HR and service delivery processes in CTC and RCH in the region Morogoro, Lindi, Tabora and Arusha
- **Supported QI teams to ensure proper reporting**: In Morogoro, Arusha and Dodoma the ASSIST team in collaboration with R/CHMT supported QI teams to ensure proper reporting and request of the PMTCT program commodities using requesting and reporting forms and validating the number of dispensed drugs with total number of PLHIV given drugs during the reporting period. This was in response to data quality assessment that revealed inconsistency on numbers of clients and ART dispensed from some of the facilities. Teams were encouraged to perform interfaculty mapping of LTFU patients and tracking of missed appointment to avert the number of patients with high risk of being lost.
- **Addressed gender gaps**: *Morogoro region*: ASSIST has been following up integration of essential services including inclusion of gender priorities including provision of FP services at the CTC in Morogoro (see Figure 18). The percentage of male partners tested at RCH every month increased from 17% in January 2012 to 75% in September 2013.
- **Improved and sustaining male participation through positive engagement of men in a supporting environment.**
- **Improved male partners' testing for HIV and sustained use of CD4 monitoring** (see Figures 19 and 20).

Figure 18: Ngerenge Health Center, Morogoro Region, Tanzania: Percentage of partners tested for HIV at RCH (Jan 2012-Sept 2013)

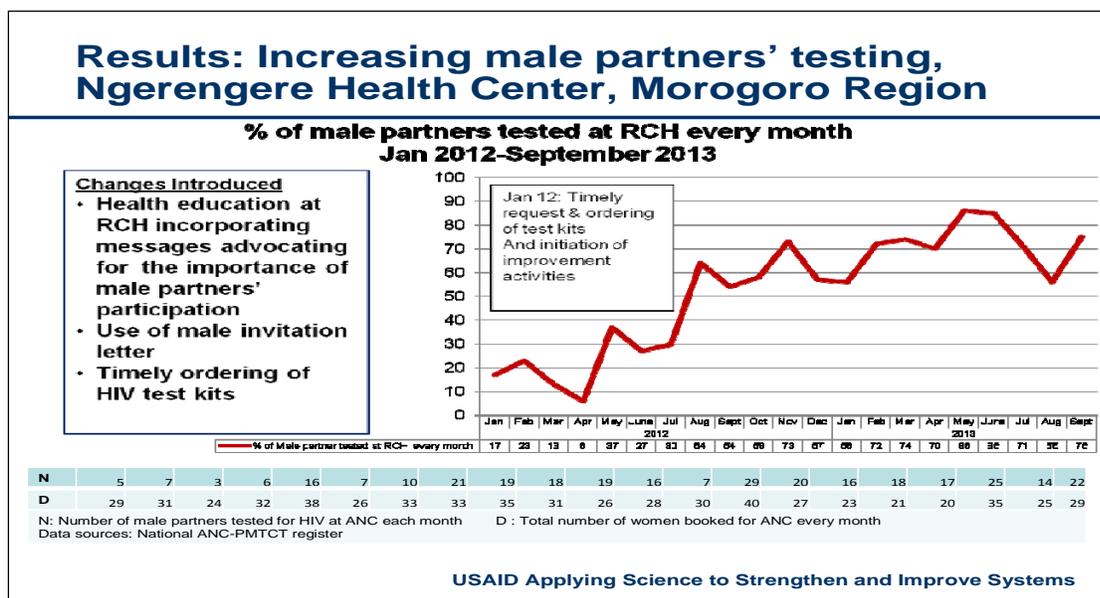
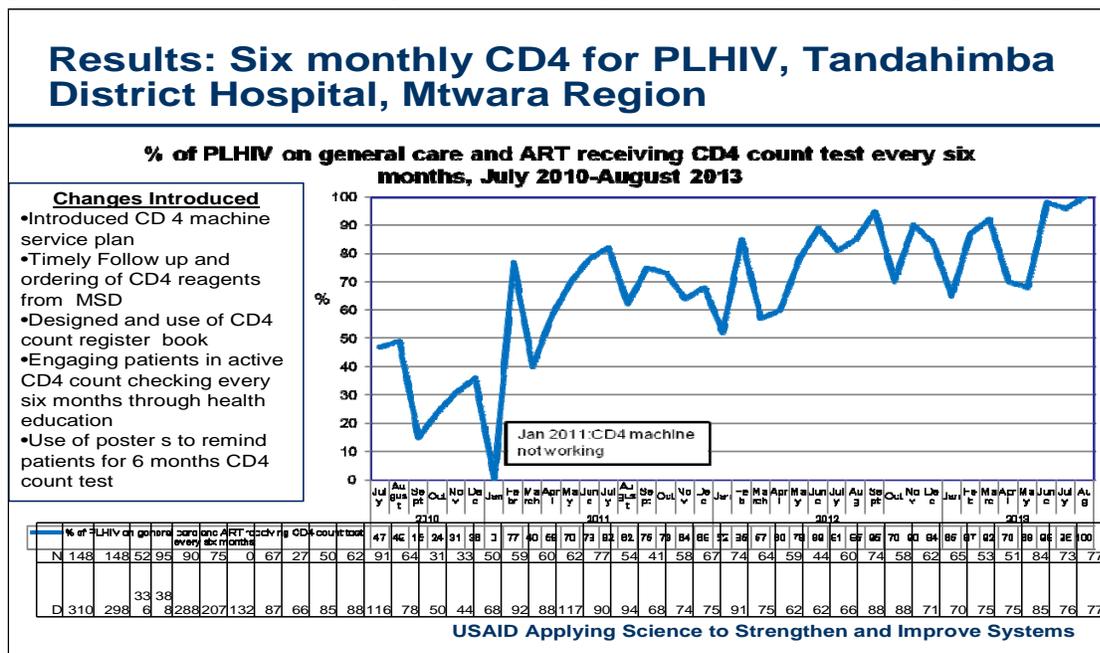


Figure 19: Tandahimba District Hospital, Mtwara Region, Tanzania: Percent of PLHIV on general care and ART receiving CD4 count every six months (July 2010-Aug 2013)



Improvement Strategy

ASSIST engaged RHMTs, CHMTs and IPs to establish improvement activities in Dodoma and Morogoro regions. The regions, through the use of improvement collaborative approach, were used to bring multiple teams to work on common goals through testing of changes to address the prevailing gaps. ASSIST involved R/CHMT and ART/PMTCT Regional IPs in designing the Dodoma Collaborative to promote process ownership.

Spread Strategy

The RHMT, CHMT and IP in respective regions where ASSIST supports improvement have managed to spread best practices to lower level facilities in clinical meeting with health facility in charges and CHMT to foster establishment of QI activities in these health facilities.

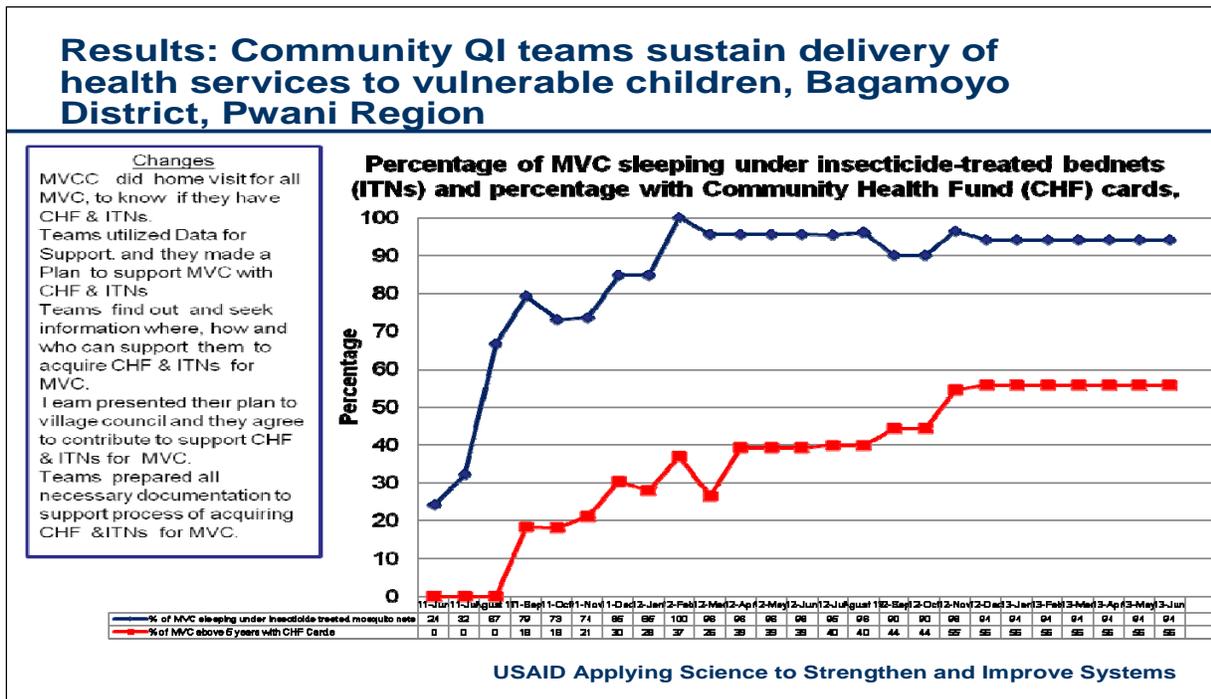
Activity 4. Support MOHSW, MVC IPs and local structures to strengthen quality of care, support and protection to Most Vulnerable Children through QI approaches

- **Continued to support Most Vulnerable Children Committees (MVCCs)/QI teams through learning and coaching sessions:** ASSIST, in collaboration with DSW, conducted a three day refresher OVC QI training which was held in the Morogoro region April 10–12, 2013, aimed at equipping Social Welfare Officers from Dar es Salaam, Pwani, Tanga and Kigoma regions with MVC QI knowledge and skills based on the National MVC QI guidelines to be able to facilitate MVC QI in their respective districts. A total of 36 district social welfare officers participated. During this training participants were able to share what their districts are doing in order to improve the quality of services that are provided to vulnerable children and identified QI gaps as well as developing QI plans to address the gaps based on the knowledge and skills acquired from the training. In May 2013, ASSIST, in collaboration with Tanzania Interfaith Partnership, conducted a one day QI advocacy meeting with MVC stakeholders in Kigoma Unifi Municipality and Kigoma Rural districts. A total of 47 MVC stakeholders participated during this advocacy meeting. In addition, a learning session was conducted in Kigoma Unifi Municipality and Kigoma Rural districts to strengthen the knowledge, skills and conduct of the professionals, frontline workers and volunteers responsible for protecting children from violence, abuse, neglect and exploitation. A total of 39 participants participated during learning sessions. ASSIST, in collaboration with Bagamoyo District Council, continued to support MVCCs/QI teams through a

coaching session which was organized in three wards of Kiwangwa, Dunda, and Fukayosi. A total of 118 QI teams/MVCC members participated. Coaches from the district were able to provide guidance on different challenges raised by teams such as processes of acquiring birth certificates and Community Health Fund (CHF) cards.

- **QI teams continued to sustain and mobilized local available resources and opportunities to support vulnerable children and caregivers**
 - With ASSIST support, MVCC from Masugulu village managed to raise funds from local resources to support five vulnerable children through secondary education. In addition, the team has savings of about TSH500, 000 (\$312) that was also locally raised and can be used to fund any vulnerable children's pressing needs.
 - Teams have been given skills to update MVC registers for the period of January to June 2013 and use the document as a reference to the actual number of vulnerable children and as a record of their specific needs. With this knowledge they have engaged various actors in planning support for the vulnerable children.
- **MVCC/QI teams in Bagamoyo working in collaboration with village leadership managed to improve and sustain access to basic health care services for vulnerable children (see Figure 21).**

Figure 20: Bagamoyo District, Tanzania: Percentage of MVC sleeping under insecticide treated nets (ITNs) and percentage with CHF cards (June 2011-June 2013)



Improvement Strategy

During implementation of this activity, the district authority, specifically those involved with MVC services, the Social Welfare Office and Community Development have been effectively involved to ensure ownership and sustainability. Furthermore ward and village authorities have been engaged to ensure they provide support to QI teams/MVCC, vulnerable children and caregivers.

Spread Strategy

We have been advocating for MVC improvement activities and support for MVC services to be across sectors and department in the council such as education, Tanzania Commission for AIDS (TACAIDS), and health.

Activity 5: Work with MOHSW and stakeholders to develop community home-based care (CHBC) QI program and monitoring framework and support country wide scaling up

- **Built capacity to apply SOPs for HBC:**
 - *Tanga City:* Supported the RHMT, CHMT, HBC supervisors and providers in Tanga City on how to properly apply SOPs for HBC in routine service delivery in 14 wards and proactively link clients to various community-based services available in the city.
 - *Muheza District:* Supported the CHMT in Muheza district to review and translate from English into Swahili the monitoring and evaluation tools for HBC and MVC.
 - *Kilulu, Kicheba and Genge wards of Muheza district:* Provided capacity building to RHMT and CHMT on M&E and QI functions including compilation of providers' reports, extraction of indicator data as well as equipping teams with QI concepts and how to overcome implementation bottlenecks. In these sessions, two RHMT members, three CHMT members, three designated District hospital staff, 19 HBC supervisors, and 117 HBC providers and MVCC members were involved.
 - *Tanga City:* Positive results have been noted through the application of SOPs and QI techniques such as: improved linkages among community-based service providers; increased frequency of clients' referrals; and improved access to service.
- **Conducted coaching through telephones and e-mails:** *Tanga City and Muheza:* ASSIST staff conducted telephone and e-mail communications to support teams on challenges encountered during implementation of HBC SOPs and job aids in Tanga and Muheza districts. A total of 14 supervisors and three CHMT members were involved in this coaching.

Cross Cutting Activities

- **Conducted Data Quality Assessment (DQA):** *Morogoro region:* Conducted DQA in five health facilities in Morogoro region (two from District Council and three from the Municipal Council) to verify data quality as per ASSIST project goals to determine whether findings observed by the health facility during QI activities truly represent what is being measured by those health facilities in the region. The DQA consisted of document finding and comparing actual to reported indicators, security of the rooms where data was stored, and determining areas of improvement in data collection, documentation, analysis and reporting by the QI teams. Most of the information provided by the QI team members was correct. All facilities had secure rooms for data storage and they had a clear flow of patients' files. However, it was found that there were several blanks in the CTC cards which needed to be filled in. The areas which were commonly left out were the demographic part, the eligibility criteria and different tests to be conducted to patients (e.g. liver function or renal function tests). The gaps identified were then discussed with the QI teams and action plan to work on them was developed.
- **Conducted training on integrating gender into QI programming in Dar es Salaam, Tanzania:** ASSIST held a two day gender training during the third quarter in Dar es Salaam that brought together 28 participants from USAID ASSIST, Tibu Homa Project and TACAIDS to learn how to integrate gender into QI programming. The two day training was facilitated by Dr. Taroub Faramand from ASSIST partner Women Influencing Health Education and Rule of Law (WI-HER, LLC).
- **Engaged in KM activities to support QI**
 - Two USAID ASSIST Tanzania staff participated in a PHFS meeting in Uganda. The meeting brought together HCI and ASSIST staff from four countries and was aimed at having participants share and to learn about activities to improve PMTCT services.
 - Six USAID ASSIST Tanzania staff participated in the PMTCT Option B+ training of trainers since the MOHSW is preparing for country's' roll out of PMTCT Option B+. During the training, they were provided technical support on revision of M&E tools and monitoring indicators emphasizing on: timing for initiation of ARTs, logistics and supplies, tools for M&E of the program. ASSIST has taken a leading role to develop QI indicators for PMTCT Option B+.
 - ASSIST was represented at a regional health forum in Lindi region, the "Joint Partnership Strategy towards Improved Health Status in Lindi". ASSIST and other IPs were invited to

share their experiences in implementing QI activities in the region. They also discussed and presented achievements and challenges faced when working with the region and its districts.

- o Documented a success story on integration of FP into CTC in Manyara region.
- o Five abstracts were submitted and accepted for the International Society for Quality Assurance in Health Care (ISQua) conference in Edinburgh in October 2013 and one for the National FP conference in September.

Improvement Strategy

In FY13 USAID ASSIST supported the MOHSW, NGO/CBOs and other IPs to use the process improvement model and principles such as Smart Integration, Sustainability and Ownership to engage CHBC and MVC actors at all levels in designing and implementation of improvement efforts. ASSIST continues to support the MOHSW and IPs at national level in their efforts to spread application of the HBC SOP countrywide.

Spread Strategy

In FY13, ASSIST supported the MOHSW-led effort to scale up HBC SOP use nationwide. The scale-up first covered Eastern, North and Central zones using a group of national HBC TOTs concurrent with scale-up of training of HBC providers on revised HBC curriculum.

Improvement in Key Indicators

Activity	Indicators	Baseline	Last value
1. To support MOHSW and PMTCT IPs to scale up programs providing women and their families improved access to quality care along the PMTCT cascade	<ul style="list-style-type: none"> • % pregnant women who book ANC at 14th week of pregnancy • % HIV positive screened for TB at RCH • % of male tested at RCH • % of women counseled for Family Planning at CTC • % Exposed infants practicing exclusive breastfeeding • % of HIV+ PW counseled for FP at ANC • % HIV positive pregnant women who receive ARVs • % Exposed infants practicing exclusive breastfeeding • % Non pregnant women accessing FP tested for HIV 	Kilimanjaro – September 2011 9% 0% 16% 0% 48% 13% Iringa region 43% (Jan 2010) 41% (Jan 2010) Manyara region 8% (Jan 2012)	35% (May 2013) 99% (August 2013) 64% (August 2013) 87% 84% 100% 85% (May 2013) 78% (May 2013) 100% (August 2013)
2. To support MOHSW and HIV Free Survival Partners towards elimination of HIV infection in children and reducing deaths among HIV-infected mothers through nutritional services for mothers, infants and young children and health systems strengthening of	<ul style="list-style-type: none"> • % of infants who are malnourished • % of PNC and PW who are malnourished • % of mothers who attend post-natal care • % of HIV+ post-natal care women initiated on ART • % of infants who are EBF • % of infants tested by DNA/PCR and receive results • % of mother-baby pairs attending post-natal clinic 	Nzega District – April –June 2013 (Baseline Data) 0% 0% 0% 43% 22% 41% 0%	

the postnatal continuum of PMTCT care			
3. To support MOHSW and IPs to scale up QI activities for ART services to achieve sustainable improvements in patients' coverage, retention and clinical outcomes	<ul style="list-style-type: none"> • % Percentage of patients on ART LTFU • % of HIV patients receiving CD4 test every 6 months • % of HIV patients assessed for active TB • % of male partners tested for HIV 	<p>Morogoro Region 15% (Oct 2012)</p> <p>Tandahimba Mtwara 70% in October</p> <p>Morogoro region 71% (Oct 2008)</p> <p>Morogoro 7% (Jan 2012)</p>	<p>7% (September 2013)</p> <p>100 % (Sept 2013)</p> <p>85% (Apr 2013)</p> <p>76% (Sept 2013)</p>
4. To support MOHSW, MVC IPs and local structures to strengthen quality of care, support and protection to Most Vulnerable Children through QI approaches	<ul style="list-style-type: none"> • % of MVC sleeping under ITNs • % of MVC above 5 years with CHF cards 	<p>Bagamoyo district- June 2011</p> <p>24%</p> <p>0%</p>	<p>June 2013</p> <p>94%</p> <p>56%</p>

What Are We Learning?

- Engagement of local community and influential leaders promotes service uptake as observed in increased male partner testing for HIV in Kilimanjaro QI efforts.
- Service integration improves uptake and address long lasting missed opportunities during service delivery; the case of improved FP uptake among CTC clients in Manyara.
- Following scaling up trainings to lower level facilities, we learned that council level QI teams can facilitate QI trainings with minimal support from ASSIST and RHMT staff.
- Conducting individual need assessment among HBC clients improves referral to various HBC linked services.
- Focused counseling for men during home visits by HBC providers improved number of referrals for male clients to other services.
- As changes are implemented, management of the efforts (change management) is imperative for achieving sustained results.
- Engagement of local community and influential leaders promote service uptake as observed in increased male partner testing for HIV.
- Service integration improve uptake and address long lasting missed opportunities during service delivery (the case of improved FP uptake among CTC clients).
- Developing knowledge nuggets can be useful to share experience with other ASSIST countries and implementing partners.
- Use of 'Knowledge Cafés' in learning sessions allows participants to explore solutions to health system challenges (Mbeya)
- Conducting feasibility tests before actual study helped to inform study design (Mtwara).
- Strengthening Public Private Partnerships improves accessibility and quality of health services.

Directions for FY14

- Develop National PMTCT Improvement Framework in the context of Option B+
- Prototype the new improvement framework for Option B+ in one model district (Mwanza)
- Establish a model district in child protection focusing on vulnerable children (Mkuranga)
- Develop an improvement framework for infant and childhood ART services and support the MOHSW and IPs in implementation.

1.13 Uganda

Background

In 2005, the Quality Assurance Project (QAP) began work in Uganda. The success of QAP led to the work of HCI in 2008, the next generation of continuous QI in Uganda. As the project life cycle of HCI has run its course, ASSIST has begun activities in Uganda.

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

- Build the capacity of USG partners to improve quality of HIV/AIDS, TB, MNCH, RH/FP, Nutrition, and OVC services in Uganda.
- Build the capacity of the MOH and MGLSD to coordinate and oversee implementation of national QI plans and strategies.

In addition – and relating to both of these objectives – the project worked in FY13 to generate new knowledge and evidence-based best practices in QI as part of a continuous learning and adapting agenda.

During this year, the project worked with the responsible ministries and the established government structures to ensure government ownership. In addition, the project worked with the leaders at the district and facility level to ensure that there is coordination of the services provided and resources are used in the most optimal way. Throughout the year, ASSIST staff documented what they learned and are continuously sharing information with the ministries and other partners.

Program Overview

What are we trying to accomplish?	How will we know?	At what scale?
<p>1. Improve HIV Care and Treatment</p> <ul style="list-style-type: none"> • HIV counseling and testing • Prevention messages for the HIV negative • ART initiation for the eligible HIV positive • Retention in care, clinical outcomes • Early infant diagnosis and treatment • Engage facility leaders to participate in QI activities • Improve Management of patients with TB/HIV co-infection • Community linkages and follow up 	<ul style="list-style-type: none"> • Proportion counseled and tested who get their results • The percentage of eligible ART clients started on ART • The percentage of ART clients retained in care • Percentage of infants initiated into care • The percentage of ART clients clinically well • Percentage of HIV patients screened for TB • Percentage of HIV /TB co-infected patients started on TB treatment • HIV/TB completion • Proportion of sites with improvement aims • Percentage of clients retained in care • Percentage of clients with a good clinical outcome 	<p>51 sites in 39 districts</p> <p>Engaging leaders: 12 sites in three districts</p>
<p>2. Safe Male Circumcision (SMC) services</p> <ul style="list-style-type: none"> • Work with MOH and partners to follow the MOH standard operating procedures to guide clinical practice in line with WHO recommended guidelines. 	<ul style="list-style-type: none"> • Proportion of sites adhering to standards • Proportion of clients counseled before the operation • Proportion of adverse events following SMC services • Proportion of clients that are followed up after SMC 	<p>30 sites in 26 districts</p>

What are we trying to accomplish?	How will we know?	At what scale?
<ul style="list-style-type: none"> • Improve quality of SMC services 		
<p>3. PHFS</p> <ul style="list-style-type: none"> • Increase coverage, retention and outcomes of mothers and infants accessing eMTCT and NACS services. 	<ul style="list-style-type: none"> • Proportion of infants born to HIV-positive women in eMTCT programs that are alive at 12 months of age and HIV negative • Number and proportion of infants and mothers who are found to be malnourished at any point during the reporting period 	22 sites in six PFHS supported districts
<p>4. Improve Maternal and Newborn Health</p> <ul style="list-style-type: none"> • Contribute to the collective efforts of partners to reduce maternal and perinatal mortality in the four SMGL districts 	<ul style="list-style-type: none"> • Proportion of mothers whose pregnancy is monitored using a partogram • Proportion of mothers in labor who receive AMSTL • Percent of newborn babies receiving essential newborn care • Proportion of maternal deaths • Proportion of perinatal deaths 	Facilities in four districts
<p>5. FP</p> <ul style="list-style-type: none"> • Integrate FP into HIV and maternal health 	<ul style="list-style-type: none"> • Proportion of clients attending HIV and MNCH clinics that are counseled on FP services • % HIV positive clients of reproductive age and leaving the facility with a modern FP method of their choice, post obstetric event 	17 SMGL sites in four districts
<p>6. Improving and Institutionalizing QI in the health sector</p> <ul style="list-style-type: none"> • Form QI committees in accordance with the MOH national QI framework and strategy 	<ul style="list-style-type: none"> • Number of partners supporting the QI framework and site/districts with functional QI teams will serve as a measure towards institutionalization • Number of IPs supported and joint plans made will be an indicator of the support we are providing to the other USG partners 	National (112 districts)
<p>7. Develop an OVC national QI framework and institutionalize QI in OVC</p> <ul style="list-style-type: none"> • Support the MGLSD, SCORE and other OVC partners to incorporate QI into OVC assessment, care, referral, follow up, and measurement of social status outcomes. • Improve access to essential services for orphans and other vulnerable children and their caregivers 	<ul style="list-style-type: none"> • Proportion of Civil Society Organizations (CSOs) correctly and consistently using national standard tools for identification, selection, care and follow up of vulnerable children • Proportion of CSOs continuously testing changes to improve service delivery to vulnerable children • Proportion of CSOs improving in adherence to OVC standards • Proportion of CSOs with appropriate referral and linkages to ensure provision of at least three core program areas plus PSS to vulnerable children 	10 CSOs in four districts
<p>8. Finalization of newborn health guidelines and pilot testing training materials</p> <ul style="list-style-type: none"> • Mapping of newborn health partners to plan and coordinate roll-out of HBB-plus: geographic coverage and achievements 	<p>Newborn health guidelines and training materials developed:</p> <ul style="list-style-type: none"> • HBB-plus ENC Facilitator Flipchart • HBB-plus Essential Newborn Care Learner Workbook • HBB-plus Clinical Mentoring Guide • HBB-plus Clinical Mentorship Report Format • Newborn health QI standards and indicators 	National

What are we trying to accomplish?	How will we know?	At what scale?
	Developed <ul style="list-style-type: none"> • Manual of newborn health indicators developed • Number of the National Newborn Steering Committee members whose capacity has been built in QI • Proportion of districts and health facilities implementing quality newborn health services according to standards • Proportion of health facilities offering quality newborn health services according to standards 	

Key Activities, Accomplishments, and Results

Activity 1. Continuum of HIV care, treatment and support

- **Developed joint work plans with partners:** Developed joint work plans with nine partners (STAR-EC, STAR-E, STAR-SW, NUHITES, MILD MAY, IRCU, MUWRP, UPHS and SPEAR) and identified and agreed upon 51 sites for intensive support (roughly 10 sites in each of the four regions of Uganda). The selection of the sites was done in collaboration with the USAID partner working in that region. The criteria for selection included high patient load, existing gaps in coverage, retention and clinical wellness. MOUs were developed for review by the partners and are awaiting signature.
- **Identified performance and service provision gaps in 51 health facilities through a baseline assessment of HIV/TB care services:** Conducted baseline assessment in the 51 health facilities in the 39 districts supported by nine IPs (NU-HITES, STAR E, STAR EC, STAR-SW, MILD MAY, SPEAR, MUWRP, UPHS and IRCU). Carried out analysis of the results of the baseline assessment and identified site specific gaps in HIV/TB care that needed to be addressed. Gaps in service provision included: low HCT uptake at 48 facilities; poor linkages of HIV positive clients, including HIV positive babies, into HIV care; poor linkages of HIV/TB co-infected patients to ART; poor TB treatment completion and cure rates.
- **Supported facilities to identify improvement projects for implementation:** Shared the baseline assessment results with the 47 facilities where data had been collected. Included an additional four private health facilities. Supported facilities to identify change ideas that have worked elsewhere through sharing the ART care and treatment and the chronic care change packages generated from the QI work under HCI with the facility QI teams. Forty eight (48) facilities out of 51 have active QI teams with improvement projects going on and changes are being tracked (apart from Kiswa where it has been challenging to establish an MOU with a partner). Facilities were supported in two coaching sessions each for continuous implementation of the QI projects.
- **Built the capacity of implementing partners to implement HIV/COR in the facilities they support:** Involved partners (STAR E, STAR EC, STAR SW, IRCU, MUWRP, Mild May, SPEAR and NUHITES) in the coaching visits at varying levels and sharing of the dash boards for the HIV/COR indicators. Shared USAID ASSIST work plan and trip plans with the IPs to synchronize activities.

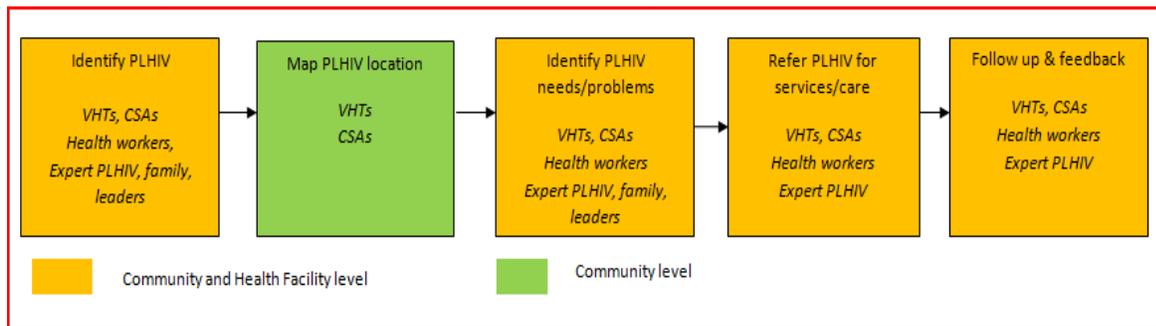
Activity 1(b). Continuum of HIV care, treatment and support (community component)

- **Conducted a situation analysis on client retention and adherence in three USG partner sites:** Data on physical address, appointment keeping and adherence status was collected from 1,406 PLHIV who attended HIV clinics in the month of June 2013 in Kamuli hospital, Bugiri hospital and Kabwohe Health Center IV. In Bugiri and Kamuli Hospitals (STAR EC region), over 90% of the patients adhered to their medications. Appointment keeping in Bugiri and Kamuli Hospitals stood at 64% and 73% respectively, which was below the national target of 85%.
- **Selected villages for QI intervention:** Following the situation analysis, a total of 14 villages

were selected in the STAR EC region. The villages selected were those that contributed to 80% of the retention gap. The villages in STAR SW villages will be selected when data analysis for one health facility is complete or a new site to replace Kabwohe Health Center IV - where retention/adherence gaps don't exist - is done. Analysis of data from the selected STAR-SW sites showed no apparent QI gaps in the retention/adherence of HIV clients. Plans are on-going to have partners suggest other areas with QI gaps in HIV for support.

- **Conducted baseline assessment on QI indicators:** A baseline assessment on improvement indicators was conducted in seven villages in Bugiri Hospital's catchment. The indicators include complete PLHIV referrals, follow ups, adherence support and appointment keeping. There was no documentation on referrals made and follow up of patients, partly due to lack of a structured community-health facility linkage system and data systems
- **Conducted QI training for community actors:** Conducted two community trainings in Bugiri and Kamuli districts in QI, HIV/AIDS care, and gender. A total of 70 participants comprising of Village Health Teams (VHTs), Community Support Agents (CSAs) Community Development officers (CDOs) and People with HIV/AIDS (PHA) network representatives were trained. In the training we defined a community-health facility linkage process and facilitators for each step. The facilitators in the linkage process guided the community QI team formation as illustrated in Figure 21.

Figure 21: Uganda: Community-health facility linkage process



- **Formed Community QI teams:** Seven community QI teams were formed in Bugiri district based on the community-health facility linkage steps shown in the Figure above. Team roles, leadership, and norms were defined. Action plans were made and some of the changes being tested are listed in Table 7.

Table 7: Changes tested for community-facility linkages

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

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

Improvement Strategy

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

Spread Strategy

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

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

- **Conducted coaching visits:** Supported three intervention sites to review the action plans developed in June. Facilitated sites to implement targeted changes to address gaps in provision of HIV chronic care while focusing on selected improvement aims; improvements in records and adherence, helping sites improve clinic efficiency by introducing changes to reduce client waiting time. Facilitated sites to prepare for the first learning session in Q1 FY14. Some of the changes being tested at the facilities are listed in Table 8:

Table 8: Changes being tested at the facilities

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

Activity 1(d). Leadership collaborative

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

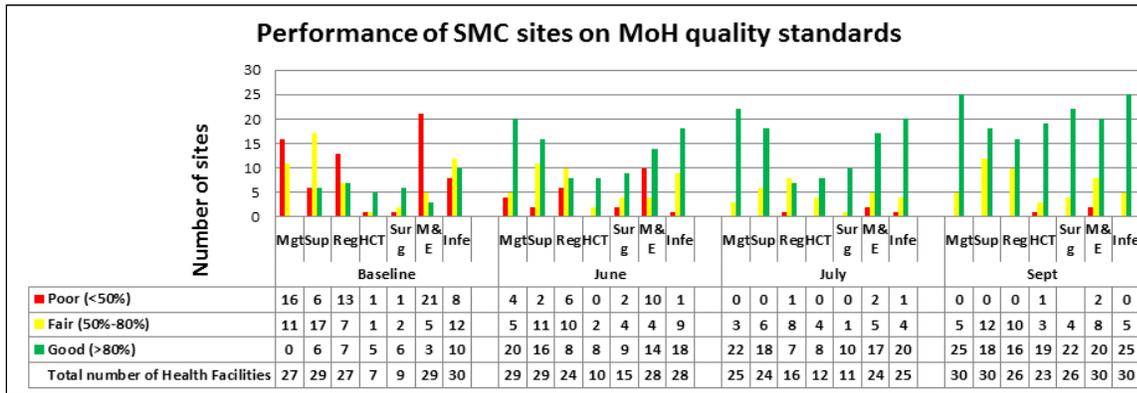
Improvement Strategy

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

Activity 2. SMC

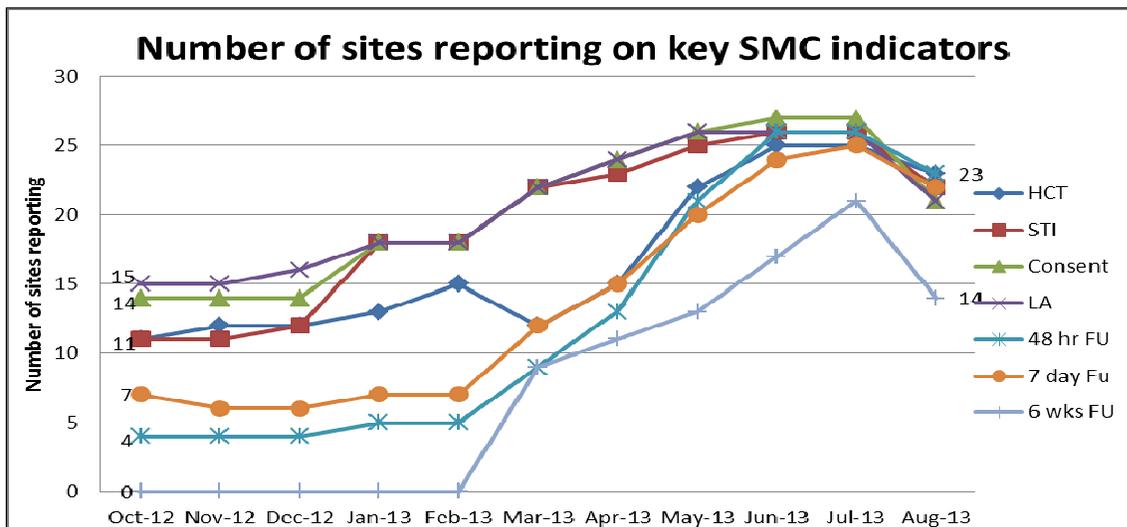
- **Built consensus for QI activities among MOH and SMC stakeholders:** Conducted a series of meetings with the Ministry and SMC stakeholders to build consensus on how QI can enhance the national SMC strategy. Supported the National Task Force (NTF) for SMC to convene and review progress of SMC services in Uganda. Supported the MOH to conduct the Second National QI conference. This conference among other objectives was aimed at taking stock of the national QI efforts.
- **Worked with IPs and districts to carry out baseline and follow-up of quality standards in SMC:** Adapted a self-assessment tool developed by WHO/PEPFAR to align it to the MOH SMC policy, minimum standards of procedure, and SMC strategic plan. Worked with implementing partners and district health office staff to conduct site self-assessments aimed at identifying gaps that impede implementation of SMC services according to the MOH/WHO standards.
- **Assessed health facilities providing SMC to determine their baseline status.** Based on the findings from using the assessment tool, supported facility teams to improve adherence to MOH quality standards: This was done through supporting the formation and functionality of district QI teams; supported the training of new regional coaches through joint coaching. These will join a pool of existing national coaches who provide support to district teams on ad hoc basis.
- **Performance of SMC sites performing “good” on different MOH quality standards increased from considerably from baseline to September 2013.** 22 shows the performance of the SMC sites on the MOH quality standards, showing significant site improvement over the last four months. At the baseline assessment many sites scored below 50% in the standards and in September of the 30 sites assessed, 23 sites were scoring above 80% in the standards. The two standards with performance below 50% include individual counseling and testing for HIV and M&E due to no pre-operative and post-operative counseling for HIV being offered to the SMC clients and lack of standardized SMC data tools respectively.
- **Addressed gender considerations in SMC:** At the national level, ASSIST successfully proposed to the MOH SMC NTF to integrate gender into the national SMC quality standards. At all available opportunities (i.e., trainings), a session on gender integration is included which has generated a lot of interest among the participants. At the health unit level, ASSIST has empowered health workers to develop innovative ways of encouraging women to participate in SMC activities. Teams were supported to test changes to help promote partners involvement in SMC. Indicators to measure partner involvement were developed.

Figure 22: Uganda: Performance of SMC sites on MOH quality standards (May – September 2013)



- HIV counseling and testing:** There was an increase in the percentage of clients that were counseled and tested and received results from 91% in October 2012 to 96% in March 2013. The number of sites reporting adverse events increased from only eight sites in October 2012 to 21 in September 2013 currently. The initial increase in the percentage of clients experiencing adverse events noted in the months of January to May 2013 followed the orientation of the site teams on the importance of documentation and provision of adverse events grading scales to aid identification of adverse events. The improvement noted after May 2013 was due to establishment of systems of investigating adverse events at the sites, institution of CME sessions and having the guardians of the minors attend post-operative health education. For post-operative follow-up at 48 hours, at baseline, there were only five of the 30 sites that were carrying out 48 hour follow-up. Most health workers told clients to come back if they had a problem. A root cause analysis showed that most health workers had a knowledge gap on the usefulness of the follow up visit. Further, there were many data gaps in the registers. ASSIST started by mentoring sites on the importance of the follow up visit, trained them in QI and assisted them to form QI teams. With this, sites started testing changes like repackaging of health education information to include need to return for follow up, improving documentation and telling clients to return for bandage removal. Currently, 48 hour follow-up is at 68% and number of sites offering it has risen from five in October 2012 to 25 in August 2013.
- Figure 23 summarizes details of how the number of sites engaged in the various SMC indicators has been improving since baseline in October 2012 to August 2013. It can be observed that for all indicators, there has been a demonstrable increase in the number of sites involved.

Figure 23: Uganda: Number of facilities reporting various SMC indicators (Oct 2012-Aug 2013)



- Work on seven-day follow-up increased from seven sites at baseline (October 2012) to 22 sites in August 2013. Facility staff repackaged their health education messages to include the importance of day seven follow-up. Currently, seven day follow-up stands at 33% with the peak being 47% for 25 sites in July. A decline in August was observed due to sites conducting outreach SMC activities which still pose a challenge to follow up at seven days.
- There has been an improvement in the number of sites conducting six week follow-up from three sites in February to a high of 21 sites in July. There has been an increase in the number of sites reporting clients returning for review after six weeks from nine sites in April to 15 in July.

Improvement Strategy

ASSIST is working with the MOH to improve the delivery of SMC services through: Intense support to 30 sites, light support to 12, building MOH QI structures (setting up QI teams at the district and facility levels based on the MOH QI framework and strategic plan) and supporting the MOH SMC taskforce to meet quarterly to review and provide guidance to the partners carrying out SMC activities.

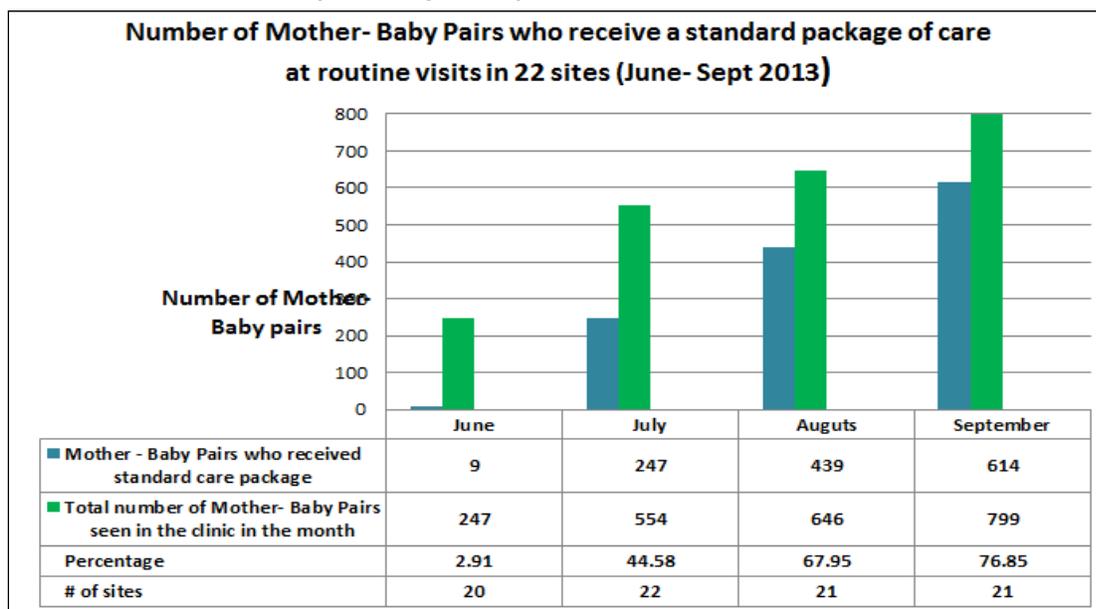
Spread Strategy

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

Activity 3. PHFS

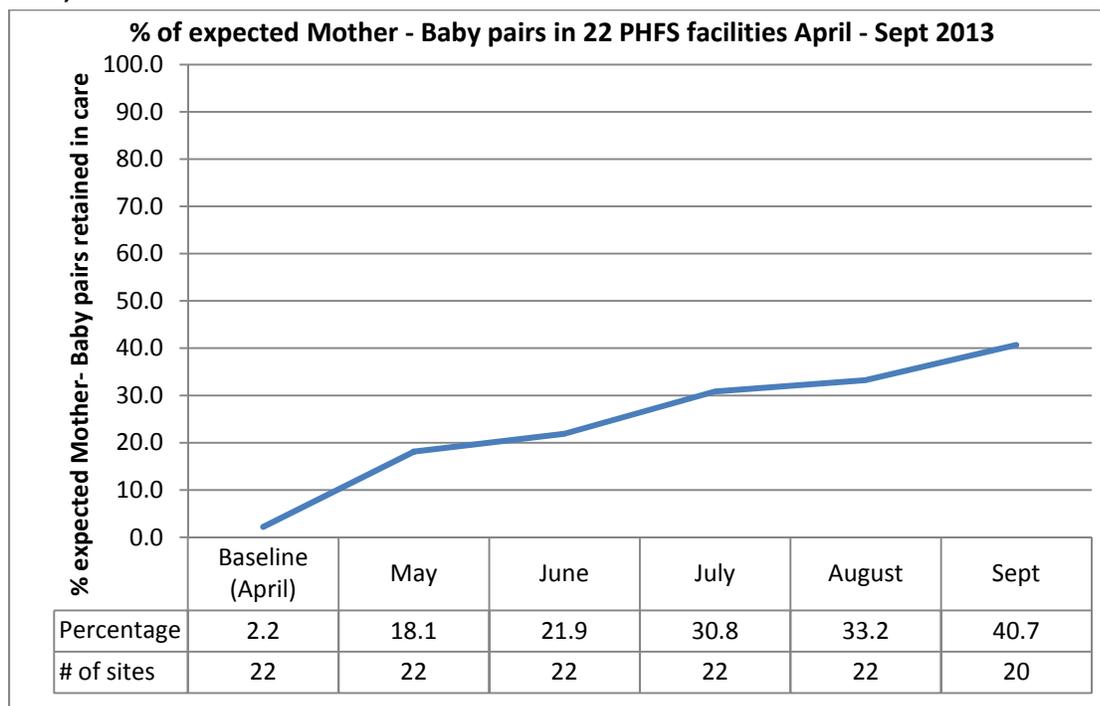
- **Defined role of ASSIST in PHFS through a series of consultative meetings with partners: Partners included FANTA, SPRING, TASO, and MOH.**
- **Developed a set of indicators for monitoring the PHFS initiative through consultative meetings.**
- **Conducted a baseline assessment in seven out of 22 health facilities.**
 - Tested change ideas and rolled out action plans in 22 health facilities. ASSIST developed change ideas in one of the IP's sites where ideas were discussed on how to improve retention of mother-baby pairs in care and improvement in data quality of exposed infant diagnosis (EID) registers that had been identified at the site would also be achieved. From this prototype visit we were able to develop the first coaching tool to use for similar coaching visits in the other 21 health facilities. The same approach that was used in the prototype visit was rolled out in all 22 health facilities with the support of the regional and district coaches and IPs (TASO and SPRING). Coaching teams were assigned two to three sites to support and coaching was done in all the sites in the same week. Coaching visits were carried out among all the 22 health facilities.
- **Sites delivered standard package of care:** The standard package of care for mother-baby pairs includes ART for the mother, Cotrimoxazole or Nevirapine for her baby, Infant and Young Child Feeding (IYCF) counseling and nutrition assessment and an appointment for the next visit. Twenty health facilities worked to provide every mother-baby pair who was seen in the month with this standard package of care, and the percentage of mother-baby pairs who received all components of care increased from 2.9% in June to 76.8% in September 2013 in 21 sites as shown in Figure 24 below. The specific changes which the sites tested to improve the quality of care provided at routine visits include:
 - Dispensing drugs (ARVs and Cotrimoxazole) in the clinic instead of the pharmacy (nine sites)
 - Assigning a nurse or peer educator the responsibility of taking mother and baby's anthropometric measurements for nutrition assessment (eight sites)
 - Increase the clinic days from one to two days a week so that mothers and their babies can get all the services (one site)

Figure 24: Uganda: Number of mothers-baby pairs who received standard package of care at routine visits in 22 sites (June-Sept 2013)



- **Retention of mother-baby pairs in care:** Overall the data on retention is becoming more available and the site teams have tested changes to improve retention as shown in Figure 25 below. By the end of September 2013, 36% of mother-baby pairs in 17 PHFS sites were retained in care, compared to only 2.2% in April 2013. The number of sites which tested specific changes which were identified in the last quarter to improve retention of mother baby pairs increased as follows:
 - Giving mothers and babies the same appointment dates (21 sites)
 - Keeping the mother and baby's clinical charts together (22 sites)
 - Merging ART and EID clinic services so that both mother and baby are seen together (17 sites)
 - Increasing the number of days in the week that the clinic runs for mothers and their babies to access care and spread workload for the staff (seven sites)
 - Following up mothers who were lost to follow up by making phone calls and using peers to trace these mothers and return them to care (seven sites)

Figure 25: Uganda: Percentage of expected mother-baby pairs in 22 PHFS facilities (April-Sept 2013)



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

Improvement Strategy

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

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

Spread Strategy

Shared at each coaching visit with the site teams and attached an inventory of changes which might improve some of the focus areas to the coaching guides.

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

K one mg IM (0.5 mg for preterm babies); immunization with oral polio vaccine and BCG and thermal protection (drying baby, cap and socks, blanket, room temperature, delaying bathing baby until after 24 hours). A package of changes tested include: developing job aids and displaying protocols for each element of ENC and displaying them in the labor suit; staff charity project for warm clothes for newborns whose mothers come without them, assignment of a focal person to oversee provision of the Essential Newborn Care (ENBC) package, individual mentoring/on the job training and schedule health education talks for each element of the ENBC package.

Spread Strategy

ASSIST has engaged the leaders at district and facility levels during quarterly review meetings to create ownership.

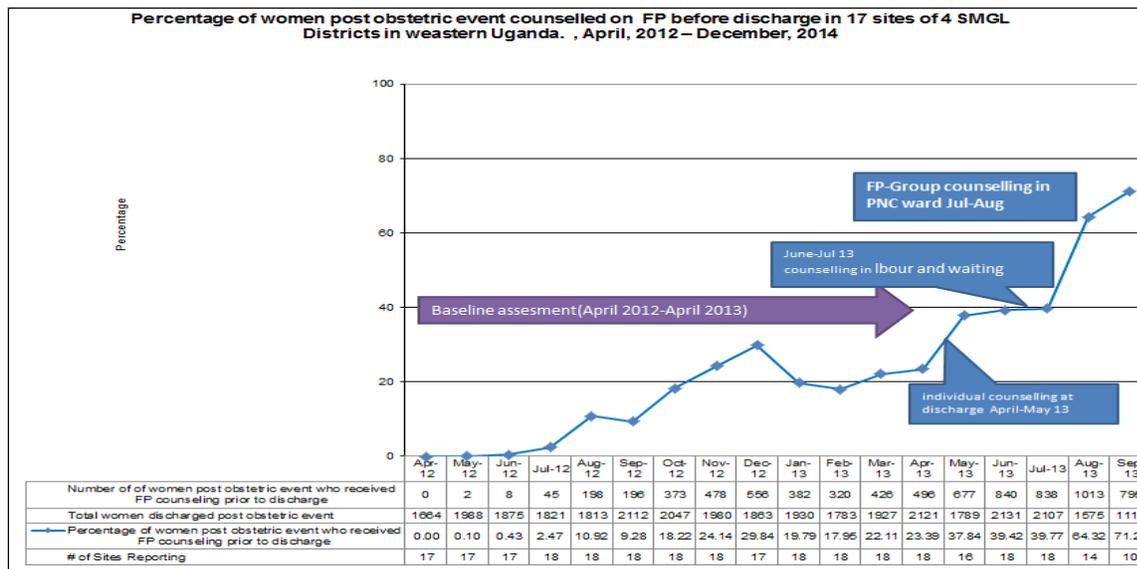
The facility teams have been supported to understand and own the outcome of their improvement work through use of data and including QI activities in the facility work plans

Through the capacity built in the partners and the district health team members, they are using a similar QI approach to scale up MNCH QI activities to other non ASSIST supported districts and facilities during support supervision visits.

Activity 5. FP

- **Conducted a baseline assessment in 17 high volume health facilities in four SMGL districts to review the integration of family planning into MNCH:** Baseline assessment in showed that only 27.56% of post obstetric women are counseled on FP before discharge and none counseled with a partner. None was provided with the FP method of choice at discharge. Mothers were being told to come back at six weeks for FP services and immunization.
- **Increased individual FP counseling:** FP individual counseling stands at 71% by September 2013 compared to 38% in May 2013 as seen in the 27, couples counseling stands at 20% by September, compared to 3.9% in May 2013. FP uptake at discharge is beginning to pick up and results stand at 4.15% by September compared to 0.2% in May 2013 (Figure 27).

Figure 27: Uganda: Percentage of women post obstetric event counseled on FP before discharge in 17 sets of four SMGL districts in Western Uganda (April 2012-Sept 2013)



- **Conducted site coaching sessions:** Conducted two joint (with the district health teams and the regional and the district QI coaches) site coaching support visits to 17 public facilities working on improving integration of FP into the SMGL program in the four SMGL districts of western Uganda.
- **Conducted learning session/stakeholders meeting:** Conducted one learning session to enhance spread of best practices among the SMGL and the FP integration participating sites. Held a stakeholders meeting with the district health team regional coaches and Marie Stopes

Uganda to share the baseline assessment results and plan for implementation to improve FP service delivery.

Improvement Strategy

Worked with the MOH and the district health teams to support 18 MNCH QI teams of the four SMGL districts of Western Uganda integrate FP into immediate post obstetric event care services, using QI approaches.

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

Activity 6. OVC

- **Together with MGLSD, OVC partners SCORE and SUNRISE developed a QI framework** to guide the implementation and institutionalization of QI in national OVC structure with a goal of promoting the provision of quality comprehensive services for vulnerable children and their households. Together with MGLSD and the OVC partners, agreed on indicators to measure the OVC QI framework.
- **In collaboration with the MGLSD and other OVC partners developed a self-assessment tool for measuring and monitoring adherence to OVC standards.** Supported the MGLSD to organize an OVC stakeholders' meeting to introduce and share the OVC QI framework, OVC QI collaborative and the self-assessment tool.
- **Conducted a baseline assessment for QI:** In collaboration with MGLSD, conducted a baseline assessment in the districts of Rukungiri, Amuru, Busia and Mukono with aim of identifying gaps at the CSO, sub-county and district level so as to design appropriate QI interventions based on need. The results obtained were shared with the partners and the OVC structures at sub-county, district and national levels.
- **Collaborated with the MGLSD to organize and conduct QI training for selected district, sub-county and CSOs representatives (June 2013):** Trained district coaches were trained so that they can orient the District OVC Coordination Committee and Sub-Count OVC Coordinating Committee members to use QI approach to manage and improve OVC services in their respective districts and sub-counties. The CSOs oriented to QI approaches so that they can apply them in their work to measure and improve the services provided to vulnerable children. At the CSO training, each CSO used a prioritization matrix and the baseline data to identify two areas to start the improvement work. Most teams (six) selected economic strengthening, three chose food and nutrition security, two chose PSS, two chose education and one chose health as areas for improvement and developed improvement aims and indicators.
- **Conducted QI training:** By the end of the year all selected 10 CSOs had been trained in QI and were working on at least two focus areas for improvement.
- **Conducted coaching session:** Three joint coaching visits by ASSIST, MGLSD, partners and district based coaches were conducted to support QI team formation and ensure they are functional. Teams were supported to use their data to identify gaps in the process of care for the selected areas of improvement; however there was a general problem with availability and completeness of data given that the teams do not use standardized data tools and compiled data on individual vulnerable children or households on quarterly basis. All CSOs have existing group structures at community level where households meet regularly to participate in communal activity for example: saving, learning new skills in farming or business. The QI teams were asked to use the existing structures of groups to collect monthly data on the wellbeing of the vulnerable children and their households. By the end of the year at least seven CSOs were able to get data from over fifty percent of the vulnerable households supported. This data was used to identify the gaps in the process of care for the selected areas and monitor improvements.

Improvement Strategy

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

Spread Strategy

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

Activity 7. Supporting the MOH to coordinate QI and institutionalization

- **Supported the MOH in QI training:** Supported the MOH to build the capacity for district QI committee members from 11 districts and the NUHITES project staff.
- **Supported the first QI stakeholders meeting to develop a joint work plan:** Supported the MOH to hold the first stakeholder meeting with QI partners to develop a joint work plan for October 2013 to September 2014.
- **Participated in the Annual Health Sector Review:** Supported the MOH compiling the Annual Health Sector Report for FY2012/13 and the Midterm Review for the Health Sector Strategic and Investment Plan (HSSIP 2010/11 – 14/15).

Improvement Strategy

The collaborative improvement strategy was adopted as outline in the QI Framework and Strategy. Districts have been given QI knowledge and encouraged to start QI projects.

Activity 8. Applying KM principles and techniques to gather learning from improvement work and develop knowledge products

- **Developed a number of knowledge products which have been shared with partners through the following methods:**
 - Case studies: The PHFS component has generated a case study documenting the successes experienced in specific sites that we are working in. The PHFS case study is entitled: *“Implementing the PHFS Initiative in Uganda: Retention of Mother-Baby Pairs in Kisoro District Hospital.”* It has been shared with the partners both within Uganda and internationally, who are implementing PHFS for their learning, it has also been uploaded to the ASSIST web portal. The case study was also shared with stakeholders who attended the PHFS regional meeting in Kampala in October 2013.
 - OVC success story entitled: *“Applying QI to improve process of loan repayment at Agape Nyakibare Civil Society Organisation.”* This success story has so far been shared with the USAID mission in Uganda, and will soon be uploaded to the ASSIST web portal.
 - The Implementation of the National QI Framework, being piloted in Rwenzori region has started developing an implementation guide that is highlighting the experience of institutionalizing QI through the MOH systems.
 - Knowledge Nuggets: A statement or explanation, based on experience, from which others can learn and improve their working practices. The PHFS component has developed and distributed two knowledge nuggets providing information to partners. They have been uploaded on the PHFS listserv: Prototyping interventions at one site and having detailed

guidance for coaches helps to kick start improvement work in other sites; and avoid comprehensive baseline data collection up front and start up the improvement work with a small number of indicators.

- Blogs: SMC and the Health workforce component of the project have started writing blogs to inform on their experience in implementing QI.
- SMC blog has been uploaded on: Bringing women on board in SMC in Uganda:
<http://assist.k4hdev.org/blog/bringing-women-board-safe-male-circumcision-uganda-0>
- Health workforce blog on: Knowledge for Health website at the link below:
<http://www.k4health.org/blog/post/strengthening-human-resources-health-uganda>
- Developing change packages of best practices: Each component this year has used the learning sessions to begin documenting and collecting evidence of tested changes that have shown some improvement. This will allow for the project to continually inform stakeholders of what is working in QI at the facilities.

Summary of Key Indicators

Activity	Indicators	Baseline	Last value
HIV Continuum of Response	Percentage of HIV positive Eligible clients started on ART	Apr'13 (80.1%), 30 sites	Aug'13 (71%), 41 sites
	Percentage of HIV positive on ART that are retained in care	Apr'13 (87%), 32 sites	Aug'13 (79%), 35 sites
	Percentage of TB/HIV co infected clients ever started on ART that are seen in a month	Apr'13 (57%), 35 sites	Aug'13 (58%), 42 sites
	TB completion rate	Apr'13 (42%), 34 sites	Aug'13 (40%), 39 sites
	Percentage of HIV positive on ART that are clinically well (working functional status, no weight loss of >2kgs, and No new OIs)	Apr'13 (63.7%), 36 sites	Aug'13 (61%), 41 sites
SMC	Percentage that experience moderate to severe adverse events	Oct'12 (0.5%), 8 sites	Aug'13 (0.4%), 21 sites
	Percentage that return within 48 hours post operation	Oct'12 (58%), 4 sites	Aug'13 (68%), 23 sites
	Percentage that return after 1 week follow-up	Oct'12 (54%), 7 sites	Aug'13 (33%), 22 sites
	Percentage that return after 6 weeks	Oct'12 (0%), 2 sites	Sept13 (7%), 14 sites
PHFS	Percentage of HIV negative women retested for HIV as per national guidelines	Apr'13 (12%), 5 sites	Sept'13 (26%) 9 sites
	Percentage of HIV exposed infants whose mothers were put on ART	Apr'13 (92%), 15 sites	Sept'13 (92.4%) 17sites
	Percentage of HIV positive mothers who receive IYCF counseling at each visit	Apr'13 (24%), 15 sites	Sept'13 (76%) 13 sites

	Percentage of HIV positive mothers who receive maternal nutrition counseling at each visit	Apr'13 (23%), 15 sites	Sept '13 (81.2%) 14sites
	Percentage of exposed infants reporting to be adhering to recommended IYCF practices	Apr'13 (73%), 20 sites	Sept'13 (71%) 17sites
	Proportion of HIV positive pregnant and lactating mothers who receive nutrition assessment every month	Apr'13 (20%), 19 sites	Sept'13 (72.2%) 17sites
	Proportion of exposed infants who receive nutrition assessment every month	Apr'13 (32%), 16 sites	Sept'13 (81.2%) 16sites
	Proportion of HIV positive mothers who are found to be malnourished during the reporting period	Apr'13 (0.88%), 11 sites	Sept'13 (3%) 12sites
	Proportion of exposed infants found to be undernourished and receive therapeutic or supplementary feeding support at any point during the reporting period	Apr'13 (100%), 3 sites	Sept'13 (00%) 6sites
	Proportion of HIV positive mothers found to be undernourished and receive therapeutic or supplementary feeding support at any point during the reporting period	May'13 (0%), 2 sites	Sept'13 (48.4%) 3sites
	Proportion of exposed infants who are found to be malnourished at any point during the reporting period	Apr'13 (5%), 1 sites	Sept'13 (0%) 8sites
	Proportion of mother-baby pairs retained in care each month	Apr'13 (8%), 15 sites	Sept'13 (41%) 22sites
	Percentage of HIV positive lactating women initiated on ART	Apr'13 (41%), 8 sites	Aug'13 (92.2%) 16 sites
FP	Proportion of women Post Obstetric event that are counseled on FP before discharge	April 13 (23%), 18 sites	Sept 13, (71%) 10 sites
	Proportion of women Post Obstetric event that are counseled of FP with partner before discharge	April 13 (00%), 18 sites	Sept 13 (20%), 15 sites
	Proportion of women Post Obstetric event that are provided with a FP method of choice at discharge	April 13 (00%), 17 sites	Sept 13 (4%), 15 sites
	% of mothers delivering at the facility who receive AMTSL per week.	Jan 12(05%) ,10 Sites	Sept 13 (96%), 20 sites
	% of mothers delivering at the facility who were correctly monitored by a partograph per week.	Jan 12(04%) ,10 Sites	Sept 13 (73%), 20 sites
	SMGL (20 sites)	% of live births who received ENBC per week	Jan 12(01%) ,10 Sites

What Are We Learning?

- How we can identify communities affected by poor retention or adherence? Documentation of PLHIV's physical locations on their ART clinic records helps to identify communities with retention

or adherence gaps.

- When focus is put on improving patient level data (data quality), a noticeable improvement will occur in other process indicators.
- Engagement of district and health facility leaders in QI work helps to create ownership and sustainability.
- Retention of mother-baby pairs is paramount. If they are not retained, elimination cannot be measured and services cannot be provided.
- Uptake of FP remains low despite the increasing counseling. This is attributed to myths and misconceptions in the communities
- When IPs are involved in joint QI work, good level cooperation is received from health facilities and remedial actions that require direct involvement of partners at the facilities is forthcoming.
- Involvement of community structures leads to improvement as evident in the OVC and community HIV work.

Directions for FY14

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

ASIA

1.14 India

Background

Beginning in FY13, USAID India invited ASSIST to work on enhancing improvement capability in the Indian health system at the national, state, district, facility and community levels through engaging and capacitating national and state structures to conduct improvements. Consistent with the February 2013 Call-To-Action, the technical focus will be on the “R-MNCH+A” continuum – Reproductive Health, Maternal, Neonatal, Child, and Adolescent Health. The work is to include both public and private entities. ASSIST is to work with and through the Government of India, National Rural Health Mission, supporting their Technical Support Unit, the State Governments in six selected USAID priority States, and 30 priority District Governments. USAID India has determined that ASSIST is to also engage key professional organizations including:

- National Institute of Health and Family Welfare
- National Health System Resource Centre
- Federation of Obstetrics & Gynecological Societies of India
- Indian Academy of Pediatrics

Program Overview

What are we trying to accomplish?	How will we know?	At what scale?*
1. To improve care along the R-MNCH+A continuum in priority USAID districts; develop the capacity to conduct improvement among health care workers at the community,	<ul style="list-style-type: none"> • Document improvements in care along the R-MNCH+A continuum • Health workers at the community, facility, district, state and national level are implementing improvement and achieve results • Leadership at the community, facility, district, state and national levels are engaged in leading improvement 	ASSIST is expected to work in: all six USAID-supported states, and all 30 of the USAID-supported districts, and one “Block” in each of the selected districts: Delhi: two districts, two blocks Himachal Pradesh: four districts, four blocks Punjab: five districts, five blocks Uttarakhand: three districts, three blocks Jharkhand: 11 districts, (staff placed in six

<p>facility, district, state and national level; and enhance commitment and capability of leaders at the community, facility, district, state and national level to lead health care improvement</p>		<p>districts) Haryana: seven districts, seven blocks Total expected number of facilities: 400-500 Total expected population coverage: 3.5-4M</p>
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Key Activities, Accomplishments, and Results

- ASSIST started activities in August 2013. To date, the focus has been setting up the administrative structure, recruiting staff, meeting the key government and NGO partners and developing the project work plan which was approved by USAID India on September 23, 2013.
- Administrative activities have focused on recruiting the Senior Finance and Administration Manager to oversee daily operations and finalizing standard operating procedures. Interviews for state and district coordinators are 80% complete.
- Finally, ASSIST has made progress in establishing key relationships with government partners. The ASSIST staff has initiated discussions with the Joint Secretary in the Ministry about how to improve care. In the state level, discussions about the ASSIST work plan have been initiated with senior leaders in Haryana, Himachal Pradesh, Jharkhand, and Punjab.

Directions for FY 14

Improvement work will be active in 27 districts across the RMNCH+A spectrum.

Improvement Strategy

Document improvements in care along the R-MNCH+A continuum. Health workers at the community, facility, district, state and national level are implementing improvement and achieve results. Leadership at the community, facility, district, state and national levels are engaged in leading improvement.

2 Global Health Core-Funded Activities

2.1 Family Planning/Reproductive Health

Background

ASSIST core-funded FP work builds on the work of the predecessor USAID Health Care Improvement project to continue to generate innovations and learning related to service delivery strengthening models and improvement approaches that can support more effective and sustainable delivery of a full range of high-quality FP services.

At the request of the PRH unit, ASSIST core-funded FP activities in FY13 were combined to the extent possible with field funding and other sources of partner funding to maximize the reach of core FP funds. ASSIST continued to apply improvement approaches to support country implementation work and to develop technical leadership materials related to client-centered counseling and delivery of a comprehensive package of FP methods including long-acting methods (e.g., implants, IUCDs), injectables, Lactation Amenorrhea Method, oral contraceptives and barrier methods for women of reproductive age across a range of service types.

Program Overview

What are we trying to accomplish?	How will we know?	At what scale?
1. Promote better health and social outcomes for women of reproductive age and children through delivery of high-quality FP services during routine MNCH, RH & HIV services	Global Technical Leadership: <ul style="list-style-type: none"> Increased use of improvement methods by FP/MNCH partners Menu of FP quality measures 	Global
	<ul style="list-style-type: none"> Routine FP counseling for women at every MNCH/RH and HIV service-delivery contact Increased % of women started (or continued) on modern FP method of choice during routine MNCH, RH and HIV services Improved choice & appropriate use of a range of FP methods, including long-acting FP methods (implants & IUCDs) 	<p>Niger: Two districts (20 sites: mix of rural/urban, primary and secondary maternities)</p> <p>Mali/Senegal: Maternities participating in WHO Safe Childbirth Checklist activity</p> <p>Uganda:TBD</p>

Key Activities, Accomplishments, and Results

Activity 1: Promote better health and social outcomes for women of reproductive age and children through delivery of high-quality FP services during routine MNCH, RH and HIV services

Global Technical Leadership

- **ASSIST staff participation and presentation at technical meetings and technical briefs:**
 - ASSIST FP Lead, Dr. Kathleen Hill, participated in the Technical Advisory Group (TAG) on High Impact Practices in FP June 6 – 7, hosted at the UNFPA offices in New York and co-sponsored by USAID, UNFPA, and IPPF. ASSIST staff participated in the preparation of a presentation on mHealth and FP and also contributed to the development of a brief on integration of FP with immunization services.
 - ASSIST staff participated in a July 2013 technical meeting on long-acting FP methods convened by the USAID Office of Population and Reproductive Health (PRH).

In FY13, ASSIST has focused its FP core-funded global technical leadership work on two areas, in particular, for which quality considerations are essential for delivery of effective and safe client-centered FP services:

- **Robust measures and indicators of quality of FP service delivery that can be feasibly integrated into routine facility and MOH health information systems to support continuous improvement of FP services:**
 - A menu of operational quality of care FP service delivery indicators are under development which can be adopted and adapted by country governments and partners to support routine monitoring and continuous improvement of front-line FP services, including indicators of quality of LARC services and FP services for specialized populations (e.g., older women; women with co-morbid conditions).
 - In FY13, ASSIST continued to test and expand on FP service indicators developed initially under the HCI project. In particular, ASSIST FP work in Uganda, Mali, and Niger tackled indicators and strategies to improve continuity of FP services for women initiated on short-acting methods who require more regular contact with FP services.
 - During Q4, ASSIST staff met with USAID PRH counterparts to discuss the ASSIST FY14 work plan. Maureen Norton (USAID PRH) expressed interest in having ASSIST develop technical tools on pregnancy risks and special FP needs among older women and women with co-morbid conditions (e.g., hypertension).

Niger PFPF services Improvement Intervention

- **Promoted Healthy Timing and Spacing of Pregnancy (HTSP) via improved integration of**

FP counseling and services into routine public and private sector MNCH services:

- ASSIST has been working in close collaboration with the Niger Ministry of Public Health, managers and front-line providers to promote HTSP via improved integration of FP counseling and services into routine public and private sector MNCH services in the Niamey and Birnin Konni districts.
- Completed the baseline assessment and results analysis. Dr. Maina Boucar and the Niger team completed a draft of a concept note that describes the objectives and the overall workplan of this activity and the specific improvement intervention. These objectives and a final improvement strategy is being refined with key stakeholders in light of the final baseline assessment results and key stakeholder input.
- During Q4, a visit to Niger was conducted by USAID West Africa and E2A project with meeting with Dr. Maina Boucar to discuss collaboration on USAID-funded FP work in Niger.

Table 9 below summarizes the four improvement aims defined by ASSIST design team and under discussion with the Niger MOH and partners to achieve the overall goal of ASSIST FP work. It is anticipated that the improvement aims summarized above will be sequentially introduced as part of the phasing of the improvement work to maximize results.

Table 9: Goal and improvement aims of USAID ASSIST FP work in West Africa

Improvement Goal: Achieve better health outcomes for women, children, and families by promoting HTSP with a focus on reducing unmet need for FP services during the early and extended post-partum period via integrated delivery of FP and MNCH services
Improvement Aim 1: Achieve HTSP for women of reproductive age by improving integration of mixed methods FP counseling and services into routine maternal and newborn early post-partum health care services (including long-acting methods)
Improvement Aim 2: Achieve HTSP by improving integration of mixed methods FP counseling and services into routine (and possibly non-routine) infancy and early childhood health visits (e.g. immunization, well-child visits, possibly sick-child contacts)
Improvement Aim 3: Decrease LTFU of women using short-acting methods, and reduce requested reversal of long-acting methods, by improving FP counseling, screening, and follow-up of FP users (via facility, community and mHealth platforms)
Improvement Aim 4: Strengthen routine FP information systems to support continuous improvement of integrated FP/MNCH services, including development of simple FP uptake, retention and service quality indicators that can be integrated into routine health management information systems to track and inform continuous improvement of post-partum FP services

Mali and Senegal: Integration of PFP into a WHO Safe Childbirth Checklist intervention in selected maternities:

- The WHO Safe Childbirth Checklist, developed through a rigorous WHO international consultation in 2009, contains 29 items that address the major causes of maternal death and neonatal deaths in low-income countries; the checklist includes post-partum FP as one of its priority items. HCI participated in the 2009 WHO international consultation to develop the first draft of the checklist and in subsequent early field testing of it in Mali in 2010.
- In 2012 WHO PSP launched the Safe Childbirth Checklist Collaboration as a platform for organizations working in maternal and newborn health to work with WHO to study the implementation and usefulness of the checklist in diverse health care settings with a focus on implementation questions related use of the checklist in diverse settings to improve quality and safety of maternal newborn and FP services. ASSIST is collaborating closely with its partner, WHO PSP, to implement the checklist activities in Senegal and Mali. The work in Senegal will be supported by a combination of core FP and core MNCH funds while the implementation and research work in Mali will be primarily supported through Mali field funds. However, every effort will be made to promote shared learning between ASSIST PFP activities in Senegal and Mali.

Senegal

- ASSIST AOR reached out to explore the Senegal Mission's interest in a FP and MNH core-funded project to test implementation of the WHO Safe Childbirth Checklist in a subset of selected maternities, including routine delivery of PFP as one of the essential checklist items. After an initial lapse, the Senegal Mission responded favorably to the request of ASSIST AOR and in Q4, a conference call was held with the USAID Senegal Mission in which the mission expressed support for the proposed activity and invited ASSIST to plan a country visit. The first draft of a concept paper for the WHO Safe Childbirth Checklist activity was completed and is being reviewed internally. The concept note will then be shared with USAID PRH counterparts and the Senegal Mission in preparation for a country visit.

Mali

- Through a combination of field and very modest core FP funds, the WHO Safe Childbirth Checklist will be introduced into a subset of maternities participating in Mission-funded ASSIST PFP and maternal newborn improvement work currently being implemented in more than 100 maternities in six districts.
- A modest research activity is being linked to the Mali Safe Childbirth Checklist activity focused on two to three priority research questions related to successful implementation of clinical checklists, with strong emphasis on implementation of the PFP component of the checklist.

What Are We Learning?

- The opportunities and challenges for integrating FP services into routine post-partum care in urban and rural low-resource settings.
- The importance of applying innovative improvement approaches to sustain regular follow up and adherence with short-acting FP methods (especially short-acting methods initiated during the post-partum period).
- The need for more robust implementation support materials and quality measures that can be feasibly integrated into routine facility and health information systems to support continuous improvement of a full range of client-centered FP services and methods, including services for women with special needs (adolescent, older women; women with co-morbid conditions).

Directions for FY14

- Continue to develop and test as part of country-level implementation FP quality of care process measures to support continuous improvement of FP measures as part of integrated FP/MNCH services.
- Participate in November 2013 Ethiopia Global FP Conference (HCI Afghanistan FP oral presentation accepted).
- Continue development of quality of care indicators and technical tools to support improved delivery of client-centered FP services (counseling, screening and method delivery) for older women and women with co-morbid conditions.
- Begin implementation of FP improvement activities in Niger based on final improvement design template in the first quarter of 2014.
- As soon as FY14 funding is obligated (core FP and MNCH), plan visit to Senegal and Mali in collaboration with ASSIST partner, WHO PSP, to launch WHO Safe Childbirth Checklist activities and develop detailed work plan.
- Consider possible FY14 implementation of FP activities in Uganda, pending final FY14 core FP funding obligation and in light of Uganda country FY14 work plan

2.2 Health Workforce Development

Background

Development of an improved health workforce is accomplished through innovative research. This research is used to develop practical tools and guidance to analyze and strengthen health workforce planning, management, and development. Applying improvement approaches to engage health workers in providing quality care and to empower health teams to deliver better services to more users is an integral part of systems strengthening. Improving performance, and increasing

productivity and engagement maximizes the existing human resources, which is crucial in low-resource settings where health worker shortages are one of the greatest challenges facing the health system.

The ASSIST project highlights health workforce development as an essential component to improving quality of care. Integrated with strategies to improve clinical practices and streamline system processes, the ASSIST applies innovative approaches to address the human factor as part of the project's quality improvement activities. Addressing factors that impact human performance has been shown to contribute to raising the quality of HIV care and services. In many countries the performance of health workers is constrained by factors such as unclear expectations, limited feedback and supervision, absence of incentives or career paths, and a need for continual professional development. In addition, work environment constraints, including regular stock-out of medicines, supply shortages, high levels of staff turnover, and unsafe or unstable conditions challenge the ability to perform.

Some of the interventions that the ASSIST's project has implemented to address these factors include:

- Clarification of roles and expectations, rationalizing tasks among team members, and introducing performance measurements; Development of financial and non-financial incentives, such as bonus mechanisms and /or public recognition to acknowledge advancements in performance and responsibilities, coupled with disincentives discourage poor performance;
- Establishing performance feedback processes among members of the care delivery team, supervisors, and community members;
- Enhancement of the work environment, including both the physical environment (such as safety and the availability of supplies) and the non-physical environment (including management practices that build confidence and security, mechanisms for coordination and communication, and protection from violence or harassment), to enable health workers to perform at their best;
- Building the competencies needed to implement tasks and perform at expected levels.

Program Overview

What are we trying to accomplish?	How will we know?	At what scale?
<p>1. Tanzania District Management Activity</p> <ul style="list-style-type: none"> • Enhance the performance of Regional and Council Health Management Teams (RHMTs/CHMTs) in their functional domains and in their capacity to implement QI practices and to support QI activities in health centers 	<ul style="list-style-type: none"> • % of facilities that submitted supply orders and reports on time to CHMT • % of supply orders and reports which were processed by CHMT within two weeks of receipt and sent to RHMT. • % of management team members with clear and rationalized job descriptions • % of management teams that self-report improved competencies in QI practices • % of newly recruited staff that are retained at 6 months • % of health facilities applying improvement approaches to improve health services • % of staff at district hospital that have undergone and annual performance appraisal 	<p>All 6 districts of Lindi Region: # of health facilities at the Region – 192</p> <p># of Health facilities per District:</p> <ul style="list-style-type: none"> • Kilwa-41 • Lindi DC-41 • Lindi Municipal-15 • Nachingwea-36 • Ruangwa-29 • Liwale-30
<p>2. Community-level QI Collaborative in Oromia, Ethiopia</p> <ul style="list-style-type: none"> • Sustain the QI team activities aimed at improving the performance of Health Extension Workers 	<ul style="list-style-type: none"> • % of pregnant women who receive ANC services from the Health Post 	<p>Two districts 18 villages</p>

<p>(HEWs) to provide ANC services at Health Post, and to spread that QI approach to performance improvement to other districts</p>		
<p>3. Community support for Village Health Team (VHT) Performance, Uganda</p> <ul style="list-style-type: none"> • Improve the engagement and performance of VHT to provide quality chronic care services to PLHIV for self management at the community level 	<ul style="list-style-type: none"> • % of VHTs who recount that they have received monthly feedback from their supervisors • % of VHTs who recount that they have received feedback from the community representatives every month • % of PLHIVs located by VHTs • % of PLHIV on ART identified by VHTs • % of PLHIV on ARV adhere to ART • % of PLHIV who have developed self management plan • % of PLHIV who have improved clinical outcomes • % of PLHIV visited by VHTS • Improved level of engagement as measured by an adapted engagement assessment tool. 	<p>One district - Buikwe</p> <ul style="list-style-type: none"> • 1 out of 112 districts (Buikwe) • 10 out of 475 villages • 1 out of 16 Health Facilities • 10 Village Health Teams • 20 out of 950 members of VHT
<p>4. Pharmaceutical HR/QI Collaborative, Uganda</p> <ul style="list-style-type: none"> • Strengthen pharmaceutical human resources (HR) and develop core competencies to apply improvement approaches • Improve the availability of HIV, TB and medicines for opportunistic infections • Improve client retention, medicines use, adherence and outcomes 	<ul style="list-style-type: none"> • % of improvement team members with core improvement competencies • % of pharmaceutical human resources with clear and rationalized job descriptions • % of sites that submitted medicines requisition orders within National Medicines Stores deadlines • % of sites with ART stock cards that are fully compliant to the ART stock card completion checklist • Number of days between stock-outs of selected HIV care and TB medicines (HERZ, Duovir-N, co-trimoxazole) • % of clients that can correctly explain how to use their medicines • % of ART clients collecting their medicines as scheduled • % of ART clients with good adherence (as defined by national standards) • % of ART clients demonstrating clinical improvement (as defined by national standards) 	<p>14 HIV care health facilities in 3/112 districts: Jinja, Tororo, Bukedea</p> <p>Average HIV prevalence in the three districts is 5.0%, with an estimated population of 1,143,800 in the 3 intervention districts</p>

<p>5. In-service Training</p> <ul style="list-style-type: none"> • Provide guidance for the improvement of in-service training effectiveness, efficiency and sustainability • Support the national assessment of the in-service training situation in one country 	<ul style="list-style-type: none"> • Publication and launch of the in-service training improvement framework and guidance • Publication of national in-service training situational assessment findings 	Global
<p>6. Global Health Workforce Alliance (GHWA)</p> <ul style="list-style-type: none"> • Provide technical assistance to USAID and OHA to contribute to agenda of the Forum so that the learning gained from the USAID projects of HCI and ASSIST may be disseminated to key audiences 	<ul style="list-style-type: none"> • ASSIST will participate and contribute, along with USAID counterparts and in collaboration with USAID objectives, to the planning meetings, sessions, and papers for the Forum • ASSIST • In addition, ASSIST will contribute to conversation among GHWA stakeholders, promoting the importance of performance improvement in advancing universal health coverage. 	Global
<p>7: mHealth support for CHW performance</p> <ul style="list-style-type: none"> • Stimulate the development and deployment of mobile electronic tools to improve the performance of low-literacy community health workers. 	<ul style="list-style-type: none"> • Cell phones will overcome obstacles to communications between VHTs and District Hospital or health centers. • # of conversations between the health center supervisor and VHT / # of weeks in the month. • VHTs will receive regular phone-supervision from supervisors, as well as feedback. • # Of conversations that included feedback and/or supervision / # of conversations • It is expected that the increased communications, feedback and supervision will lead to improved performance (measured by indicators in the Uganda community support activity) and increased engagement (also measured in the Uganda Community Support activity with an adapted engagement assessment tool) 	Uganda: (the health workforce activity will be in one District – Buikwe- and that activity will share results with one other District where mHealth will be introduced as part of the change package for a chronic care HIV project.

Key Activities, Accomplishments, and Results

Activity 1. Tanzania District Management Collaborative

- **Enhanced the performance of Regional and Council Health Management Teams in their functional domains (supplies and logistics, information flows, regional planning, HRH support) and in their capacity to implement QI practices and to support QI activities in to health centers.**
 - **CHMT Job Descriptions:** Management team members have full time professional positions, and they are assigned to management responsibilities in addition to those responsibilities when they reach a certain level in their field (for example, the District Medical Officer is always a member of the Council Health Management Team. Therefore, the primary responsibility of the CHMT members is their technical professional role. Not only does their CHMT role compete with their primary responsibilities, but also, the job descriptions for the CHMT roles which come from the national level..are vague, and do not clarify tasks or responsibilities. Therefore, there is usually little clarity regarding which CHMT members should take accountability and leadership for which roles that the team must perform. The

exercise of creating job descriptions among the district's council health management team through HCI and ASSIST has been helpful in streamlining and rationalizing tasks. The % of management team members with clear and rationalized job descriptions increased from 0% in December 2010 to 100 % in June 2013 (end of third quarter FY13)

- **Supply Orders:** Through December 2010, 74% of facilities in the Lindi Region submitted their quarterly supply orders on-time. To improve the availability of medicines and supplies in the health facilities the district management teams (CHMTs) aimed to raise the percent of on-time supply order submissions. . With assistance from the ASSIST and HCI projects, training on how to fill the Requesting and Reporting forms minimized unnecessary errors and back and forth movement to correct and re-submit requisitions. Hence, submission of properly filled orders was improved. Another change that was made in the process that a secretary or clerk was assigned with the responsibility for collecting all the reports and orders, and that person also now calls the facilities approximately one week in advance of submission date to remind them of the coming deadline and offer any support for problems with completing the documents. The percentage of facilities that submitted supply orders increased from 74% in December 2010 to 94% in the last measured quarter (third quarter of FY 13).
- **Reports are submitted to Regional Office on Time:** The clarification of responsibilities among the CHMTs helped to improve the processing of supply orders and reports to advance them to the Regional Health Management Team so as to support the timely and efficient supply chain. The % of district level reports that were processed and submitted to the region within two weeks of receipt from the facilities moved from 71% in March 2011 to 91% in June of 2013; and the % of requisitions that were processed and submitted to the RHMT within two weeks of receipt also rose slightly from 91% in March 2011 to 97% in June of 2013.
- **Staff Retention:** The indicator to monitor staff retention was established to be measured every six months. (The previous indicators are quarterly indicators). Staff Retention always poses a challenge to rural and remote facilities because when health workers arrive at their assigned post and discover the shortage in resources and the distance from amenities, they often prefer to return to a more accessible environment to wait for an alternate assignment. The CHMTs in the Lindi Region shared change ideas that were effective for influencing new staff arrivals to remain. Further complicating the challenge, new staff usually arrived un-announced, and many times did not fit the open position request that had been submitted. Therefore, the facilities staff, who are already over-stretched with immediate patient needs, were not prepared for their arrival to give the new staff any work assignments. Second, there were many times no living quarters prepared. Third, the new staff would have no stipend or spending money during the usual 6-month waiting period until they would finally be processed through the payroll to begin receiving regular monthly pay-checks. One of the interventions that proved effective in addressing these problems was what the CHMTs labelled as "Orientation Packages." With this package, the CHMTs arranged for a process of welcoming staff was established so that whenever staff arrived, a member of the CHMT had assigned someone to introduce them to the facilities staff, orient them to the facilities processes and procedures, and help them to meet the district officers. In addition, the districts set aside money from the budget to keep an apartment ready with essential necessities provided so new staff could immediately have a place to live. Finally, the districts also set aside a small stipend to allow the new arrivals to have spending money until their payroll status was confirmed, at which time they reimburse the advance from their pay-checks. After implementing these orientation packages the percentage of new staff that was still remaining at the facilities at six months after arriving went from 69% in March 2011 to 89% in March 2013.
- **QI Competencies:** One of the purposes that the ASSIST project pursued through the District Management activity was in response to the Lindi Region's desire to spread the Quality Improvement approach to other facilities within its region. Therefore, one of the goals of the activity is to improve the QI competencies of the district managers, or the CHMTs, so they will effectively orient their facilities to quality improvement and they will be prepared to coach the facilities QI teams in their developing, testing and institutionalizing changes that lead to improved delivery of care. A self-assessment with 11 different questions was developed to

determine how comfortable the CHMT members are with leading QI activities and how they rank themselves in their knowledge and skills in QI. Working with URC/ASSIST coaches, the CHMTs improved their QI scores from 0% in March 2011 to 67% in March 2013. This indicator is measured annually.

- **% of Health Facilities Applying Improvement Approaches** (out of 192 facilities): During the project, the RHMT added this indicator to monitor the spread of QI within the Lindi region. As the QI competencies improved, the CHMTs decided that they were prepared to orient their facilities in the QI approach and guide them in developing QI teams to monitor and improve their HIV indicators (indicators developed by national Ministry of Health and Social Welfare). The CHMTs lead a learning session in which they each worked with two facilities teams (and one District worked with three facilities) to establish a plan for setting up a QI team in their facilities and testing change ideas and implementing changes that improved their HIV indicators. Having added these teams in May of 2013, and continuing to work with these teams, the CHMTs have increased the percentage of facilities in the Lindi region applying QI approaches from 5% in March of 2011 (10 facilities) to 12% in March 2013 (23 facilities). This indicator is measured every 6 months.
- **Improved Supervision:** One of the approaches to improve supervision that the CHMTs identified was to follow through on performing annual performance evaluations on the district staff. They arranged a training on the evaluation technology system when they determined that the initial training had been too confusing. They also updated the manuals so that the evaluators could more easily follow them in completing the evaluations. The results of the effectiveness of these change ideas and the achievement of the goal to complete all of the annual performance evaluations will be measured in September 2013.

Improvement Strategy

Six priority areas for improvement in HIV/AIDS care delivery were identified by six district teams. These include logistics and supply chain, the information system, the QI competencies, clarification of expectations, district planning and finally human resources management. Human performance technology was applied to the district teams to support and strengthen the management process improvements.

Spread Strategy

District management teams will have developed more effective and efficient management processes that support the facilities and that enable better care delivery at both the district and facilities levels. These teams will have built a body of evidence to show easily implementable changes in daily and monthly practices can improve management performance and thus improve and support better HIV care and service delivery across the Region.

Activity 2. Virtual Support for HEW Quality Improvement Teams in Ethiopia

- **Sustained the QI team activities aimed at improving the performance of HEWs to provide ANC services at Health Post, and to spread that QI approach to performance improvement to other districts**
 - Ilu and Tole Districts: Funding was delayed through second and third quarters of FY13 after this activity was moved from the HCI portfolio to ASSIST. In the fourth quarter, Community QI teams along with the support from health center staff and the district health office continued QI activities. The Asgori health center expanded Community QI activities in two new villages. A new Community QI team identified 36 pregnant women and referred them to Asgori PMTCT center for ANC services in this quarter. They were also able to built 423 latrines out of 579 households of the villages.

Activity 3. Community Support for VHT Performance, Uganda

- **Improved the engagement and performance of VHT to provide quality chronic care services to PLHIV for self management at the community level**
 - *Buikwe District:* Patients living with HIV (PLHIV) in Buikwe District are identified through a community health system approach that brings together a network of community actors to support VHT activities. The activities include identifying and supporting HIV patients to manage their condition better. Each of the community actors performs a different role ranging

from transferring information from QI team to the community, mobilizing communities, raising awareness, linking patients to HIV support structures, mobilizing community resources among others. As of fourth quarter in FY13, the number of HIV patients identified through the community network increased from 458 to 607. As of third quarter in FY13, patients identified by VHTs alone as part of the network increased from 238 to 252 (April only data). This demonstrates that VHT's performance in patient identification doubles if they function as part of a community health system.

Improvement Strategy

Improvement activities focused 1) on bolstering performance of VHTs, community groups, and supervisors; 2) engagement of VHTs, community groups, and supervisors, 3) on self management and clinic outcomes of PLHIV in the villages where there is no improvement activities. A district manger was hired to make regular support visits to identified facilities and communities to insure continued reinforcement of community group participation with facility cooperation in QI activities as a way to support VHT performance.

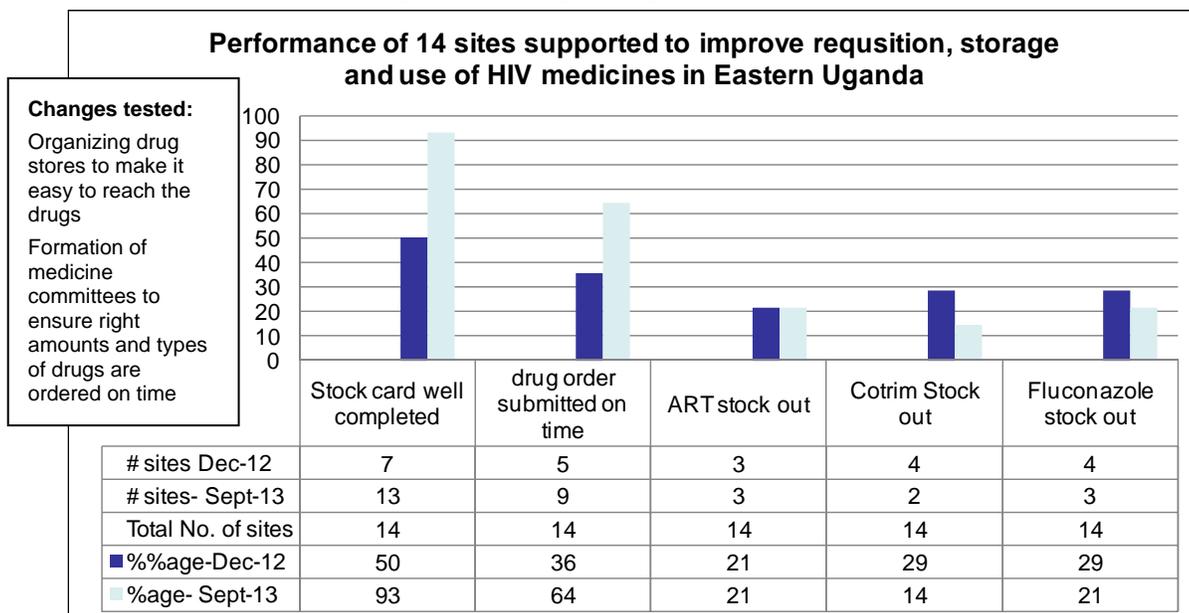
Spread Strategy

Community QI teams share their best practices in learning sessions in every quarter of the project. These learning sessions are attended by MOH managers and implementing partners. Sharing knowledge and results of successful strategies will inform managers, as well as visiting and district level decision makers.

Activity 4. Strengthening Pharmaceutical Human Resources and Improving Medicines Use and Availability in Uganda: Results and Progress in the Reporting

- **Strengthen pharmaceutical human resources and develop core competencies to apply improvement approaches.**
 - *Jinja, Tororo, Bukedea Districts:* Onsite coaching visits were conducted once every month for two months covering all the 14 sites. The purpose of the coaching visits was to support sites to identify gaps and possible solutions to the gaps. The coaching visits were conducted by coaches who were trained by USAID ASSIST staff. A total of 138 staff was mentored on quality improvement. As a result of the coaching visits, there were improvement in the number of sites that have updated stock cards for medicines, submit drug requisitions to National Medical Stores on time and fewer sites experienced drug stock out as of fourth quarter in FY13 (see Figure 28).

Figure 28: Eastern Uganda: Performance of 14 sites supported to improve requisition, storage and use of HIV medicines (Dec 2012-Sept 2013)



Improvement Strategy

USAID ASSIST is supporting 14 health units in Eastern Uganda to reduce stockouts and improve medicines use supporting staff involved in medicines management to improve processes of forecasting, storage and dispensing of medicines. All this is aimed at improving ART clients' adherence, retention in care and clinical outcomes. We are providing technical assistance to MOH district coaches who are providing monthly support to facility level improvement teams to apply the model for improvement and address human performance factor of clarity of roles and task expectations.

Spread Strategy

District coaches usually brief the District Health Officer on progress, findings, challenges and lessons learnt each month after coaching visits – this fosters greater ownership and sustainability. Learning session is planned for the next quarter to share lessons learnt across districts, central level MOH and other districts that may be interested to test effective changes.

Activity 5: In-service Training

- **Provided guidance for the improvement of in-service training effectiveness, efficiency and sustainability**
 - *Global:* USAID ASSIST in collaboration with USAID, Jhpiego, I-TECH and IntraHealth launched an open access journal series on improving health worker in-service training effectiveness, efficiency and sustainability. Published online in the WHO supported BioMed Human Resources for Health Journal on October 1, 2013, the series focuses on closing the gaps between evidence, practice and outcomes.

Activity 6: Global Health Workforce Alliance

- **Provided technical assistance to USAID and OHA to contribute to agenda of the Forum so that the learning gained from the USAID projects of HCI and ASSIST may be disseminated to key audiences.**
 - *Global:* Two sessions were developed during third quarter of FY13 in which ASSIST participated in the Global Health Workforce Alliance's Third Forum on Human Resources for Health from 10-13 November 2013.
 - One side session, which will be led by USAID, GHWA, NORAD, and the Frontline Health Workers Coalition (FLHWC) addressed the harmonization of CHW programs and the role of partners and governments in advancing the integration of those programs. ASSIST contributed one of three background papers, which is on the Monitoring and Accountability Framework, to this side session. The draft of that paper has been completed and submitted to the other authors, and being finalized by ASSIST. The other two background papers are 1) Partners' Harmonization Framework; and 2) Research Agenda. The agenda for the side session is being planned with the GHWA Forum Global Core Group partners over the next months.
 - A proposal for a second side session has been submitted on the in-service training improvement framework entitled "Improving health worker in-service training effectiveness, efficiency and sustainability: Harvesting good practices and lessons learned". ASSIST was the lead host and partnered with I-TECH, Jhpiego, USAID CapacityPlus and the CDC-supported African Regulatory Collaborative. The structure of this session was a knowledge café, followed by a summary of discussion. The objectives of the workshop are as follows:
 - To launch the first global improvement framework for health workers on IST
 - To harvest and share experiences, strategies, and lessons learned on addressing key IST challenges for health workers
 - To facilitate networking, shared understanding and learning between health workers, Ministry of Health representatives, training institutions, donors and partners to improve IST
 - The following outcomes are expected from the proposed session:
 - Participants will learn about the IST improvement framework and how to use it to improve in-service training systems for health workers

- Participants will enhance their understanding of how to evaluate in-service training program outcomes and impacts
- Participants will gain new knowledge and multi-stakeholder connections to improve in-service training that will enable health workers to provide better care
- Participant experiences, lessons learned and evidence will seed a new global wiki on in-service training improvement

Activity 7: mHealth support for CHW performance

- **Stimulated the development and deployment of mobile electronic tools to improve the performance of low-literacy community health workers.**
 - *Buikwe District:* In January 2013, the USAID ASSIST project received core funding from the USAID Office of Health Systems to be invested in the area of mHealth. Part of the core funded mHealth activity falls under a partnership between the cross-bureau activities of the Office of Health Systems and the OHA HRH project, and this part of the project should focus on how the use of mhealth may contribute to improved performance of CHWs in providing HIV care. In second quarter FY2013, a concept paper for the mhealth activity to be implemented in the Buikwe district was developed and accepted by USAID counterpart.
- **ASSIST staff developed a ledger form to record time of conversation time on cell phone during supervision and feedback session between VHTs and their supervisors (Q3FY13).**

What Are We Learning?

Tanzania District Management Collaborative

- Defining roles, responsibilities, and expectations within the management team helps to improve the performance of the management teams in supporting the facilities.
 - Improving the team members' QI competencies not only improves their ability to spread QI activities across their facilities, but also helps the teams themselves to successfully test changes that will improve their management performance and institutionalize those practices that are most effective.
 - There are variables that are beyond the CHMTs direct control that have significant impact on their ability to effectively lead and support the quality improvement for the facilities in their district. For example, even when the supply orders are sent on time, the zone supply store may not send the needed supplies because often times the stores have not received payment from the central government level. The CHMTs have discussed ideas that they or other CHMTs may test in the future to see how they might act as change agents to influence some of these variables that are beyond their direct control.

Community Support for VHT Performance, Uganda

- Revised coaches log format allows for more effective documentation by coaches of the coaching visits and provides clearer understanding of what aims each facility is focused on and what changes they are testing

Strengthening Pharmaceutical Human Resources and Improving Medicines Use and Availability in Uganda

- Coaches have used coaching logs which were standard in Uganda, however these logs were not kept by the district coaches to guide the teams month to month and were often submitted to the office for administrative purposes. With the renewal of activities in April 2013, a revised coaching log was developed to help coaches with their improvement efforts in the following ways:
 - Through the testing of the revised logs we have learned the following:
 - The log has made it easy for coaches with less experience in improvement to identify issues that need to be addressed
 - Coaches have found the revised logs to be helpful in documenting their findings, what the teams are working on and in making their coaching visits more targeted to the needs of each team.
 - Coaches don't always follow up on issues identified at previous coaching visits and tend to identify new gaps during each visit, which can result in poor continuity of coaching support

- Whenever such logs are developed, it is important that enough space is made available to take notes. Otherwise the available space tends to limit what kind of feedback is obtained from the visit

Global Health Workforce Alliance: July – September 2013

- Partners have learned about the complexities of harmonization through the process of achieving buy-in and coordination among these frameworks and activities and the World Vision Principals of Practice Framework, as well as the Earth Institute's One Million CHW Campaign framework, and the Frontline Health Workers Coalition Strategy. Through the process of harmonization, ASSIST has been instrumental in bringing partners together and creating opportunities to advance all of the initiatives.

Knowledge Management Products and Activities

- Publication of blog titled "Strengthening human resources for health in Uganda: working with frontline health workers to improve medicines use and management in HIV care" on the Knowledge for Health website: <http://www.k4health.org/blog/post/strengthening-human-resources-health-uganda>
- Launch of journal series in the open access BioMed Human Resources for Health Journal: Improving the efficiency, effectiveness and sustainability of health worker in-service training: Closing the gaps between evidence, practice and outcomes: <http://www.human-resources-health.com.series/IST>.

Directions for FY14

Global Health Workforce Alliance (GHWA)

- Participation in the 3rd Global Forum in Recife. The two side sessions will be held in Recife in November. ASSIST representatives will present and will use the opportunity to widen the network of partners and opportunities. Follow-through with harmonization efforts, implementing the monitoring and accountability framework, and pursuing the research agenda.

In-Service Training Framework

Major Products Anticipated:

- Publication of guidance for each recommendation in the IST improvement framework
- Blogs on the K4Health website and GHWA e-platform
- The Human Resources for Health Journal series on in-service training
- Flyer on the IST improvement framework
- Flyer on process for developing a national IST strategy based on HCI and ASSIST country experiences
- Technical report for rapid assessment
- Workshop report for national IST strategic framework development

Tanzania District Management Collaborative

- Gather suggestions for the Management Guide from the CHMT members to share the draft guide with them
- Gather data during first quarter of FY14 on the additional indicator to see if the orientation packages that have been developed as an improvement for retaining staff in the facilities influences staff not only to stay for the first six months, but also influences them to remain through the next month or two after they have been added to the payroll.
- Collect individual stories to reflect experiences in the improved working processes to learn more about how institutionalizing QI into the work practice effects personal experiences.
- Discuss with CHMTs how they might be able to use the monthly visits from the facilities team managers (for submitting reports and collecting salaries) might be used as an opportunity for supportive supervision and for coaching the leads of the QI teams in the 12 facilities that have developed QI teams.

Strengthen Pharmaceutical Human Resources and Improving Medicines Use and Availability in Uganda

- Learning session and synthesis of key learning for spread
- Monthly coaching visits and ongoing testing of revised coaching logs
- Finalize protocol for end line evaluation

Improvement in Key Indicators: Tanzania District Health Management Activity

Indicator	Baseline	Last value
QUARTERLY COLLECTED INDICATORS		
% of facilities that submitted supply orders on time to the CHMT	March 2011: 76%	June 2013: 94%
% of district level reports that were processed and submitted to the region within two weeks of receipt from the facilities.	March 2011: 71%	June 2013: 91%
% of supply orders which were processed by the CHMT within two weeks of receipt and sent to the RHMT	March 2011: 91%	June 2013: 97%
% of management team members that have clear and rationalized job descriptions.	March 2011: 0%	June 2013: 100%
BI-ANNUALLY COLLECTED INDICATORS		
% of newly recruited staff that received a technical orientation within two weeks of reporting	March 2011: 53%	March 2013: 89%
% of newly recruited staff that are retained at 6 months	March 2011: 69%	March 2013: 89%
% of CHMTs that have QI competencies (self-reported) according to an 11-point questionnaire.	March 2011: 0%	March 2013: 67%
ANNUALLY COLLECTED INDICATORS		
% of health facilities applying improvement approaches to improve quality of health services (out of 192 facilities)	March 2011: 5% 10 facilities	March 2013: 12% 23 facilities
% of staff at district hospital that have undergone and annual performance appraisal.	March 2011: 0%	March 2013*: 0%
<ul style="list-style-type: none"> • <i>Note that this indicator will not be measured until September 2013.</i> 		

2.3 HIV and AIDS: Prevention, Chronic Care, and Treatment

Background

The overall objective of ASSIST's core HIV portfolio is to improve and strengthen the capacity of health systems to provide and sustain high quality prevention, care, and treatment services for PLHIV. ASSIST's HIV portfolio built upon the evidence generated and lessons learned from HCI. ASSIST is continuing to work with local governments and stakeholders to: 1) identify gaps in the delivery of quality HIV services; 2) apply improvement science to address health system gaps; and 3)

quantitatively and qualitatively study the impact of these interventions and how best they can be scaled globally.

Under ASSIST in FY13, the HIV portfolio included the following HIV prevention activities: AIMGAPS, improving the quality of the delivery of VMMC services and improving safe injection and waste management practices. With respect to adult treatment, care, and support, the HIV portfolio included improving chronic care management and strengthening community linkages to health facilities for PLHIV.

Emphasis was placed on documenting and sharing knowledge generated during improvement activities through knowledge sharing meetings and the development of case studies that describe the process of change and improvement. Additionally, research was carried out linked to the activities in the HIV portfolio which will provide more robust measures to demonstrate the impact of these interventions and greater use of qualitative methods that will further aid our understanding of 'how' the improvements occurred. Thus ASSIST will contribute to the global evidence base for effective, efficient, and sustainable means to achieve high quality prevention, care and treatment for HIV and AIDS services.

Program Overview

What did we try to accomplish?	How will we know?	At what scale?
1. Improve uptake and retention of PMTCT services (AIMGAPS)	<ul style="list-style-type: none"> Increased early booking at ANC Increased HIV testing of women presenting at ANC Increased male partner involvement in ANC (including HIV testing) Increased exclusive breastfeeding among HIV-positive women 0-6 months postpartum Improved follow-up of HIV exposed infants 	Tanzania: Iringa region (1 of 30 regions in the country). Implemented by 11 of 176 PMTCT programs in 4 of 129 districts
2. Strengthening Community Linkages of PMTCT Services – Tanzania	<ul style="list-style-type: none"> TBD 	TBD
3. Improve the safety and quality of VMMC	<ul style="list-style-type: none"> Decreased proportion of clients circumcised who experienced one or more moderate or severe adverse events within the reporting period Increased proportion of circumcised men receiving counseling on risk reduction and safer sex Increased proportion of circumcised males assessed for STIs Increased proportion of males circumcised within the reporting period who return at least once for postoperative follow-up care (routine or emergent) within 7-14 days of surgery 	Uganda: Over 100 sites in 80 districts (out of 112)
4. Improve HIV Chronic Care and Treatment: <ol style="list-style-type: none"> Improve continuity and effectiveness of HIV/AIDS chronic care through implementation of an adapted CCM 	<ul style="list-style-type: none"> Increased percentage of patients retained in care Increased percentage of patients adherent to ARVs Increased percentage of patients who show clinical improvement Increased percentage of patients with complete and correctly filled medical records 	Uganda: 6 facilities in two districts – Mityana (3 intervention sites) and Nakaseke (3 control sites) Out of a total of 10 accredited ART

<p>b. Evaluate the impact of an adapted CCM on quality of HIV/Chronic Care services and measurable patient outcomes</p> <p>c. Further develop guidance for Expert Patient selection, introduction, capacity building, management, and retention based on lessons learned in the Morogoro District of Tanzania, and the Buikwe District of Uganda</p>	<ul style="list-style-type: none"> • Reduced clinic wait times • Increased percentage of providers who have access to and are using clinical guidelines 	<p>health facilities in both districts</p>
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Key Activities, Accomplishments, and Results

Activity 1. Improve uptake and retention of PMTCT services through the AIMGAPS activity

- *Iringa, Tanzania:* In the fourth quarter of the FY13, AIMGAPS activities moved from HCI to ASSIST, which included a transition from intense to light coaching support at the 11 AIMGAPS facilities, including the three sites where the community component of AIMGAPS was implemented. The transition to reduced technical assistance is to further build the capacity of the R/CHMT to provide coaching and mentoring for QI activities. 29 and 30 below show examples of how some indicators improved, while others lagged behind. The Community HSS Model was implemented under HCI to strengthen the linkages between the community and facility to increase uptake and retention of PMTCT services, including male partner testing. After implementing the model, improvements were observed in male partner testing at ANC, at the three sites with the community component. Figure 29 shows that male partner the change in testing of male partners at all 11 AIMGAPS sites, whereas Figure 30 shows that improvement in male partner testing in the three sites where the model was implemented. Moderate improvements were also seen in the percentage of women booking early (<14 weeks gestational age) at ANC.

Figure 29: Irigna, Tanzania: Percentage of HIV-positive pregnant women initiating ARVs during pregnancy versus percentage of male partners testing for HIV at ANC in 11 sites (Jan 2011- July 2013)

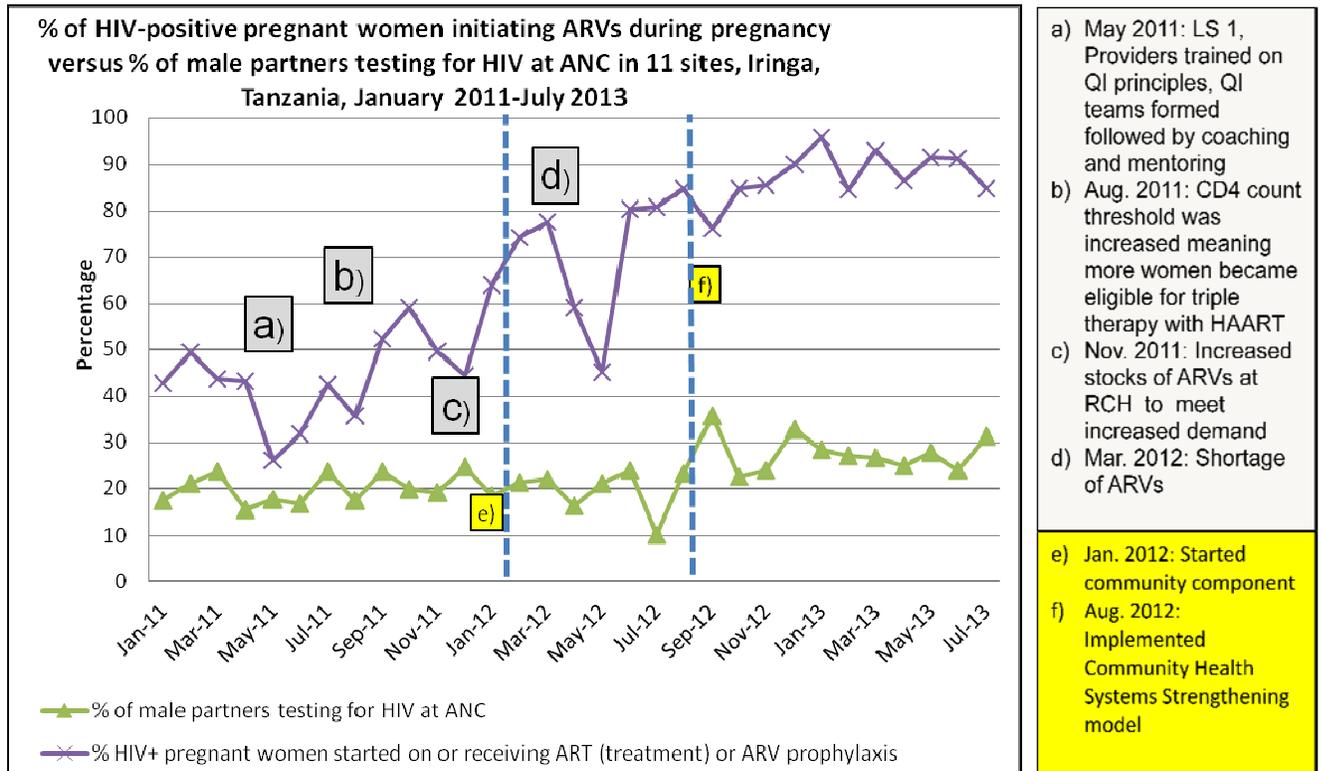
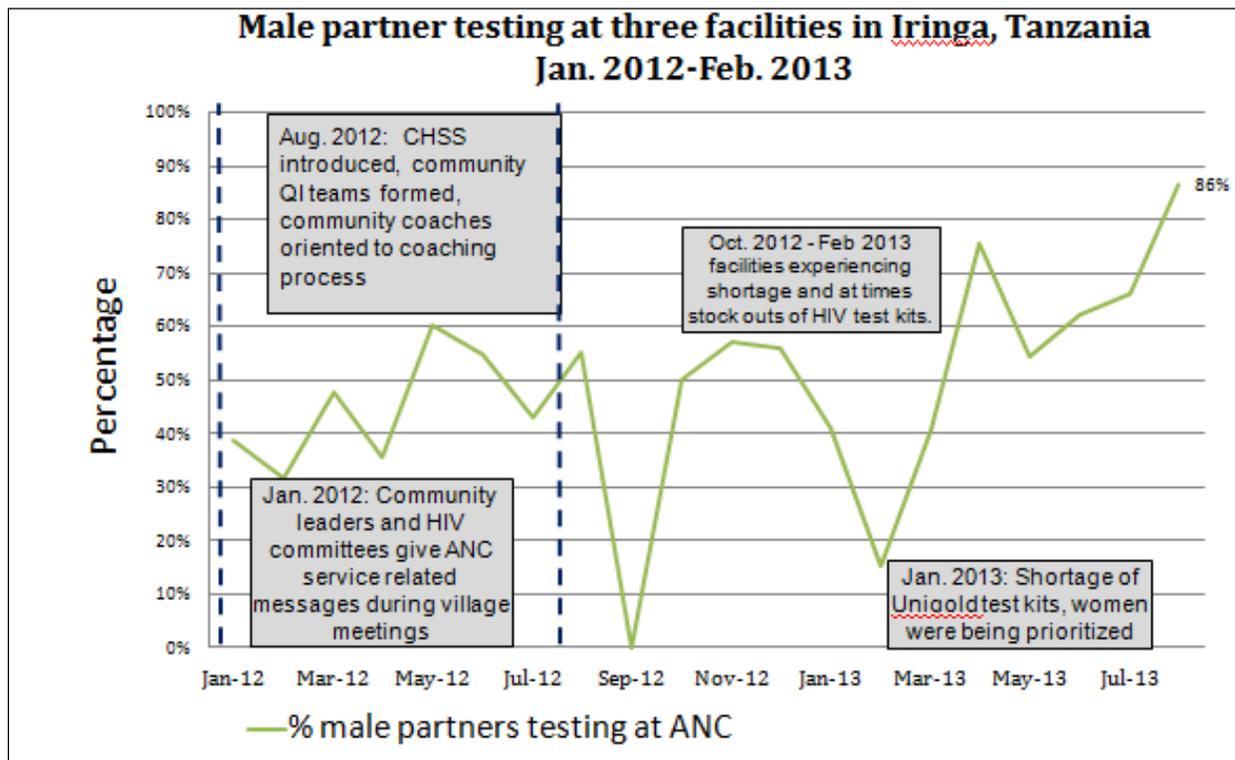


Figure 30: Iringa, Tanzania: Male partner testing at three facilities (Jan – Feb 2013)



Improvement Strategy

The AIMGAPS activity that began in FY11 has been using the collaborative improvement model. The model remained a strategy in FY13 so that all AIMGAPS sites can continue to share experiences by discussing successes and challenges at learning sessions, and continue to receive coaching and mentoring from CHMTs with technical support from ASSIST. The community HSS model was the newest strategy added onto AIMGAPS at the end of FY12. Implementation for both models will follow the Model for Improvement.

Spread Strategy

If community linkage indicators improve after implementing the community HSS model, ASSIST will determine whether the community HSS model led to those improvements. In this case AIMGAPS sites not implementing the community HSS model will act as controls to determine the effectiveness of the model. Based on successes seen in Uganda and Ethiopia after implementing the community HSS model to increase uptake of ANC, it is anticipated that this model will also increase uptake and retention of PMTCT services.

Activity 2: Strengthening Community Linkages of PMTCT Services (Tanzania)

The objective of this project is to demonstrate the impact of the community HSS model in improving the quality of services with appropriate linkages between facility and community in Muheza, Tanzania.

- **Conducted situational analysis in five villages in Muheza District, Tanzania and the following was observed:** Weak linkages between health facility and community and no linkages between health facilities and non- health community workers; facilities do not conduct supportive supervision visits and capacity building training for the community workers; existence of savings group VICOBA, MVCCs, MACS, SACCOS, VICOBA, PLHIV support groups; facilities acknowledge the need for integrating community workers with the facilities.
- The work plan has recently been finalized and QI activities will begin next quarter.

Activity 3. To improve the safety and quality of VMMC

- **Developed a dashboard of key performance indicators:** In the third quarter of FY13, the ASSIST team developed a dashboard of the seven key performance indicators for SMC/VMMC that will be used to identify gaps and monitor the effects of the improvements on these gaps.
- **Conducted 30 VMMC site baseline assessments:** In Q3 of FY13, the ASSIST team completed the 30 VMMC site baseline assessments (24 USAID, 3 DOD and 3 Walter Reed), which assess seven quality areas and are further broken down into 53 standards. The seven areas include the following: 1) Management systems; 2) Supplies, Equipment, and environment; 3) Registration, group information and IEC; 4) Individual counseling and HIV testing; 5) Surgical Procedure; 6) M&E; and 7) Infection Prevention. Partners completed additional site level self assessments. Based on the findings of the assessment, action plans have been developed. QI training has been held for the 30 sites that receive intense support, and coaching visits have started. ASSIST has also provided coaching visits to seven sites that are receiving light support from ASSIST.
- **Held learning sessions:** In Q4 of FY13, the ASSIST team held their first learning session for all 30 sites receiving intense support. The purpose of the learning session include the following: for sites and partners to share their experiences of changes that were tested; for sites to address cross cutting gaps; and for sites to receive continued support from ASSIST, MOH and Regional Coordinators in developing action plans to address gaps.
- **Results:** Since the baseline assessment was conducted, a greater proportion of sites in September 2013 are performing well (i.e. Good >80%) in all of the quality areas including: Management systems; monitoring & evaluation (see Figures 31 and 32 below); supplies, equipment and environment; surgical procedure; and infection prevention which are highlighted in the graphs below.

Figure 31: Uganda: Management systems over time in assessed PEPFAR SMC supported sites (March/April – Sept 2013)

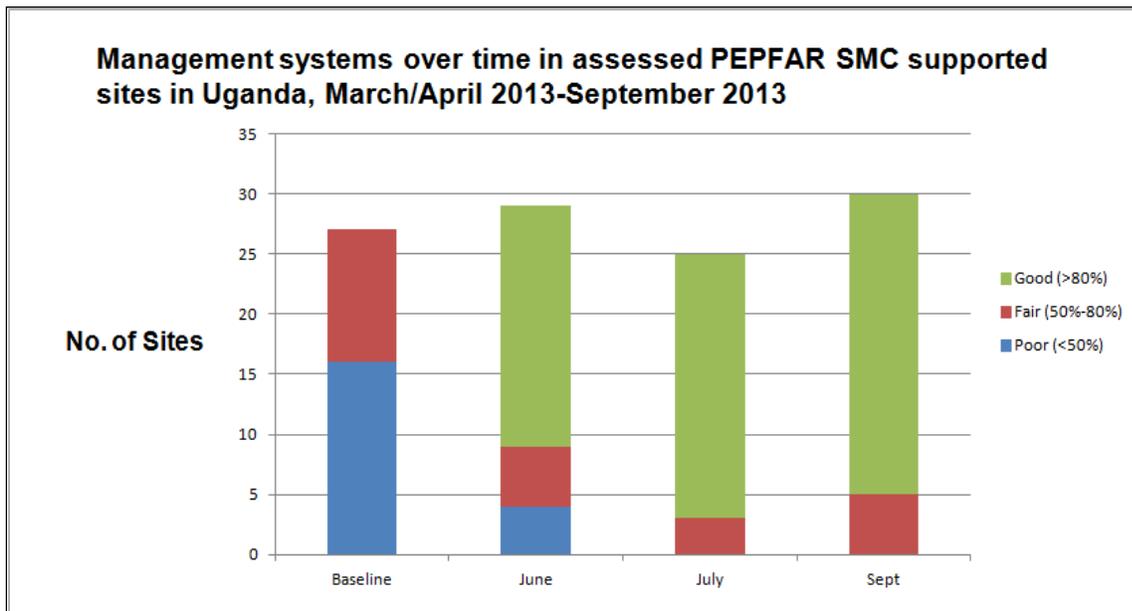
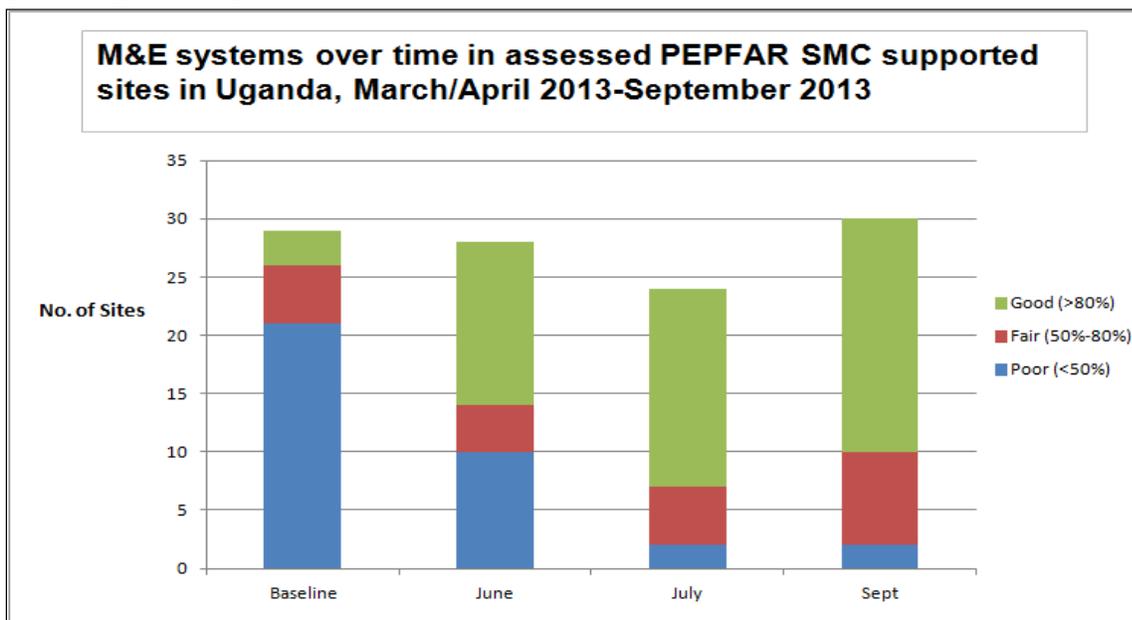


Figure 32: Uganda (M&E systems over time in assessed PEPFAR SMC-supported sites (March/April- 2013)



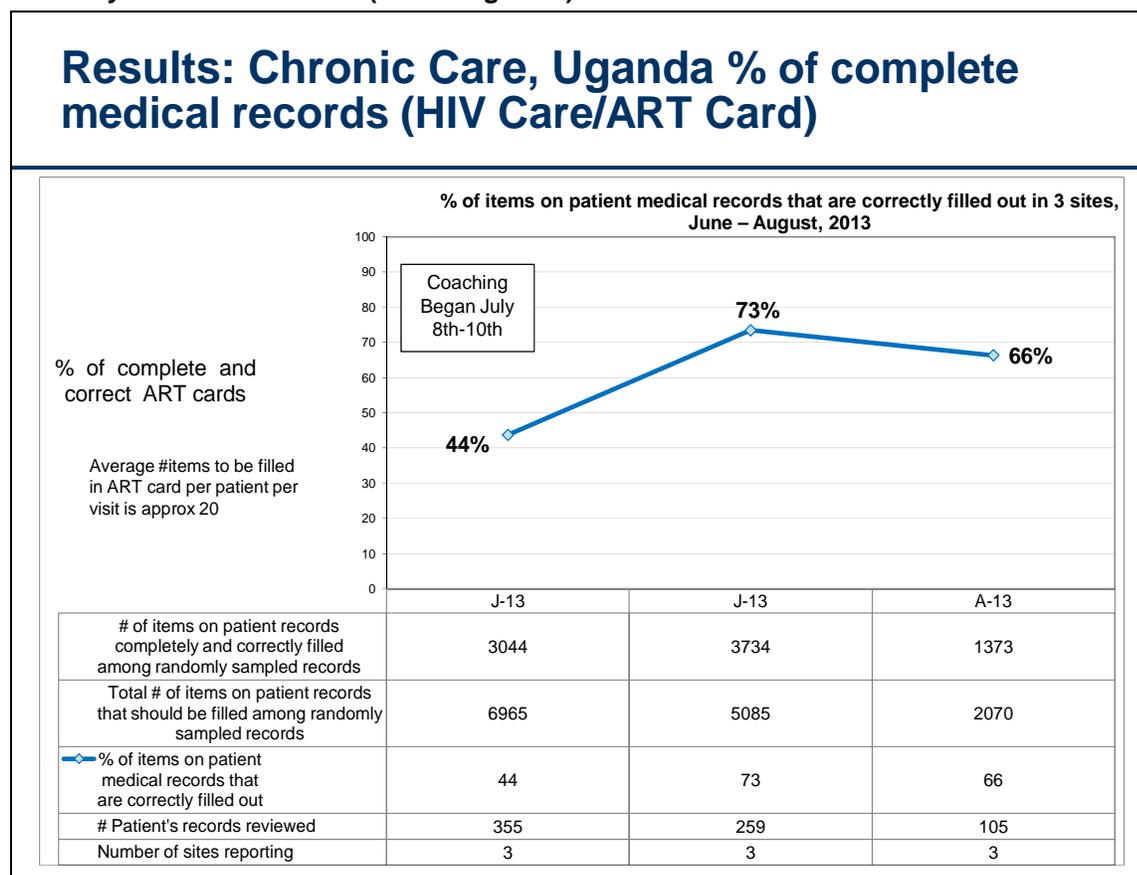
Improvement Strategy

The improvement strategy involves providing intense support to 30 sites, and light support to the remaining IP-supported sites. In addition, ASSIST will provide QI technical assistance to 10 IPs and others designated by USAID, as well as the central and local health governmental authorities. ASSIST has supported the IPs in developing both programmatic and site level QI plans. ASSIST has been providing QI training to DHMT and has held QI training for sites receiving intense support. In addition, ASSIST is using a dashboard for seven key indicators to continue to monitor improvements at the supported sites.

Activity 4a-b: Improve HIV Chronic Care and Treatment: Improve continuity and effectiveness of HIV/AIDS chronic care through implementation of an adapted CCM (Uganda)

- **Improved continuity and effectiveness of HIV/AIDS chronic care through implementation of an adapted CCM.**
 - *Mityana District:* In the third quarter of FY13, three facilities (Mityana Hospital, Mweru Health Center IV, and Padre Pio Health Center III), with support from ASSIST, the Uganda MO, and a local IP (Mildmay), were selected to participate in a QI collaborative to improve the quality of HIV chronic care in Uganda. The ASSIST Uganda team used the change package developed from the chronic care improvement collaborative under HCI project to leverage lessons learned and to spread the CCM interventions to the Mityana District. The spread of the change package and QI methodology was guided by the CCM framework. In the fourth quarter of FY13, interventions at three sites in the Mityana district focused on building the capacity of health workers to provide effective HIV chronic care and to continuously improve their health delivery systems to yield better clinical processes and outcomes. ASSIST and MOH staff facilitated a three-day QI orientation training in June 2013, followed by monthly on-site coaching by a team from ASSIST, MOH and the District Health Office to help sites implement changes targeted for improvement. Data collection was conducted monthly to help identify gaps hindering achievement of site level improvement aims. Figure 33 below shows one area of improvement where three sites focused on improving data completeness and quality of patient medical records (i.e. ART cards). As depicted in Figure 33, substantial progress in data completeness was observed in a few months of improvement work, with nearly a 30% increase over a one-month period from June to July 2013.

Figure 33: Mityana District, Uganda: Percentage of items on patient medical records that are correctly filled out in 3 sites (June-Aug 2013)



Improvement Strategy

To foster improvement, staff from Buikwe district who were involved in coaching during the two-year HCI chronic care improvement collaborative, were invited to participate in coaching in Mityana. During coaching, they shared how changes were tested so that teams from Mityana can learn from changes that were previously tested during the HCI QI collaborative. The chronic care change package document developed from the Buikwe pilot is often referred to and specific changes are selected for implementation at the three intervention sites in Mityana. In an effort to spread and sustain improvement activities, coaching visits are also designed to include at least one DHT member to be available at every coaching visit.

Activity 4c: Improve HIV Chronic Care and Treatment: To further develop guidance for Expert Patient selection, introduction, capacity building, management, and retention

- **CCM Toolkit & Expert Patient Guidance**
 - *Uganda and Tanzania:* One major goal for the Chronic Care work under ASSIST is to develop a comprehensive CCM toolkit that incorporates both Uganda and Tanzania's experiences in implementing CCM interventions to improve the quality of HIV chronic care. A core component of this toolkit is guidance related to using expert patients to support the patient self management and delivery system design components of the CCM. To develop and harmonize the expert patient guidance and strategies to use them to support patient self-management and delivery system design of the CCM, the ASSIST teams from Uganda and Tanzania convened a technical exchange meeting in Tanzania in the third quarter of FY13. The overall objective of the technical exchange was for the country teams to share experiences regarding implementation of the chronic care model with a focus on utilizing expert patients/peer mentors in supporting HIV patient self-management activities. Three members from the Uganda Chronic Care team travelled to Dar es Salaam, Tanzania to accomplish the following objectives:
 - Conduct site visits with the Tanzania team in the Morogoro Region in order to meet with peer mentors, providers, patients, CBOs and other stakeholders involved in supporting self-management processes
 - Document lessons/practices from Tanzania that can be applicable in Ugandan setting to improve the chronic care work
 - Participate in a Tanzania peer mentors meeting
 - Share Uganda's experiences with the Tanzania team in working with expert patients
 - Review and provide input to the development of the expert patient guidance document
- **Through the fourth quarter of FY13, each country team produced drafts of the expert patient guidance.** The documents are currently being reviewed and each country section will be combined into one comprehensive draft that incorporates both country experiences. The expert patient guidance is expected to be completed by the end of the calendar year.

Improvement Key Indicators

Activity	Indicator	Baseline	Last value
AIMGAPS – Tanzania	<ul style="list-style-type: none">• % of HIV+ pregnant women receiving ARVs during pregnancy• % of HIV-exposed infants who receive a definitive test• Male partner received an HIV test at ANC	Jan. 2011 43% 8% 17%	Aug. 2013 85% (Jul. 2013) 82% 31%
Chronic Care – Uganda	<ul style="list-style-type: none">• % of medical records (ART card) completely and correctly filled• % of ART patients with no	Jan – Apr (2013) 44% 42.5%	Aug 2013 66% 19%

	adherence recorded <ul style="list-style-type: none"> • % of ART patients who have shown clinical improvement 	8%	68%
VMMC – Uganda	Percentage counseled tested and received results	Oct '12 (91%), 11 sites	Aug'13 (100%), 23 sites
	Percentage assessed for STI	Oct'12 (99%), 11 sites	Aug'13 (100%), 22 sites
	Percentage with signed consent	Oct'12 (99%), 14 sites	Aug'13 (100%), 21 sites
	Percentage that experience moderate to severe adverse events	Oct'12 (0.5%), 8 sites	Aug'13 (0.4%), 21 sites
	Percentage that return within 48 hours post operation	Oct'12 (58%), 4 sites	Aug'13 (68%), 23 sites
	Percentage that return after one week follow-up	Oct'12 (54%), 7 sites	Aug'13 (33%), 22 sites
	Percentage that return after six weeks	Oct'12 (0%), 2 sites	Aug'13 (7%), 14 sites

What Are We Learning?

- On site trainings are very instrumental in ensuring sustained improved QI projects.
- Attending the facility multi-disciplinary team meetings helps improve the planning for prompt on site trainings for new nurses in the TB/HIV units.
- Motivated staff can help sustain improvements gained in a unit even when they are moved from the unit.
- Regular facility data reviews and involvement of all clinic staff in the QI plans improves performance of indicators and sustainability of the projects.
- Strengthened relationships with the facility management are crucial in ensuring that during change over not all the nurses are moved from the unit.

Directions for FY14

- Implement “Strengthening Community Linkages of HIV Care and Treatment Services (Tanzania)”.

AIMGAPS (Tanzania)

- Awaiting IRB approval to begin data collection for the endline assessment in January of 2014
- Identifying and hiring data collectors

VMMC (Uganda)

- Continued coaching visits to sites receiving intense support
- Stakeholders meeting
- Learning session planned with attendance of VMMC team from various USG entities including USAID/W, CDC and OGAC/HQ, and also partners from South Africa
- Training of data collectors to commence in late November/early December

HIV Chronic Care and Treatment (Uganda)

- Start on CCM component case studies
 - Conduct coaching and supporting sites teams to demonstrate clinical improvement for patients on ART by:
 - Reviewing charts with clinicians and helping them identify improvement areas.
 - Improve clinical skills of the team by teaching them how to correctly assess and monitor patients
 - Facilitate site teams to correctly manage TB/ HIV as co- infections

- Support QI teams to improve patient retention by:
 - Assisting QI teams to generate a list of patients lost-to-follow up and come up with measures to get them back into care
 - Continue monthly data collection to inform teams about their progress
- Finalize the expert patient guidance

2.4 Maternal, Newborn, and Child Health

Background

ASSIST core-funded MNCH work supports USAID’s Ending Preventable Maternal and Child Death (PMCD) strategy by advancing understanding of critical quality of care gaps and effective improvement approaches to close the “know do” gap between known best MNCH practices and their routine implementation in low-resource settings. Emphasis is placed on leveraging improvement approaches to scale up and sustain high-impact MNCH services for leading causes of maternal newborn and child mortality and morbidity along all points of the ANC, intra- and post-partum, PNC and early childhood continuum and household to hospital continuum. ASSIST works strategically with governments, local and international partners within country, regional and global initiatives that are well positioned to achieve widespread adoption and adaptation of improvement approaches to overcome critical MNCH quality gaps to achieve better outcomes for mothers, newborns, and children.

In FY13 ASSIST core-funded MNCH work supported a large number of global technical leadership and country-level activities focused on cutting-edge challenges in the area of measuring, implementing and scaling up of high quality MNCH services. ASSIST staff participated in many technical working groups and gave plenary presentations on improving quality of care at the 2013 Global Maternal Conference (Arusha, Tanzania) and the first ever 2013 Global Newborn Conference (Johannesburg, South Africa) in addition to supporting regional- and country-level improvement work as described below.

In addition to supporting country-level MNCH improvement work to generate learning, ASSIST core-funded MNCH work supports research and design of quality frameworks, tools, and indicators to help build quality improvement capacity among governments, providers, managers and partners and support more robust MNCH improvement work in USAID priority MNCH countries. Specific FY13 activities are described below.

Program Overview

What are we trying to accomplish?	How will we know?	At what scale?
Contribute to reduction of maternal, newborn and child mortality/morbidity by: -Strengthening capacity of Governments and partners to apply improvement approaches to strengthen, scale up and sustain high-impact MNCH services in USAID priority countries -Advancing global understanding of critical MNCH quality of care gaps and improvement approaches to close gap	Global Technical Leadership: ASSIST influences MNCH global partnerships, initiatives, research and communication forums to increase awareness of and active use of improvement approaches to achieve better health care and outcomes for mothers, newborns and children.	Global

	<p>Regional Initiatives: <i>*Working in partnership with government and international partners</i></p> <ul style="list-style-type: none"> • LAC Region KMC Initiative: Regional spread of newborn care best practices for leading causes of newborn mortality: resuscitation services (HBB) for adverse intra-partum events/asphyxia; Kangaroo Mother Care (KMC) for premature infants; neonatal sepsis prevention & management. • East/Central/Southern Africa (ECSA) MNH Regional Initiative Regional spread of maternal newborn care best practices for leading causes of mortality and morbidity in the ECSA region 	<p>LAC region (5 countries)</p> <p>East, Central and Southern Africa (ECSA) region</p>
	<p>Uganda: Saving Mothers Giving Life (SMGL)</p> <ul style="list-style-type: none"> • Improved maternal health outcomes • Regular uptake and use of improvement approaches by ASSIST-supported maternities and SMGL partners. <p>National Newborn Programming</p> <ul style="list-style-type: none"> • MOH-led spread of newborn care best practices by leveraging improvement approaches 	<p>Uganda (4 SMGL districts) <i>**Jointly core- and field-funded</i></p> <p><i>Core-funded National Newborn Coordinator position</i></p>
	<p>Mali & Senegal: Safe Childbirth Checklist Demonstrated implementation strategies for using WHO Safe Childbirth Checklist tool to improve quality of maternal and newborn facility services</p>	<p>Mali: Kayes region <i>*jointly Mission and core MNCH & FP funded</i></p> <p>Senegal (under discussion) <i>*Jointly core MNCH & core FP funded</i></p>
	<p>Anemia Control and Prevention for Pregnant Women and Children: Mali & GTL</p>	<p>Mali: Sikasso Region and GTL</p>

Key Activities, Accomplishments, and Results

Activity 1. Global Technical Leadership & Cross-cutting ASSIST project technical leadership

Designing MNCH improvement work for maximum impact: An Improvement Design Tool-Kit:

- ASSIST and predecessor USAID HCI and QAP projects, have learned over the years that the up-front strong design of improvement work that articulates clear measurable improvement aims focused on leading causes of mortality and morbidity and the evidence-based clinical interventions that can impact such mortality is a critical factor for the effectiveness of subsequent

improvement work. In FY13, the ASSIST MNCH team has designed a tool-kit to support the strong design of MNCH work, including clear articulation of measureable improvement aims focused on important mortality causes, associated proven clinical content, promising areas of change for bridging the “know-do” gap in real-life clinical processes of care, and quality of care indicators and measurement approaches for tracking progress against defined improvement aims.

- In FY13, ASSIST has developed several MNCH “improvement design packages” for important MNCH clinical conditions including for: 1) prevention and control of PPH, 2) management of Newborn Asphyxia, 3) early diagnosis and management of pre-eclampsia and eclampsia and others. These design packages are now being used to support design of strong improvement work in all ASSIST countries with MNCH work, including adaptations and iterative refinement of the improvement design tool-kit and clinical condition-specific improvement design packages.
- ASSIST will continue to disseminate and refine the tool packages and to develop additional design packages for other leading causes of MNCH mortality in FY14, including for Threatened Pre-term Labor (PTL) and management of the Pre-term Infant (KMC) and prevention and management of maternal and newborn sepsis.

GTL Activities:

- Plenary and oral presentations were given by ASSIST staff at the Global Maternal Health Conference (Arusha, Tanzania) and Global Newborn Conference (Johannesburg, South Africa).
- Engaged in active partnership in multiple technical working groups to influence consideration of quality of care issues and dissemination of improvement approaches in priority MNCH technical areas including: Helping Babies Breathe Global Development Alliance; Survive and Thrive; ICCM working group; Implementing Best Practices; LAC Neonatal Alliance; East Africa Survive & Thrive Neonatal Alliance; UN Life-saving Commodities for Maternal Newborn and Child Health Resuscitation working group; Inter-agency Technical Newborn Health Indicators (WG); Implementing Best Practices (IBP); Anemia inter-disciplinary Task Force.
- Completed full draft of ASSIST Basic Newborn Resuscitation Quality Framework; initial feedback received from members of UN Life-saving Commodities for Maternal Newborn and Child Health Resuscitation working group members (including WHO). Note: technical meeting to finalize NR quality framework planned first quarter FY 14.
- Published in the Journal of Midwifery and Women’s Health: “When the Newborn Doesn’t Breathe and There is No Resuscitation Equipment” commentary by ASSIST MNCH team member, Annie Clark
- ASSIST MNCH lead, Kathleen Hill, panel participant on a panel at a meeting on Respectful Maternity Care at the Woodrow Wilson International Policy Center (May 2013, Washington D.C.)
- ASSIST MNCH lead, Kathleen Hill, participated in a Technical Advisory Group (TAG) meeting of the Gates-funded Maternal Health Task Force (MHTF) managed by the Harvard School of Public Health Women’s and Children Health Initiative.
- ASSIST staff contributed to early drafts of the global Every Newborn Action Plan (ENAP) and provided continued support to the monitoring and evaluation section of ENAP as active participants of the Inter-agency Technical Newborn Health Indicators (WG)
- Participation in technical meetings on Respectful Maternity Care convened by USAID TRAction project and other partners, including the Gates-funded Maternal Health Task Force.

Activity 2. Regional Initiatives (LAC Regional Newborn Alliance and ECSA MNH Regional Initiative)

LAC Regional Newborn Alliance:

- During FY13 the Materno Infantil website, www.maternoinfantil.org, was maintained by ASSIST to provide continued virtual support to the LAC Regional Newborn Alliance.
- The first ever Communities of Practice on Kangaroo Mother Care and Basic Newborn Resuscitation were launched at a June 2013 LAC Newborn Alliance meeting in El Salvador. The LAC regional Kangaroo Mother Care (KMC) Community of Practice is gaining traction with 72 members from 12 countries registered on the Materno Infantil Website as of the last quarter of FY 13.

- In addition to supporting LAC regional newborn alliance activities, ASSIST is providing technical support to the Ecuador MOH to support a MOH-led national expansion of KMC in Ecuador.
- In August 2013 in collaboration with the USAID/MCHIP project and the Kangaroo Foundation, ASSIST participated in a KMC webinar to discuss implementation advances within the LAC KMC Community of Practice.

ECSA Regional MNH Initiative:

- The ECSA regional MNH initiative was officially launched in the ECSA region as part of a public private Survive & Thrive partnership. The ECSA regional MNH initiative is being led by ECSA and the Kampala-based Regional Center for Quality in Health Care (RCQHC) with support of the USAID East Africa Mission. The initiative is being closely supported by Survive and Thrive partners, including by ASSIST and other USAID projects, and by U.S.-based professional associations, including the American Academy of Pediatrics (AAP), the American Academy of Obstetrics and Gynecology (ACOG) and the American College of Nurse Midwives (ACNM) among other partners.
- ASSIST MNCH team staff member, Jorge Hermida, and ASSIST Uganda MNCH advisor, Paul Isabirye, participated in the regional launch meeting of the ECSA regional MNH initiative in Arusha, Tanzania in 2013, attended by Professional Associations and Ministries of Health from 9 countries in the East, Central and Southern Africa Region.
- During the 3-day launch meeting, ASSIST staff Jorge Hermida and Paul Isabirye provided technical support to RCQHC to conduct a one-day training session on using QI approaches to improve maternal newborn care for the over 130 participants in attendance.
- Jointly with the Regional Center for Quality of Health Care (RCQHC/Uganda) identification of key regional activities to be implemented in support of the Initiative

Activity 3. Uganda Maternal Newborn Improvement Work:

Technical Support to Uganda Saving Mothers Giving Life (SMGL) Initiative:

- In FY13, ASSIST continued support to the SMGL in Uganda leveraging a combination of core and Mission funding. In addition to providing technical support to maternities to improve early post-partum care (AMTSL and Essential Newborn Care), ASSIST led the Quality Improvement cluster of SMGL in Uganda to help define common indicators and improvement approaches focused on leading MNH quality of care challenges being addressed by SMGL.
- In FY 13, ASSIST expanded support to 10 new sites participating in the SMGL initiative for a total of 20 sites supported by ASSIST in the four SMGL districts in Uganda. Figures 34 and 35 demonstrate improvements in % women receiving AMTSL for prevention of post-partum hemorrhage and % newborns benefitting from Essential Newborn Care in the 10 established and 10 new sites supported by ASSIST.

Uganda Newborn Health program at MOH:

- A draft concept paper and work plan for strong integration of QI into the national Newborn Health plan in Uganda was developed by ASSIST in partnership with the Uganda MOH in FY 13 . The MOH-supported National Newborn Steering Committee, of which ASSIST is a member, is now considering a specific work plan to support the agreed objectives in the concept paper. The work plan includes the training of a cadre of MOH QI facilitators and the promotion of stronger linkages between the existing MOH QI structures at national, regional and district levels and national and regional newborn health activities.

Activity 4: WHO Safe Childbirth Checklist (SCC) Improvement Intervention

- **In FY 13 ASSIST laid the ground to launch implementation of a WHO Safe Childbirth Checklist improvement activity in Mali and Senegal, in collaboration with ASSIST partner, WHO Patient Safety.** Agreement of the Senegal USAID Mission was secured to test introduction of the SCC in several pilot maternities in Senegal and a first country visit is planned for January 2014. An agreement and scope of work is being discussed with WHO Patient Safety and is near completion as of the last quarter of FY 13. The Senegal SCC implementation activity will be exclusively core funded through a combination of core MNCH and core FP funds. The Mali WHO SCC activity will be jointly funded through Mali ASSIST funds and modest supplemental core MNCH and FP funds.

Activity 5. Anemia Control and Prevention for Pregnant Women and Children: Mali & GTL

- Anemia is increasingly recognized as an important cause of mortality and morbidity for women and children. Prevalence rates of severe anemia approach 30-40% in many low-resource settings, including Mali's Sikasso region where **ASSIST is implementing an integrated community-facility anemia prevention and control program with Mission funds and modest supplementary MNCH core funds.**
- **Core funds were used in FY13 to leverage the emerging global and Mali-specific anemia prevention and control best practices** to contribute to a better understanding of critical quality of care gaps in delivery of anemia best practices and use of improvement approaches as part of multi-sectoral strategies to improve anemia prevention and control.
- **In the last quarter of FY13, ASSIST staff participated in an inter-agency Anemia Task Force to regularly share emerging learning in ASSIST anemia programming in Mali** and to learn from other partners working on anemia control and prevention.

What are We Learning?

- Importance of strong integrated design of MNCH improvement work.
- Importance of defining feasible measurable indicators of MNCH quality of care and supporting high quality data collection and analysis (e.g. adaptation of medical records and registers; data management capacity-building among front-line providers and managers).
- Importance of supporting improvement work across the system, from community to ambulatory clinic to hospital to district/regional/national management structures.
- Importance of integrating delivery of improved maternal, newborn and child health best practice along the life-cycle continuum (ante-natal, delivery, post-partum, infancy, child, adolescent, reproductive health).
- Importance of considering client-centeredness of care as one important dimension of quality and as a factor that strongly influences utilization of MNCH services.

Directions for FY14

- Continue to advance understanding of pressing quality of care issues and uptake of improvement approaches to accelerate progress toward achieving improved MNCH care and better maternal, newborn and child outcomes in support of USAID's Ending Preventable Child and Maternal Deaths.
- Continue to refine MNCH improvement design packages and disseminate widely to improve quality of MNCH improvement work supported by ASSIST and partners.
- Continue to support to activities outlined above, initiated in FY13.
- Continued strong emphasis on integration of maternal, newborn, child and reproductive health

services (primarily family planning).

- Continued participation in MNCH technical working groups to influence strong inclusion of quality considerations as part of MNCH technical work.
- ASSIST will participate in WHO MNCH Quality of Care Meeting December 2013 in Geneva and follow-on activities including preparation of an MNCH quality of care report being led by WHO.
- Fully launch WHO SCC activities in Senegal and Mali in collaboration with ASSIST partner, WHO Patient Safety.
- Finalize Newborn Resuscitation Quality Framework based on outputs of upcoming technical meeting

2.5 Office of Health Systems/mHealth

Background

In FY13 the USAID ASSIST Project received OHS funding to support e/mHealth work. A series of meetings were held with USAID OHS counter-parts and other stakeholders to define objectives and a scope of work for ASSIST e/mHealth activities. It was agreed that ASSIST could best contribute to USAID agency-wide strategic objectives by supporting a series of technical leadership activities focused on identification and promotion of e/mHealth applications that can best augment HSS and QI interventions to improve delivery of high-impact health services for USAID priority conditions in low-resource settings.

Poor quality of service delivery (facility and community) and weak health systems continue to represent major barriers to achieving MDGs 4, 5 and 6. When leveraged as part of broader HSS and improvement efforts, e/mHealth technologies can help advance more effective, efficient and affordable health care services and strengthen associated essential health system functions. For example, e/mHealth technologies, when anchored appropriately within broader HSS and QI efforts, can help strengthen health worker performance, health management information systems, and supply chain management to achieve better health outcomes for patients.

It was decided that a meaningful contribution of ASSIST e/mHealth work would be to support dialogue, analysis, and evaluation of highly promising e/mHealth applications that may best augment broader HSS and QI efforts in low-resource settings. Given the rapid expansion of global e/mHealth technologies and the frequent failure to link and coordinate the applications of such technologies to broader HSS and QI efforts it was decided to focus initial activities on the development of a “HSS/QI e/mHealth” framework highlighting areas of need where e/mHealth technologies are likely to have the greatest impact on system functions, quality of care and patient outcomes.

The following objectives for ASSIST-supported e/mHealth technical leadership work were defined: 1) to develop a high-level framework characterizing key domains of health system and service delivery quality of care constraints likely to be amenable to the application of e/mHealth technologies as part of broader HSS and QI initiatives; 2) to explore evidence and expert opinion on established, promising or needed e/mHealth technologies within framework domains, with an emphasis on e/mHealth technologies that have been evaluated in low-resource settings; and 3) to support a series of activities to build consensus and subsequent uptake (or development) of e/mHealth technologies that can best augment HSS and service delivery QI efforts to improve patient outcomes.

Program Overview

What are we trying to accomplish?	How will we know?	At what scale?
1. Promote use of mHealth and eHealth technologies that can most effectively enhance HSS and QI efforts to achieve better outcomes for patients in USAID priority areas.	<ul style="list-style-type: none"> • Increased testing and use of m/eHealth technologies to enhance HSS/QI efforts: “e/mHealth QI/HSS framework” • Improved collaboration among health & technology experts to develop, test, evaluate and promote promising e/mHealth technologies that can contribute to broader HSS/QI efforts 	Global and Regional Technical Leadership

Key Activities, Accomplishments, and Results

Activity 1. Promote use of mHealth and eHealth technologies that can most effectively enhance HSS and QI efforts to achieve better outcomes for patients

- **Concept note prepared and agreed with USAID OHS counterpart and ASSIST AOR on ASSIST e/mHealth activities.**
- **Consultant was recruited and hired to conduct evidence review and stakeholder interviews and assist with development of first draft of an e/mHealth QI/HSS framework and planning for the January 2014 meeting.**
- **First draft of e/mHealth HSS/QI framework developed;** currently being reviewed.
- **Methodology agreed for e/mHealth evidence review and stakeholder interviews structured around major domains of framework and work initiated.**
- **Planning initiated for January 31st technical expert working meeting** to review framework and evidence; first draft of agenda and participant list developed.
- **e/mHealth capacity-building of ASSIST staff** (training courses, regular participation in technical meetings).

What Are We Learning?

- Potential for e/mHealth technologies to accelerate and increase efficiency of HSS and QI activities at scale to overcome common challenges (e.g. rapid aggregation of quality of care measures within HIS; logistics management information system to improve logistics management; real time clinical decision-support and provider to provider communication).
- Importance of fostering collaboration between health and technology experts.
- Importance of analyzing e/mHealth technologies as part of broader HSS and QI activities rather than as stand-alone interventions.

Directions for FY14

- Based on results of January 2014 technical meeting, the e/mHealth QI/HSS framework will be refined and a “white paper” will be developed presenting framework and results of evidence review and stakeholder interviews.
- Possible regional e/mHealth QI/HSS meeting in Sub-saharan Africa (*contingent on funding*).
- Dissemination of communications pieces geared to USAID Missions, Country Governments and partners highlighting added-value of selected e/mHealth technologies for accelerating QI and HSS efforts in priority areas.
- Testing and evaluation of e/mHealth technologies as part of ASSIST-supported HSS and QI efforts.
- Support for improved collaboration between health and technology specialists in designing, implementing, evaluating and scaling up effective HSS and service delivery e/mHealth technologies.

2.6 Vulnerable Children and Families

Background

AIDSTAR-One, funded through USAID, conducted a review of published literature and summarized the empirically based recommendations for supporting and strengthening child-caregiver relationships in the context of HIV and poverty. The resulting document, *A Review Of Published Literature On Supporting And Strengthening Child-Caregiver Relationships (Parenting)*, Richter & Naicker, 2013, was launched in March 2013 and included a three-day meeting of USG stakeholders and implementing partners to discuss the implications of these research findings on current and future programming for vulnerable children.

The March 2013 Parenting meeting hosted in Washington, DC was a successful first step. While there was some representation from indigenous Africa-based parenting organizations, the meeting was largely comprised of USG stakeholders and DC-based IPs who share a common interest in expanding the evidence base and promoting the implementation of skilled parenting programs in Africa. The need for an Africa-based meeting was duly acknowledged. In July, USAID requested that ASSIST support the development and co-hosting of a follow-up meeting in Africa of Africa-based

stakeholders. This proposed meeting is one in a series of planned events aimed at gathering information on parenting practices and effective parenting interventions in Africa.

Africa Parenting Meeting

In FY14 ASSIST will organize and conduct a meeting of Africa-based and international experts in the field of child-caregiver relationships to explore the parenting programs already existing in Africa and the successful components and common elements of those programs. The attendees will also develop recommendations for moving the field forward. The meeting, and activities leading up to the gathering, will incorporate KM strategies and techniques aimed at maximizing participant contributions to knowledge sharing and synthesis during and after the meeting.

The objectives of the December 2013 meeting are to:

- Share program experiences of existing parenting programs from low-income, HIV-affected settings in Africa, to understand the successful components and common elements of the programs.
- Identify priority child-caregiver strengthening interventions and objectives used to meet needs of families affected by HIV and AIDS
- Explore the elements of culturally relevant and competent parenting interventions in African cultures
- Examine and assess existing tools and resources used by parenting programs
- Share key research findings on child-caregiver relationships (parenting) and explore a elements common to developing parenting programs in low-income, HIV-affected settings
- Identify gaps in program implementation that affect the quality and sustainability of parenting programs and opportunities to build an evidence base and community of practice on parenting interventions.
- Collect recommendations that would inform the creation and implementation of appropriate PEPFAR parenting programs in the future.
- Initial planning for the meeting was conducted in July to September 2013.

Program Overview

What are we trying to accomplish?	How will we know?	At what scale?
<ol style="list-style-type: none"> 1. Bring together a community of international and country experts on parenting programs to gather knowledge on current parenting programs and recommendations for a way forward 2. Conduct a survey of existing parenting programs 	<ul style="list-style-type: none"> • Meeting held in Cape Town in December 2013 • Results of survey documented and presented at meeting • Final synthesis report on knowledge shared in the meeting and recommendations for moving forward 	Sub Saharan Africa

Key Activities, Accomplishments, and Results

Activity 1. Africa Parenting Meeting

- **An initial planning meeting was held with the USAID OVC TWG in July.** Activities were pending approval of the SOW which was approved late September. We have begun development of the survey which will be finalized with the TWG early November.

What Are We Learning?

We are learning about existing parenting programs in low-income, HIV-affected Sub Saharan Africa and the successful components and common elements of the programs. Through the experts meeting we will identify gaps in program implementation that affect the quality and sustainability of parenting programs and opportunities to build an evidence base and community of practice on parenting interventions and collect recommendations that would inform the creation and implementation of appropriate PEPFAR parenting programs in the future.

Directions for FY14

- Convene in December 2013 in Cape Town, South Africa, a meeting of Africa-based and international experts in the field of child-caregiver relationships to explore the parenting programs already existing in Africa and the successful components and common elements of those programs.

3 Common Agenda Activities

3.1 Global Technical Leadership

Program Overview

The USAID ASSIST Project's global technical leadership activities on behalf of USAID seek to further advance and inform the field of improvement globally by engaging and building capacity of USAID IPs and global health organizations to expand the application of improvement approaches in global health programs and serve as a conduit and catalyst for sharing, learning, and advancement in the field of improvement, including but not limited to: district management, HR management, chronic care, gender equality, provider productivity, community-level services, local supply systems, KM, and evaluation of improvement methods.

What are we trying to accomplish?	How will we know?	At what scale?
1. Expand the use of modern improvement approaches in USAID-assisted health care systems and by USAID cooperating agencies through global technical leadership for USAID's worldwide efforts to improve health care in developing countries	<ul style="list-style-type: none"> • Partner with global health organizations to expand the use of improvement science • Partner with USAID cooperating agencies in countries and globally to apply modern improvement methods • Assist governments in low- and middle-income countries to develop policies supporting the application of modern improvement methods in the health sector 	<ul style="list-style-type: none"> • Global
2. Demonstrate the results of USAID's investment in health care QI	<ul style="list-style-type: none"> • Produce technical reports and submit articles to peer-reviewed journals that describe improvement interventions and measure their impact • Disseminate evidence for the results, cost-effectiveness, and benefits of applying modern improvement approaches in USAID-assisted health care systems through presentations, briefings, and content on the ASSIST KM system 	<ul style="list-style-type: none"> • Global
3. Support the development of improvement competencies in ASSIST staff and counterparts	<ul style="list-style-type: none"> • Help to standardize the teaching of modern improvement approaches • Enhance ASSIST staff and counterpart capacity to design, implement, and support applications of modern improvement methods 	<ul style="list-style-type: none"> • In every country supported through ASSIST

Progress, Results, and Accomplishments

Activity 1. Expand the Use of Modern Improvement Approaches

- **During the year, ASSIST staff made 47 presentations at 20 regional and international conferences**, thereby sharing knowledge of lessons learned from the use of modern improvement approaches.
- **In October 2012, Dr. M. Rashad Massoud led a panel discussion at the ISQua annual conference in Geneva, Switzerland: "Making Health Care Better in Low and Middle Income**

Economies: What are the next steps and how do we get there?” Present were some attendees of the April 2012 Salzburg Global Seminar: Dr. Edward Kelley and Sir Liam Donaldson (WHO PSP); Dr. Jean Nguessan of URC; Dr. Sylvia Sax of Heidelberg University; Dr. Bruce Agins of HEALTHQUAL International, and Dr. Ezequiel García-Elorrio of the *International Journal of Quality in Health Care* editorial board.

- **Dr. Massoud partnered with Dr. Donna Jacobs and further shared insight gained from the Salzburg Global Seminar at the Infection Control African Network (ICAN) conference in Cape Town, South Africa from November 27-29, 2012.** Dr. Massoud and Dr. Jacobs facilitated a Knowledge Café: How to operationalize the Salzburg Global Seminar statement, “Better Care for All, Every Time: A Call to Action.” Key recommendations put forth by ICAN member countries included creating strong information dissemination systems, allocating adequate resources for R&E, clearly defining national goals and leadership, supporting QI and IPC activities within MOHs as well as in-service and pre-service training, and incorporating community forums in health care settings. ASSIST staff will compile the ICAN recommendations into a possible article for *Antimicrobial Resistance & Infection Control*, an online open-access journal.
- **A key technical leadership activity during the second quarter of FY13 was ASSIST’s support of a “Thoughtful Conversation on National Improvement Strategies and Infrastructure for Improving Health Care” in Kenya from February 19-21, 2013.** The meeting was facilitated by Dr. Lucy Musyoka, Deputy Director of Medical Services and Head, Department of Standards and Regulatory Services, Ministry of Medical Services of Kenya, and Dr. Massoud, with Ms. Dorcas Amolo, ASSIST Chief of Party in Kenya. Ms. Roselyn Were, Dr. Mwaniki Kivwanga, Dr. Subiri Obwogo. Dr. Nigel Livesley, Dr. Donna Jacobs, and Ms. Kate Fatta of ASSIST also participated, and the project also supported the participation in the seminar of Mr. Sven-Olaf Karlsson, former CEO of Jonkoping county council, Sweden, and Dr. Bruce Agins, Director of HEALTHQUAL International.
- **During the third quarter, ASSIST Uganda supported the MOH to convene its Second National QI Conference: Evidence-Based Improvements in Health Care.** The conference provided strong evidence of the priority placed by the MOH on improving health care quality throughout the health system.
- **In September 2013, The ASSIST Tanzania team made recommendations to the MOHSW on incorporating improvement strategies in the National Guidance on PMTCT Option B+ Roll Out.**

Activity 2. Demonstrate the Results of USAID’s Investment in Health Care QI

- **In conjunction with the formal ASSIST Project launch in October 2012, the temporary website – www.usaidassist.org – was made live.** To further efforts to promote the project’s activities and new scope, Ms. Kate Fatta and Ms. Feza Kikaya staffed an information table at the USAID KM Expo in February 2013.
- **In FY13, ASSIST staff participated in 20 regional and international conferences, making 47 oral and poster presentations** (see Table 10).
- **ASSIST staff made five briefings throughout the year as part of the project’s effort to promote awareness of QI approaches and results** (see Table 11).
- **In September, the ASSIST Twitter page was launched as @usaidassist and was used to promote key project activities in Q4** (e.g. CHW Central website launch; new peer-reviewed publications; APAC Forum; and ASSIST events).

Table 10: USAID ASSIST conference presentations, FY13

Conference	ASSIST Staff Participation
CORE Group Fall Meeting October 11-12, 2012 Washington, DC	<ul style="list-style-type: none"> • Lani Marquez, together with Lenette Golding, CARE, led the interactive session, “InKnowvation: Simple Techniques for Tapping into All the Knowledge in the Room”
International Society for Quality in Health	<ul style="list-style-type: none"> • M. Rashad Massoud led the 45-minute panel, “Making Health Care Better in Low and Middle Economies” (panelists included: Ed Kelley,

<p>Care (ISQua) Conference October 21-24, 2012 Geneva, Switzerland</p>	<p>Sir Liam Donaldson, Jean Nguessan, Sylvia Sax, Bruce Agins, and Ezequiel García-Elorrio)</p> <ul style="list-style-type: none"> • Maina Boucar made the oral presentation, “Spread of better care practices and quality improvement for maternal and newborn services from Niger to Mali” • Donna Jacobs made the oral presentation, “Sustaining the Gains : Quality Improvement of HIV and AIDS programs in South Africa (2007 – 2011)” • Edward Broughton made the oral presentation, “Maternal health service improvements in Kunduz Province, Afghanistan” • M. Rashad Massoud led the oral presentation, “Managing knowledge for improvement: Why knowledge management approaches are new and essential tools for improving health systems” together with Tim Shaw of U. Sydney • Mabel Namwabira made the short oral presentation, “Engaging Clients in Quality Improvement (QI): A pre and post assessment of a client engagement intervention at 12 HIV facilities in Western Uganda” • Edward Broughton presented the poster, “Applying Modern QI Concepts to Improve Maternal Care in Low Resource Setting” on behalf of Youssef Tawfik
<p>Global Symposium on Health Systems Research October 31- November 3, 2012 Beijing, China</p>	<ul style="list-style-type: none"> • Edward Broughton led the satellite session, “How do we learn in order to strengthen health systems?” as a 45-minute interactive talk followed by two small-group discussions. The presentation was divided into three sections: 1) using real-time data for learning; 2) cost-effectiveness analysis and 3) the use of qualitative research in improving health systems. It was attended by about 30 people, including Tim Evans, the chair of the conference organizing committee. (Planned participation of Rashad Massoud, Sarah Smith, Ram Shrestha, and Tana Wuliji in the session was not possible due to hurricane-related flight cancellations.)
<p>Infection Control Africa Network (ICAN) November 27-29, 2012, Cape Town, South Africa</p>	<ul style="list-style-type: none"> • M. Rashad Massoud and Donna Jacobs facilitated a Knowledge Café at the ICAN conference to engage participants in brainstorming about next steps for operationalizing the Salzburg Global Seminar statement, “Better Care for All, Every Time: A Call to Action”
<p>ISQua Regional Africa Meeting February 4-5, 2013 Accra, Ghana</p>	<ul style="list-style-type: none"> • M. Rashad Massoud served as one of the opening keynote speakers addressing, “What is ‘quality’ health care?”. He also led the plenary session on “Options for large-scale spread of high impact interventions” and chaired the “Open Agenda” session. • Maina Boucar served as one of two keynote speakers addressing, “The Science of Improvement: How do we improve care?” • Elizabeth Hizza made the oral presentation, “Improving PMTCT service uptake across the continuum and spread of best practices in Tanzania” at the panel session, Access to quality health care • Dorcas Amolo made the oral presentation, “The Role of Government and Policy in mainstreaming QI in OVC programmes in Kenya” in the session, Case studies/Role of government • Roselyn Were made the oral presentation “To facilitate improvement of Vitamin A supplement uptake in Njiru District Nairobi Kenya” • Samson Haumba made the oral presentation, “Utilisation of QI approaches to improve TB/HIV treatment outcomes in Swaziland” in the panel, Options for large-scale spread of high impact interventions • Joseph Kundy presented the poster, “Leveraging patient self-management to address chronic care among PLHIV in Tanzania”

	<ul style="list-style-type: none"> • Obwogo Subiri presented the poster, “Partnership Model for Incorporating QI into National Systems” • Jean Nguessan presented the posters, “Improving the quality of HIV care in facilities in Côte d’Ivoire: Comparing sites that did and did not participate in collaborative improvement” and “Implementation of a Laboratory Quality Improvement Process Towards Accreditation in Cote d’Ivoire: Lesson learned and way forward” • Nana Mensah-Abrampah will lead the Knowledge Café on “Salzburg Seminar Recommendations” with assistance from Feza Kikaya, Donna Jacobs, Nigel Livesley, and Maina Boucar • ASSIST also sponsored the participation of Mr. Stephen Okiror of Bukedea Health Center in Uganda, to present his poster, “Improving Patient Safety during ‘Safe’ Medical Male Circumcision by Use of a Locally Designed Checklist in Bukedea Health Centre IV in Eastern Uganda” • The project also sponsored the participation in the conference as invited speakers, Dr. Francis Omaswa and Ms. Robinah Kaitiritimba from Uganda. Dr. Omaswa was the Opening Keynote Speaker discussing, “What is ‘quality’ health care?” Ms. Kaitiritimba served as Session Chair of the 45-minute plenary on patient-centered care. She also served as a facilitator during the Salzburg Global Seminar Knowledge Café.
4th Annual East African Health and Scientific conference March 27-20, 2013 Kigali, Rwanda	<ul style="list-style-type: none"> • Tana Wuliji made a plenary presentation on the core competency framework for improvement and moving towards integration of these core competencies into health worker education and training at the session organized by the Regional Center for Quality in Health Care (RCQHC) on “Quality Improvement Movement in Africa”
Global Newborn Health Conference April 15-18, 2013 Johannesburg, South Africa	<ul style="list-style-type: none"> • In the plenary panel session 3A: Systems Aspects of Delivering Newborn Care at Scale, Kathleen Hill presented “Health systems strengthening: Improving the quality of newborn care services.” • In the plenary panel session 1D: Country experiences in delivering an integrated maternal and newborn package, Jorge Hermida presented on Ecuador’s experience with integrated EONC networks in Cotopaxi Province. He also presented in the concurrent session 3D: Using data for decision-making for delivery of newborn health services at country level, on “Experiences using routine monitoring data for quality improvement of newborn health in Ecuador.”
Launch of the website “Turning the World Upside Down” April 15, 2013 London, UK	<ul style="list-style-type: none"> • M. Rashad Massoud participated in the formal launch of the new website www.ttwud.org, held in London in conjunction with the International Forum • He contributed a case study to the new website on “Development of the Spread Methodology in Russia” and filmed an introduction to the case study which made be viewed at: http://www.ttwud.org/casestudy/development-spread-methodology-russia
International Forum on Quality and Safety in Healthcare April 16-19, 2013 London, UK	<ul style="list-style-type: none"> • M. Rashad Massoud, Humphrey Megere and Nigel Livesley attended the conference. • M. Rashad Massoud led a 90-minutes session on “What healthcare leaders can learn about systems from developing healthcare systems” with participation of URC, NHS and IHI staff • M. Rashad Massoud co-led day mini-course on Chronic Conditions Care with Sir John Oldham
CORE Group Spring Meeting	<ul style="list-style-type: none"> • Allison Foster and Ram Shrestha led, together with Anya Guyer of Initiatives, a round table discussion on CHW Central as a “Power

April 23-26, 2013 Baltimore, MD	Breakfast” on Wednesday April 24
Women Deliver 3rd Global Conference May 28-30, 2013 Kuala Lumpur, Malaysia	<ul style="list-style-type: none"> • Tana Wuliji presented, together with Joe Naimoli of USAID, findings from the CHW Summit in the presentation “What can community and health systems do to improve community health worker performance?” • Ram Shrestha also attended and held meetings with Tana and Malaysian and Timor Leste health officials.
Annual Meeting of the Latin American and Caribbean (LAC) Neonatal Alliance and the LAC Regional Technical Meeting on Priority Interventions for Newborn health, June 25-28, 2013 San Salvador, El Salvador	<ul style="list-style-type: none"> • More than 100 health professionals representing 19 countries in the LAC region participated. • Jorge Hermida, Mario Chavez, Ivonne Gomez, Nicaraguan MOH official, Gustavo Barrios (Nutrisalud), and Guatemalan MOH official participated. • Jorge Hermida presented on the Kangaroo Mother Care virtual community of practice that has been created on www.maternoinfantil.org
LAC Summit on Quality and Safety, July 15-17, 2013, Mexico City	<ul style="list-style-type: none"> • Jorge Hermida attended (his expenses were funded by URC)
CDC-supported African Regulatory Collaborative Summative Congress, July 29- August 2, 2013	<ul style="list-style-type: none"> • Obwago Subiri of ASSIST Kenya presented on the “In-service Training Framework” developed under ASSIST and HCI. Dr. Subiri also facilitated the breakout sessions.
ECSCA 7th Best Practices Forum (BPF) and the 23rd Directors’ Joint Consultative Committee Meeting, August 12-14, 2013, Arusha, Tanzania	<ul style="list-style-type: none"> • Macdonald Kiwia (ASSIST Tanzania) made the oral presentation: “Strengthening District Quality Improvement Leadership for Better Performance” • Martin Muhire (ASSIST Uganda) made the oral presentation: “Creating a link between management of HIV and other chronic conditions” • Together with colleagues from the Regional Center for Quality in Health Care (RCQHC), Jorge Hermida carried out a five-hour QI workshop following the ECSCA BP Forum. He reported that nearly 100 representatives from Ministries of Health and Professional Associations from 18 African countries participated.
Global Implementation Conference - Putting Implementation into Practice: Tools for Quality and Sustainability August 19-21, 2013 Washington, DC	<ul style="list-style-type: none"> • Edward Broughton presented “Is quality health care worth the effort? Tools and measures to find out” • Ram Shrestha and Amy Stern presented “Strengthening the Community Health System to Improve the Performance of Health Extension Workers: Ethiopia Case Study”
Asia Pacific Forum for Quality Improvement in Health and Healthcare September 25-27, 2013 Auckland, New Zealand,	<ul style="list-style-type: none"> • M. Rashad Massoud and Tana Wuliji attended and conducted a workshop on: Innovations from Low Resourced Countries that Can Benefit Nations with Higher Level Resourcing • M. Rashad Massoud conducted a half-day Session on Designing improvement for local ownership, great results, and learning” with Brandon Bennett and Chien Earn Lee from Singapore. • Posters from previous meetings were revised, printed and brought along under the following topics: <ul style="list-style-type: none"> - Achieving Better HIV Care by Combining Performance Management

	<p>and Quality Improvement Approaches</p> <ul style="list-style-type: none"> - Assuring Infants and Mothers Get All PMTCT Services (AIMGAPS) - Sustainable Scale-up of AMTSL for Prevention of PPH in Ecuador - Community-led Improvements in Quality of Services to Vulnerable Children in the Bagamoyo District, Tanzania - Improving Quality of Prevention, Screening and Treatment Services of CV Diseases in Georgia - Helping People Help Themselves – A comprehensive approach to improving chronic HIV care and treatment in Uganda and Tanzania - A Global Improvement Framework for Health Worker In-Service Training
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Table 11: USAID ASSIST presentations to USAID, international donor, and cooperating agency staff in FY13

Date/Venue	ASSIST Staff Presenters and Topics
October 17, 2012, USAID, Washington, DC	<ul style="list-style-type: none"> • URC and its partners convened a formal launch of the USAID Applying Science to Strengthen and Improve Systems Project at the Ronald Reagan Building. Mr. Robert Clay and Ms. Karen Cavanaugh of the USAID Global Health Bureau addressed the event as well as Dr. James R. Heiby, the USAID ASSIST Agreement Officer's Representative. • Ms. Barbara Turner, President of URC, and Dr. M. Rashad Massoud, Senior Vice President of URC and USAID ASSIST Project Director, also spoke at the launch event.
February 11, 2013, USAID, Washington, DC	<ul style="list-style-type: none"> • ASSIST partner Dr. Taroub Faramand of WI-HER, LLC, and Dr. Ram Shrestha of URC presented on how the project integrates gender concerns in improvement, giving examples of community-level work supported by Dr. Shrestha.
February 26, 2013, USAID, Washington, DC	<ul style="list-style-type: none"> • Ms. Kate Fatta and Ms. Feza Kikaya staffed an information table on ASSIST's knowledge management activities at the USAID Knowledge Management Expo held in the Ronald Reagan Building.
April 11, 2013, Online Webinar, Webber Training Teleclass Education	<ul style="list-style-type: none"> • Dr. M. Rashad Massoud delivered the lecture "Improving Health Care: Global Overview" for the Webber Training Teleclass Education for Infection Prevention and Control, an online learning platform sponsored by the Canadian International Development Agency to build capacity in infection prevention and control.
September 11, 2013, USAID OHA, Washington, DC	<ul style="list-style-type: none"> • Dr. M. Rashad Massoud presented on the project's activities and results related to "A Promised Renewed" and "AIDS-Free Generation" at the September 11, 2013 OHA Partners Meeting in Washington, DC.

Publications

- During FY13, ASSIST submitted one manuscript for publication in a peer-reviewed journal. In addition, the project published two case studies, 10 short flyers and one technical report (see Table 12).

Table 12: USAID ASSIST publications, FY13

Articles Submitted for Publication in Peer-Reviewed Journals
<ul style="list-style-type: none"> • Naimoli J, Frymus D, Wuliji T, Franco L, Newsome M. "A Community Health Worker "logic model": towards a theory of enhanced performance in low- and middle-income countries." Submitted 16 July 2013 to <i>BMC Health Services Journal</i>.
Case Studies (Date Published)
<p>A community-led approach to improve early childhood development (ECD) and nutrition in Blantyre District, Malawi using quality improvement methods. <i>Case Study</i>. (June 2013)</p> <ul style="list-style-type: none"> • Uganda: Retention of Mother-Baby Pairs in Kisoro District Hospital. <i>Case Study</i> (July 2013)

Flyers and short reports (date published)
Applying Science to Strengthen and Improve Systems. A New Five-year Cooperative Agreement in the USAID Office of Health Systems (2-page flyer) (October 2012)
Applying Science to Strengthen and Improve Systems (4-page flyer) (February 2013)
Integrating Gender in Improvement: Approach of the USAID ASSIST Project (2-page flyer) (February 2013)
USAID ASSIST Project: Uganda Technical Assistance (4-page flyer) (June 2013)
Meeting the Different Needs of Boys and Girls in Services for Vulnerable Children (4-page flyer) (June 2013)
PMTCT: Addressing the Needs of Women and Their Partners to Improve Services (4-page flyer) (May 2013)
Addressing the Needs of Men, Women, Boys and Girls in HIV and ART Services (4-page flyer) (May 2013)
A Global Improvement Framework for Health Worker In-service Training: Guidance for Improved Effectiveness, Efficiency and Sustainability (4-page flyer) (April 2013)
A Global Improvement Framework for Health worker in-service training: Guidance for improved Effectiveness, Efficiency and Sustainability (4-page flyer) (July 2013)
Tanzania District Health Management Activity: Quality Improvement as a Management Practice in the Lindi Region (2-page flyer) (August 2013)
Technical and Research Reports (Date Published)
A Thoughtful Conversation on National Improvement Strategies and Infrastructure for Improving Health Care in Kenya. <i>Technical Report</i> . (June 2013)

Reporting to USAID

- USAID Applying Science to Strengthen and Improve Systems Project FY13 Work Plan (Performance Period: October 1, 2012—September 30, 2013), submitted on November 27, 2012.
- USAID Applying Science to Strengthen and Improve Systems Project Gender Integration Strategy, submitted on December 27, 2012.
- USAID Applying Science to Strengthen and Improve Systems Project Knowledge Management Plan, submitted on December 27, 2012.
- The USAID ASSIST Project Semi-annual Performance Monitoring Report was submitted to USAID on May 15, 2013.

Activity 3. Support the Development of Improvement Competencies

- **In FY13, a competency framework for tasks relevant to the design and application of improvement approaches in ASSIST was finalized for initial review.** The framework is intended to support the development of competency-based learning modules targeted to priority needs initially of ASSIST staff, and then eventually of country counterparts. Feedback will be used to revise and finalize the competency framework and help identify priorities for the development of learning modules.
 - The framework was revised by Dr. Tana Wuliji who adapted it to create a self-assessment instrument on improvement competencies that was used by newly recruited improvement advisors in the ASSIST Uganda office before they undertook a basic training course in March. This training program, along with training conducted by ASSIST staff on qualitative research, were video recorded in preparation for editing into short instructional videos on a learning platform organized around the competency framework.
- **Ms. Kim Stover began reviewing the improvement capacity building content of the HCI Portal to select material that will be presented on the ASSIST Knowledge Portal, drawing on the improvement competencies framework.**

Directions for FY14

- Increase awareness of project work and accomplishments across all levels outside of current

circles of interaction via new approaches to relaying the work, messages and impact of ASSIST project work (succinct messaging, evaluation of poster and flyer text, presentations, etc).

- Launch ASSIST Facebook page and promote launch of ASSIST Portal. Use Facebook presence to highlight new content on the ASSIST Portal, particularly blog posts by staff on insight gained from participation at regional and international meetings and conferences.
- Launch ASSIST French Facebook page and promote the dynamic database of French resources available on the ASSIST Portal, including blog posts by Francophone staff.
- Use ASSIST Twitter to connect with global health counterparts and ASSIST beneficiaries. Continue to nurture ASSIST staff (Twitter champions) to use their personal Twitter handles to develop meaningful exchanges surrounding important meetings and conferences.
- Develop a concerted, 'whole' approach to outreach materials and conferences presence (flyers, posters, abstracts, booths, etc) that creates a recognizable theme for the project that attracts both internal and external audiences
- Search for new opportunities (conferences and meetings) for attendance at all levels (national, regional and global), encompassing traditional attendance (abstracts) but novel attendance (hosting an event).
- Evaluate the possibility of hosting events and if feasible testing such events to develop on a larger scale in the future.

3.2 Knowledge Management

Background

Building on HCI's KM system and the information communication technology innovations of partner Johns Hopkins University Center for Communication Programs (JHU-CCP), ASSIST is applying KM concepts and techniques to support the generation and harvesting of learning from improvement efforts, evaluation, and research at the country level and the integration of insights across countries to contribute to the global evidence base. In the first year of project implementation, our focus was on building the capacity of ASSIST staff in applying KM concepts and techniques and developing the ASSIST Knowledge Portal, to make learning from improvement available in a wide variety of formats. The ASSIST Portal, www.usaidassist.org, will serve as the central repository of improvement knowledge that is generated by every project activity and country program. The knowledge generated through improvement activities will first and foremost be expressed in each country in the form of knowledge packaged and disseminated locally through coaching visits, learning sessions, knowledge-sharing events, local websites, resource repositories in local institutions, competency development, and local publications. The ASSIST Portal will organize this packaged knowledge to make it available globally and add to it knowledge developed through global activities and research. In addition to the knowledge repository features of the site, the ASSIST Portal will seek to connect implementers through communities of practice, experience locators, discussion forums, and pushing out content based on the self-identified interests of site users. The ASSIST Portal will actively seek contributions from other implementers outside the project, to serve as a global resource on health care improvement, not limited to information about the project's work.

Program Overview

What are we trying to accomplish?	How will we know?	At what scale?
1. Develop and continuously refine the KM strategy for ASSIST	<ul style="list-style-type: none"> • Global KM plan/strategy developed for project and submitted to USAID • Annual KM reports submitted to USAID • Staff routinely apply KM concepts and approaches to synthesize, harvest, and spread learning from project-supported improvement efforts • Evaluations demonstrate added value of KM • Case studies document results and added value of gender focus in improvement 	Global

What are we trying to accomplish?	How will we know?	At what scale?
2. Develop a Knowledge Portal for improvement evidence and information and incorporate content from HCI, ASSIST-supported activities, and other implementers	<ul style="list-style-type: none"> • ASSIST knowledge portal is acknowledged as go-to source on learning and experience on improvement • ASSIST technical teams regularly contribute content to the site through blogs and case studies • Other implementers contribute and link to content on ASSIST knowledge portal 	Global
3. Document improvement knowledge and learning from activities supported by the USAID ASSIST Project	<ul style="list-style-type: none"> • Number and variety of case studies posted on the ASSIST knowledge portal • ASSIST country and technical teams have defined key learning questions for their improvement activities and apply KM concepts to gather/synthesize that learning • Blogs and resources posted on the ASSIST knowledge portal convey key learning from improvement efforts supported by the project • Proportion of ASSIST country teams that are establishing local knowledge repositories of key learning from improvement efforts 	In each country supported by ASSIST
4. Promote the use of improvement knowledge through the ASSIST KM system	<ul style="list-style-type: none"> • ASSIST social media sites connect improvement knowledge with other implementers • ASSIST supports vibrant Communities of Practice • ASSIST-supported country programs will actively use content on the ASSIST knowledge portal 	Global
5. Integrate gender in improvement activities	<ul style="list-style-type: none"> • ASSIST-supported country teams integrate gender considerations in the planning and implementation of improvement activities • Training materials, technical briefs, and tools are available to help implementers • Case studies document applications of gender integration 	Global

Key Activities, Accomplishments, and Results in FY13

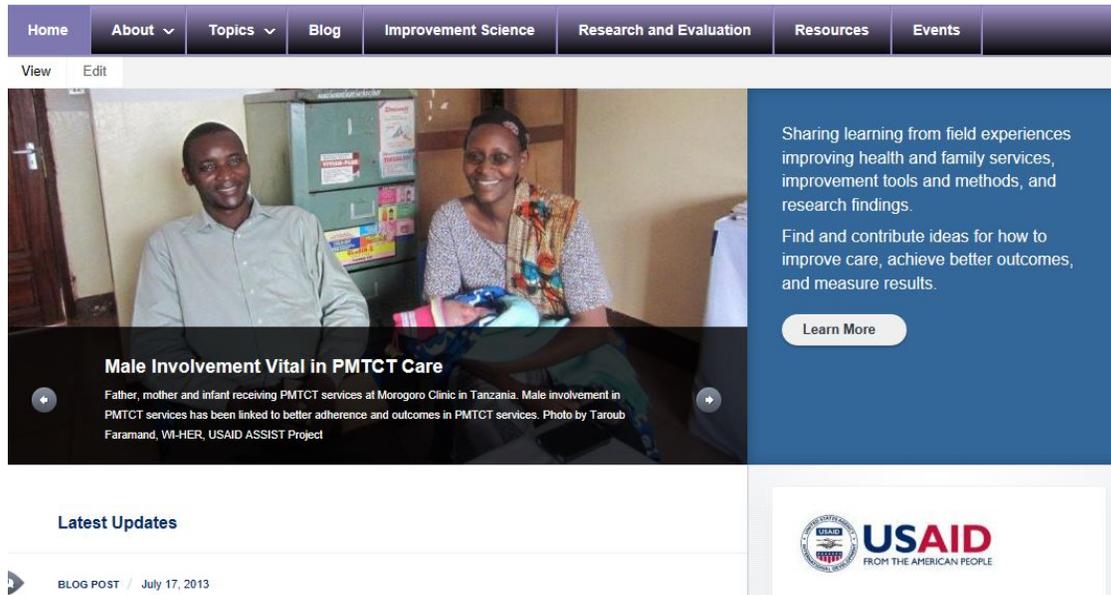
Activity 1: Develop and Continuously Refine the ASSIST KM Strategy

- **Developed a detailed KM plan and strategy for the project (Q1 FY13):** We gathered inputs for the strategy through a virtual consultation in November 2012 with the USAID AOR, ASSIST partners, and an expert consultant, Dr. Nancy Dixon. An important part of the conversation addressed engaging users in the ASSIST web portal. Priorities identified included: a) getting other implementing partners involved and included, specifically those who are working on improvement but not part of the ASSIST team; b) engaging MOH and professional associations in the portal (including sister sites like www.maternoinfantil.org); c) featuring other implementers' work--praising it and disseminating insights from it—and developing joint content with other projects are both strong strategies for engaging key groups outside the project; d) initiating specific collaboration with other partners that gets featured and engage thought leaders that people want to hear and know about their thoughts; e) implementing specific activities to motivate our own staff to take ownership for the project's KM strategy; f) continuing to foster in-person exchanges which could feed into the portal and creating face-to-face contacts that facilitate connections beyond the portal; and g) finding ways to attract those who have not yet developed an interest in improvement, especially policy makers.
- **Developed field staff capacity to apply KM concepts and techniques:** Two regional trainings were held involving ASSIST staff from 11 African countries: one was held in English in March 2013 in Durban, South Africa, and the other in French in June 2013 in Abidjan, Cote d'Ivoire. The four-day trainings built the capacity of country staff to incorporate KM into improvement programs,

including how to develop KM strategies for their improvement work, how to apply KM principles and techniques to the design and facilitation of learning sessions, and how to design knowledge transfer/handover processes, events and written products to convey key learning about a specific practice area or topic. The training workshops involved a cross-section of staff, including Chiefs of Party, technical advisors, KM/communications specialists, and monitoring and evaluation staff. Participants practiced several KM techniques during the training and received written guidance on how to apply specific KM techniques. Additionally, participants practiced creating knowledge nuggets – turning learning into actionable information –and were introduced to the concept of creating knowledge assets – compilations of knowledge nuggets and supplemental information (case studies, videos, etc.) to enable new implementers (i.e., Ministry or other local partners) to apply essential learning from improvement activities.

Activity 2. Develop a Knowledge Portal for ASSIST

- **Developed portal and prepared for soft launch December 2013:** In October 2012, a temporary page was launched at www.usaidassist.org to provide basic information on the project and the implementing team. In November, the ASSIST KM Director met with the web design and support team at JHU-CCP in Baltimore to define specifications for the ASSIST web portal using JHU-CCP's Sites4Dev platform, which is based on the Drupal content management system. Sites4Dev uses the Drupal content management system to make it easy to manage and add new content to the site, but standardizes the look and feel of the site with the web features that JHU-CCP has found to be the most popular in global health websites. As design worked continued, CCP engaged specialized assistance from Sonjara, a consulting firm specializing in web utilization review, to provide guidance on 508 compliance, organization of resources, development of the content management plan, and defining profiles of categories of expected users of the site to help to inform the design of site features. The main expected user groups include: ASSIST field staff; Ministry officials and technical staff; In-country NGO and implementing partner staff; ASSIST headquarters staff and partners; USAID Mission staff; USAID Washington staff; clinical staff/health workers/service providers; researchers; and international agencies and donors.
- **The final design of the site was presented to the AOR in July 2013.** The key topics that will be featured on the site are Improvement Science, R&E on Improvement, Community Health, FP and Reproductive Health, Gender, Health Workforce Development, HIV and AIDS, MNCH, Nutrition, and Vulnerable Children and Families. Resources on the ASSIST Portal will include all publications and resources formerly available on the HCI Portal and will be categorized as: Case Studies, Improvement Stories (includes collaborative profiles and improvement reports from the HCI Portal), Journal Articles, Training Materials, Reports (includes all technical and research reports, methodology papers, and manuals), Short Reports (includes flyers and summary research reports), and Improvement Method Summaries. The latter are a new feature on the ASSIST Portal to provide comprehensive descriptions of modern improvement methods. Another prominent feature of the site will be blogs that share key results or learning from ASSIST-supported improvement work or research and highlight new resources (including those developed outside the project) or events. All ASSIST staff and partners, including field staff, will be encouraged to contribute blogs to the site. The site will also feature ASSIST Project country program descriptions and highlight events related to health care improvement, including conferences. The R&E section will feature a searchable database of the project's Original Research.



Home About Topics Blog Improvement Science Research and Evaluation Resources Events

View Edit

Male Involvement Vital in PMTCT Care
Father, mother and infant receiving PMTCT services at Morogoro Clinic in Tanzania. Male involvement in PMTCT services has been linked to better adherence and outcomes in PMTCT services. Photo by Taroub Faramand, WI-HER, USAID ASSIST Project

Sharing learning from field experiences improving health and family services, improvement tools and methods, and research findings.
Find and contribute ideas for how to improve care, achieve better outcomes, and measure results.
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Latest Updates

BLOG POST July 17, 2013

 USAID
FROM THE AMERICAN PEOPLE

In the final quarter of FY13, CCP acquired the new server which will house the ASSIST Portal, and transfer of all technical resources from the HCI Portal to the ASSIST development server was completed. The soft launch of the site will occur in December 2013 and the formal public launch in January 2014.

Activity 3. Document Improvement Knowledge and Learning from Activities Supported by the Project

- **Provided KM training to ASSIST Nigeria staff:** ASSIST KM Specialist Ms. Kate Fatta traveled to Nigeria from November 27-December 7, 2012 to provide initial KM training to ASSIST/Nigeria staff. There she worked with the Nigeria M&E/KM Advisor to plan the second Learning Session, making use of KM approaches. In addition, she worked with the COP and M&E Advisor to develop a strategy for meeting the learning agenda for FY13, including planning for how results and successful changes will be documented and shared as well as planning for the preparation of case studies and knowledge products.
- **Provided KM training to ASSIST Cote d'Ivoire staff:** In February 2013, ASSIST Social Media Coordinator Ms. Feza Kikaya traveled to Cote d'Ivoire to provide training to the team there, including the KM intern, on the development of knowledge and communications products. She worked with the COP to develop the ASSIST Cote d'Ivoire learning agenda for FY13, including determining how best to incorporate KM approaches to promote learning and how best to build upon existing approaches of synthesizing learning. They also set priorities for the preparation of flyers (English and French versions), conference materials, and case studies. She also met with national HIV care program and USAID officers to understand their priorities for case studies and to explain ASSIST's knowledge management initiatives. These officials expressed interest in the content that will be featured on the ASSIST Portal and in participating in the planned ASSIST regional KM training in French.
- **Conducted regional KM training in Durban, South Africa:** At the training in Durban in March 2013, Ms. Marquez, Ms. Fatta, and Ms. Cassie Mickish of JHU CCP worked with staff from Cote d'Ivoire, Malawi, Mozambique, South Africa, Swaziland, Tanzania, and Uganda to plan their documentation efforts around key learning questions and to plan for how they will synthesize knowledge across improvement activities to convey key learning to others so that they can apply it in their context.

- **Developed Malawi and Uganda case studies:** Two case studies detailing the improvements made by specific teams were developed by the ASSIST Malawi and Uganda teams. The first case study under ASSIST was written by Ms. Tiwonge Moyo of the ASSIST Malawi team, describing community-based improvement work in a sub-district of Blantyre District. Both Ms. Moyo and Dr. Nigel Livesley, formerly the ASSIST Regional Director for East Africa, wrote blogs to accompany the case study. The second case study was developed by the ASSIST Uganda team on the work of Kisoro District Hospital to improve retention in care of mother-baby pairs.

Activity 4. Promote the Use of Improvement Knowledge through the ASSIST KM System

- **The KM team worked with the ASSIST headquarters PHFS team to develop a strategy for sharing learning internally and with the larger PHFS community through the PHFS listserv and Facebook page which are managed by ASSIST partner IHI.** The ASSIST PHFS team held its first regional knowledge exchange in June 2013 in Kampala, bringing together team members from Kenya, Malawi, Mozambique, Tanzania, Uganda, and headquarters to learn from each other, develop a common strategy of measures and key change concepts, and identify the key learning questions that all teams will try to answer through the PHFS improvement work. Insights from the Uganda team, which is further along in the implementation of PHFS activities than the other countries, were particularly helpful to the other teams. A summary of the conclusions of the meeting was shared on the PHFS listserv and Facebook page and posted on the HCI Portal at <http://www.hciproject.org/publications/implementing-partnership-hiv-free-survival-rolling-out-improvement-work-uganda> in August. The Uganda team also developed two “knowledge nuggets” on key learning about simplifying the baseline assessment in order to launch improvement work more quickly and prototyping the strategy in one site before rolling it out to all sites. The headquarters ASSIST PHFS team has created a space for internal technical sharing among the ASSIST PHFS teams on URC’s corporate intranet, CONNECT. The one-page “nuggets” are accompanied by the detailed coaching guides that were developed and refined through field testing by the Uganda team and a simplified data collection tool that they found more helpful for starting up improvement work with facility-based teams.
- **The Community of Practice on Kangaroo Care in Latin America was launched by the ASSIST team in Ecuador June 2013):** Twenty-five colleagues working on Kangaroo Care in several countries joined the community in its first week. The Spanish language virtual community of practice platform is hosted by ASSIST at www.maternoinfantil.org. The community of practice website was launched at the LAC Newborn Health Alliance Tech Meeting held in El Salvador, June 25-28. The purpose of the virtual communities of practice is to facilitate the exchange of experiential knowledge about how to efficiently and sustainably implement Kangaroo Care in MOH hospitals in the LAC Region.
- **In preparation for the launch of the ASSIST Portal, in September we transitioned the HCI Twitter handle to reflect our new project: @usaidassist.** Using the ASSIST Twitter handle, we alerted our followers about the upcoming launch of our new website. We continued to promote key activities that took place in the quarter, including the launch of the newly-designed CHW Central website, the publication of our Nicaragua neonatal sepsis article in the IJQHC, our participation in the APAC Forum, and other relevant events in which the project had a presence. We have also started transitioning our HCI Facebook presence to ASSIST, and will officially publish the ASSIST Facebook page in the first quarter of FY14. We also provided guidance to our Kenya team in the creation of their country-specific Facebook page (ASSIST Kenya). A French language ASSIST Facebook page is also in development to complement the planned French resources section of the ASSIST Portal and to facilitate learning among our Francophone staff and counterparts.

Activity 5. Integrate Gender in Improvement Activities

Please see Table 13. Further details are provided below.

Table 13: ASSIST gender integration activities FY13

ASSIST Countries	Examples of Gender Activities in FY13
Global	<ul style="list-style-type: none"> • Submitted USAID Applying Science to Strengthen and Improve Systems Project Gender Integration Strategy, December 27, 2012. • Provided technical support to integrate gender in the ASSIST core-funded Health Workforce Development activities. • Provided literature reviews to the monitoring and evaluation team on gender issues in: HIV partner testing, male compliance to care, gender roles in safe male circumcision and gender roles in chronic care. • Provided technical assistance to integrate gender in PMTCT, PHFS, HIV chronic care, HBC, Nutrition, MNCH, FP, TB, SMC, OVC and NCD in ASSIST countries. • Developed and piloted a field training on gender-based violence and how it affects health outcomes in Tanzania and Uganda. • ASSIST partner Dr. Taroub Faramand of WI-HER, LLC, and Dr. Ram Shrestha of URC presented at USAID in February, 2013 on how the project integrates gender concerns in improvement, giving examples of community-level work supported by Dr. Shrestha. • Dr. Faramand presented on gender integration at the project's first work planning workshop for all ASSIST staff in October 2012, and discussed proposed gender integration activities with chiefs of party and headquarters staff from different technical areas. • Developed a simple gender integration framework using improvement approaches now applied as an integral component of improvement activities. • Published and distributed gender integration technical briefs for the following technical areas: post-partum family planning, HIV testing and care, prevention of mother-to-child transmission of HIV, safe male circumcision, care for orphans and vulnerable children and a summary of the Gender Integration approach available as a flyer. Technical briefs on gender integration in SMC and PFP programs were drafted. A case study on gender integration training in Uganda was also drafted.
Cote d'Ivoire	<ul style="list-style-type: none"> • Conducted a refresher training in Bouake for nine QI coaches, and analyzed the participation rates of males and females to address gender considerations.
Mali	<ul style="list-style-type: none"> • Provided technical assistance for anemia control and prevention improvement in Bougouni (Sikasso) at the community level by making suggestions to the change package.
Tanzania	<ul style="list-style-type: none"> • Provided technical assistance to build ASSIST staff capacity in gender integration in improvement activities in Tanzania. This included conducting a two-day training on integrating gender into QI programming in Dar es Salaam, Tanzania during the third quarter that brought together 28 participants from USAID ASSIST, Tibu Homa Project and TACAIDS. As a result the Executive Director of TACAIDS adopted improvement approaches to integrate gender in their programs. • The project addressed gender gaps in the Morogoro region through including provisions of FP services at the CTC and improving and sustaining male partner testing at RCH visits through positive engagement of men in a supporting environment.
Uganda	<ul style="list-style-type: none"> • Provided an interactive training for and technical support to the Uganda ASSIST team on methods and illustrative action steps to integrate gender in all phases of improvement work in April 2013. Dr. Faramand also provided follow-on gender training to ASSIST Uganda in August 2013, providing technical support to partners and supporting the ASSIST Uganda team to adapt learning session materials to address gender issues and developing training materials to use for

	<p>gender trainings in the field. This included PowerPoint presentations, guidance for the instructor and activities and examples specific to the trainees' interests, needs and background.</p> <ul style="list-style-type: none"> • Provided technical support to integrate gender in the Safe Male Circumcision program. This included leading a gender integration discussion in an SMC learning session with 12 partner organizations from the Eastern Region in Uganda, and led to the adoption of female involvement to improve outcomes and reduce adverse effects in the SMC program by the National Task Force. • Conducted QI training with a focus on gender for community actors in Bugiri and Kamuli districts. A total of 70 participants comprising Village Health Teams (VHTs), Community Support Agents (CSAs) Community Development officers (CDOs) and • Provided technical assistance to integrate gender in the Uganda national standards of care for Orphans and Vulnerable Children and incorporated gender as part of quality improvement training for two NGOs, ANPPCAN and REPSSI, providing support to OVC. • Documented a case study on gender integration training in Uganda, what works and what does not work to be shared with professionals interested in gender integration. • Developed tools to integrate gender by adopting an improvement approach.
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- **Dr. Taroub Faramand of ASSIST partner WI-HER presented on gender integration at the project's first work planning workshop for all ASSIST staff (October 2012):** During the planning workshops, Dr. Faramand and ASSIST's Specialist for KM and Gender Integration, Ms. Cait Lutfy of WI-HER, discussed proposed gender integration activities with chiefs of party and headquarter staff from different technical areas. These discussions and follow-up meeting with headquarters staff in November resulted in the development of the ASSIST gender integration strategy which was submitted to USAID in December.
- **Provided an interactive training for and technical support to the Uganda ASSIST team on methods and illustrative action steps to integrate gender in all phases of improvement work:** During April 2013, Dr. Taroub Faramand and Ms. Caitlyn Lutfy of WI-HER spent two weeks in Uganda to provide an interactive training for and technical support to the Uganda ASSIST team on methods and illustrative action steps to integrate gender in all phases of improvement work. On the second day, all 28 members of the Uganda URC team participated in the workshop reviewing gender concepts and introducing gender-based violence and strategies to conduct their own gender trainings for local teams. The workshop concluded with the teams of each technical area integrating gender into their work plans. As a result, gender-related improvement activities were adopted for programs in SMC, Community Health for HIV, leadership and governance in HIV Services, OVC, and PHFS.
- **Conducted a gender training in Tanzania:** Dr. Faramand then traveled to Tanzania to conduct a gender training for ASSIST staff and staff of TACAIDS. Training materials were adapted to the Tanzanian context, and new materials developed to respond to local needs. The training addressed gender concepts and definitions, gender analysis, identifying gender aims and drivers, sensitization exercises, gender-based violence, and examining the data to ensure that we are addressing gender-related gaps and issues.
- **Provided follow-on gender training to ASSIST Uganda:** Dr. Faramand returned to Uganda in August 2013 to provide follow-on assistance in gender integration to the ASSIST Uganda team. She led the gender integration discussion in an SMC learning session with 12 partner organizations from Eastern Region in Uganda. She provided technical support to partners to design changes to test to address gender gaps they identified and supported ASSIST Uganda team to adapt learning session materials to address gender issues. She also participated in a coaching session in Buikwe Community in Uganda and led a discussion on gender integration with members of the QI team in Buikwe community. She also guided ASSIST Uganda staff on how to lead a session on gender integration at the community level and provided tools for the ASSIST team to use during coaching sessions.
- **Developed technical briefs and case studies:** Technical brief on key issues and strategies on

materials on gender integration in PMTCT, ART, and OVC programs were published in May and June, and additional technical briefs on gender integration in SMC and PFP programs were drafted. A case study on gender integration training in Uganda was also drafted.

What Are We Learning?

- Framing the learning questions within country improvement programs is challenging and represents a new way of thinking about the learning agenda of an improvement activity. Country and technical teams need support to develop the learning agenda in each improvement activity, define responsibilities for gathering and synthesizing learning, and develop knowledge products.
- Learning sessions and other improvement events need to be designed to allow participants to share in small groups and integrate new knowledge in the large group. Giving people the opportunity to share in small groups and ask questions of each other, and using techniques such as storytelling and knowledge cafes, enables implementers to learn far more than through formal presentations.
- It takes practice and dialogue with potential users to develop concrete lessons learned that provide practical, actionable advice for others. Describing “what we did” is not as useful as describing “what we would do” if we had to repeat the experience. Yet often when we approach documentation of “lessons”, we try to describe how we did something. Describing what you would advise others to do takes a somewhat different mindset and can benefit from checking with potential users about what they want to know about an experience.
- ASSIST staff engagement on Twitter, including live tweeting from events where ASSIST results are presented, helps to increase the project’s visibility and adds value and substance to related conversations occurring in the Twittersphere.

Directions for FY14

- We will launch and promote through social media the ASSIST Knowledge Portal and launch the ASSIST Facebook page. We will reach out to other implementers and ASSIST partners to share our content and to highlight their resources, news, and events.
- We will continue with in-country technical assistance, focusing first on Kenya, Malawi, Tanzania and Uganda, to support country team in applying KM methods. We will highlight specific applications of KM techniques on the ASSIST Portal and facilitate sharing of knowledge products developed by ASSIST teams.
- During FY14, we will evaluate target audience response to the site, refine it, and add new features incrementally, based on user testing and feedback. We will also conduct field studies to measure the added value and costs of KM approaches as part of improvement work.
- We will use social media (ASSIST Facebook in English and French and ASSIST Twitter) to promote new content on the ASSIST Portal and connect with specific groups who will be interested in that content, encouraging conversations about improvement and increasing access to improvement knowledge and tools. We will use the French Facebook page to deepen our engagement with our francophone counterparts, and to promote the availability of French resources and blog posts on the ASSIST Portal.
- We will continue to create new resources to support implementers in addressing gender issues within specific services (e.g., male circumcision) as well as document key learning relevant to gender integration coming out of ASSIST-supported activities in the form of blogs, improvement stories, and case studies. We will actively disseminate gender resources on the ASSIST knowledge portal to country and technical teams as well as other implementers and share our learning about gender integration in conferences and through peer-reviewed publications.

3.3 Research and Evaluation

Background

The R&E unit provides technical support and guidance on country-led research and syntheses of learning across country projects on improvement topics such as validity of improvement-related data, sustainability and institutionalization, spread and cost-effectiveness for most ASSIST activities. The R&E unit works to disseminate knowledge from these studies to encourage wider adoption of improvements methods used in projects.

In FY13, the R&E unit of ASSIST began several country-led research programs including the study of pediatric TB diagnostic testing in Swaziland, the effectiveness and efficiency of using brief physician interventions to decrease alcohol and tobacco use in pregnancy in Ukraine, integrated HIV care for mothers and their infants, studies on PMTCT services and retention in care in Tanzania and studies on testing and follow-up for HIV services in Burundi. The R&E team also provided technical assistance for OVC measurement plans and the planning of services in Nigeria, Kenya and Uganda as well as assistance with country planning on how to validate 25% of country-reported data.

Program Overview

Research Activities	What are we trying to accomplish?	How will we know?	At what scale?
1. Validation of >25% of improvement indicators	<ul style="list-style-type: none"> Demonstrate that data reported by the ASSIST project are accurate, reliable and relevant 	<ul style="list-style-type: none"> Completed reports on validity studies on 25% of indicators. Plans implemented to address deficits in validity when detected 	No less than 25% of total number of country reported indicators with completed validity assessment
2. Evaluation of improvement interventions using comparisons with control groups for at least 10% of improvement indicators	<ul style="list-style-type: none"> Demonstrate the positive impact of the ASSIST intervention on improvement indicators 	<ul style="list-style-type: none"> Completed evaluation reports for 10% of indicators 	Comparison reports on no less than 10% of country-reported indicators
3. Economic analysis of improvement approaches and strategies	<ul style="list-style-type: none"> Advance global learning on comparative advantage and economic efficiency of QI activities 	<ul style="list-style-type: none"> Completed cost-effectiveness studies of improvement approaches and strategies 	At least one economic analysis for every ASSIST country with an improvement program
4. Conduct rigorous research into mechanisms for improving the quality of care	<ul style="list-style-type: none"> Advance learning on the science of improvement as applied in lower and middle income countries 	<ul style="list-style-type: none"> Completed studies evaluating the design of improvement activities 	Every ASSIST country program
5. Evaluating design of improvement activities for lower and middle income countries	<ul style="list-style-type: none"> Advance learning on the science of improvement as applied in lower and middle income countries 	<ul style="list-style-type: none"> Completed studies evaluating the design of improvement activities 	Every ASSIST country program
6. Evaluation of methods and approaches for effective design and implementation	<ul style="list-style-type: none"> Advance global knowledge on scale up of improvement interventions 	<ul style="list-style-type: none"> Completed studies evaluating methods and approaches for effective design and implementation of scale up 	Selected ASSIST country programs with scale up activities

of scale up			
7. Generate and disseminate learning from multi-country research	<ul style="list-style-type: none"> Contribute to the QI and global health fields 	<ul style="list-style-type: none"> Grey literature, peer-reviewed publications, conference presentations, other meetings or presentations 	Globally available publications on learning from implementing improvement programs
8. Capacity building for research and support to country programs	<ul style="list-style-type: none"> Build research and data management capacity of HCI staff 	<ul style="list-style-type: none"> Provided guidance and training to HCI staff for research and data management 	Every ASSIST country program

In FY13, the ASSIST R&E team conducted work on thirteen studies. To date, the team has developed protocols for 10 of these studies. Six studies have begun or have been cleared to begin data collection because they have passed ethical review by the URC and local IRBs. Two studies have begun data collection. (See Table 14 below)

Table 14: USAID ASSIST research studies underway as of end FY13

	Country	Study	Research Area	Status	Program Area
1	Burundi	Factors associated with not returning to health centers among pregnant women who tested positive for HIV	Improving Care	Protocol drafted	HIV & AIDS
2	Burundi	Factors associated with HIV testing among male partners of pregnant women	Improving Care	Protocol drafted	HIV & AIDS
3	Mali	Impact of anemia collaborative intervention in Mali	Design of Improvement Activities	Concept paper developed	MNCH
4	Mali	Risk of anemia attributable to malaria, iron deficiency and parasites in Mali	Design of Improvement Activities	Concept paper developed	MNCH
5	Nigeria	Validation of OVC data at the community level	Validation	Tools completed, evaluation to commence FY14	OVC
6	Swaziland	Increasing diagnosis of childhood TB in Swaziland: Clinical utility and validity sample collection and diagnostic methods among children in Swaziland	Improving Care	Approved by IRB – Study underway	TB
7	Swaziland	Injection Safety, Waste Management Practices and Related Stigma and Discrimination in Swaziland: A national assessment, exploratory study, and evaluation	Improving Care	Protocol in review with Swaziland IRB	HIV & AIDS
8	Tanzania	Factors associated with missed appointments among ART clients in Mtwara Region	Improving Care	Protocol drafted	HIV & AIDS
9	Tanzania	A qualitative evaluation of "Assuring Infants and Mothers Get All PMTCT Services" (AIMGAPS)	Design of Improvement Activities	Protocol in review with Tanzania IRB	HIV & AIDS
10	Uganda	The effectiveness and efficiency of applying the chronic care model to clients with HIV in Uganda: A non-randomized controlled evaluation	Design of Improvement Activities	Baseline data collection complete	HIV & AIDS

11	Uganda	Improving the quality of safe male circumcision in Uganda: An evaluation and qualitative exploration	Improving Care	Protocol approved by URC and Uganda IRB	HIV & AIDS
12	Uganda	The effectiveness and efficiency of integrated service delivery to HIV-positive mothers and their babies in Uganda	Design of Improvement Activities	Protocol approved by URC IRB. Preparing submission to Makerere U. IRB	HIV & AIDS
13	Ukraine	Improving Alcohol and Tobacco Control during Pregnancy in Ukraine	Design of Improvement Activities	In review by IRB in Ukraine	MNCH

Key Activities, Accomplishments, and Results

Activity 1. Validation of 25% of improvement indicators:

ASSIST is mandated to validate 25% of the total number of country reported improvement indicators. Appropriate validation methods vary depending on indicator types and the validity questions surrounding them. Table 15 illustrates some of the approaches to validation that ASSIST has developed for implementation in various countries. There has also been significant technical assistance provided by the R&E team to develop improvement indicators for country activities.

Table 15: Approaches to validation of improvement indicators

Validity question	Possible collection methods	Example
Do data recorded in patient charts/facility or community registers accurately reflect what happened in patient encounters?	Direct observations; mystery patients; exit interviews	Direct observation by experts of deliveries is compared to patient records to determine the agreement in records of compliance with AMTSL
Do data recorded in improvement reports accurately reflect what is recorded in patient charts / facility or community registers	Chart/register audits	Expert chart reviewers audit ART medical records to determine their agreement with what the improvement teams recorded for patient compliance from the same records
Does a positive score in the indicator mean that the actual outcome is positive for the patient?	Direct observations; exit interviews	Interviews with patients on their experience with care can be compared with the indicators of "patient-centered care" to determine if there is consistency in results

- **Built validation of data into the study**, "The effectiveness and efficiency of applying the chronic care model to clients with HIV in Uganda: A non-randomized controlled evaluation" which is described in greater detail below. ASSIST seeks to build validation of improvement indicators into broader evaluations when that validation of data fits into and strengthens the study design. The accomplishment is that data have been collected for the baseline phase of this study and preparation and planning for endline data collection has also been completed. A test for the validity of the data will be conducted using sources of client data to determine their agreement with each other. For example, CD4 counts in patients on ART will be used to determine their association with other measures of client health status.

Activity 2. Evaluation of improvement interventions using comparisons with control groups for at least 10% of improvement indicators

There are three main approaches ASSIST is using or planning to use with regard to include

control groups:

1. Identifying similar facilities, community health areas or systems that are not exposed to the ASSIST intervention and measuring the same indicators at these sites. This may involve sending trained data collectors to control sites to ensure the accuracy of the data gathered from these control sites where the capacity for record keeping and data collection may be low.
 2. Step-wedge designs: If a staggered start to the intervention is planned, a step-wedge design may be used, where data collected during the non-intervention period from sites that are starting in a later phase serve as the control sites for sites that are starting in the first phase of intervention. This avoids the potential problem of collecting data from sites at which there is no plan to intervene, as in the aforementioned method (above).
 3. Cross-over designs: In country programs where there is implementation of two or more components, a cross-over design can be used whereby one group of sites implements one component while a second group of sites implements the other component. Indicators for both components are measured in both sets of sites and each acts as the other's control. For example, if one set of sites is implementing the chronic care model to ART patients while another set of sites is working on integration of PMTCT services, the chronic care sites act as the control sites for the PMTCT evaluation while the PMTCT sites act as the control for the chronic care sites. At some point in time, the interventions switch and further comparisons can be conducted at that time.
- **Finalized a protocol for a study of “The effectiveness and efficiency of applying the chronic care model to clients with HIV in Uganda: A non-randomized controlled evaluation.”** Data collection for this study began in the April-June quarter of FY13 and will continue into FY14.
 - **The USAID ASSIST project is planning a follow-on to the chronic care improvement intervention implemented by HCI in Buikwe from October 2010 to October 2012.** Under ASSIST, the chronic care model will be spread to two neighboring districts, Mityana and Nakaseke in Central Uganda. This is a controlled (pre/post-intervention or interrupted time-series) study using quantitative and qualitative data from a random sample of clients receiving HIV services at any one of the sites participating in the study. The study seeks to answer the following research questions:
 1. Are clients exposed to the chronic care model more likely to remain on treatment and maintained in the continuum of care than clients treated with standard care?
 2. Are clients exposed to the chronic care model more likely to remain adherent with their treatment regimen than clients treated with standard care?
 3. Are providers exposed to the improvement intervention more likely to have access and knowledge of the national treatment guidelines than clinicians not exposed to the intervention?
 4. Are client charts more likely to be completed in clinics participating in the improvement intervention than client charts from clinics not exposed to the improvement intervention?
 5. Do clients exposed to the chronic care model demonstrate better outcomes than clients treated with standard care?
 6. Are clients who receive care in intervention clinics more likely to receive care in a timely manner than those receiving care in clinics in which there is no chronic care intervention?
 7. If outcomes are better among clients exposed to the chronic care model compared to those treated with standard care, what is the cost-effectiveness of the chronic care model in this setting?
 - Quantitative data will primarily be collected from client medical records. The estimated sample size is 370 in each of the control and intervention groups for a total of 740. A test for the validity of the data will be conducted using client interviews to verify the accuracy of the information appearing in the medical record. CD4 counts will be used as a measure of clinical status.

- Baseline CD4 tests will be conducted for clients who do not have a documented CD4 taken 30 days before of baseline data collection. As CD4 tests every six months is part of standard care, follow-up CD4 counts will be taken from medical records. Data on wait times will also be collected. Qualitative data will be collected from client and provider interviews.

Activity 3. Economic analysis of improvement approaches and strategies

- **Finalized a protocol and tools for a study of “Increasing diagnosis of childhood TB in Swaziland: Clinical utility and validity sample collection and diagnostic methods among children in Swaziland.”** The study, described in more detail under Activity four below, has been approved by both the US-based and the Swaziland IRB. There is a cost-effectiveness analysis component included in this study and planning the development of tools has been completed.
- **Finalized a protocol and tools for a study of “The effectiveness and efficiency of integrated service delivery to HIV-positive mothers and their babies in Uganda.”** The study has been approved by URC’s IRB and is in review with the ethics committee at Makerere University in Kampala, Uganda. There is a cost component examining the incremental efficiency of different modes of services delivery with respect to initiation on ART and retention of mother-baby pairs into care.

Activity 4. Conduct rigorous research into mechanisms for improving the quality of care across clinical areas

- **Completed a study protocol and tools for “Injection Safety, Waste Management Practices and Related Stigma and Discrimination in Swaziland: A national assessment, exploratory study, and evaluation.”** While there is substantial literature in the HIV field on stigma and discrimination from the perspective of people living with HIV, there have been fewer studies globally about health worker experiences providing HIV care, the associated stigma and its impact on their job satisfaction and engagement in their work. Further, there is little research around injection safety and waste management in Swaziland. This study will seek to understand:
 1. What type of injection safety and waste management practices and policies exist within facilities in Swaziland?
 2. What type of stigma and/or discrimination do health care providers feel or express related to HIV care and treatment and other blood-borne pathogens?
 3. How do improvement activities around injection safety effect HIV-related stigma and discrimination?
- This study will use both qualitative and quantitative methods to explore existing practices and policies, issues of stigma and discrimination, identify opportunities for improvement in injection safety, and measure the impact of those improvement efforts. A concurrent transformative strategy (Creswell 2009) will be employed in which baseline data on injection safety and waste management practices and the presence and form of any related stigma and discrimination will be collected to inform the design of an improvement intervention. Endline data, also captured through mixed methods, will provide evidence of change.
- **ASSIST’s research protocol for a study on “Improving the quality of safe male circumcision in Uganda: An evaluation and qualitative exploration” was approved by the URC IRB and the local IRB in Uganda.** ASSIST is working to register the study with the National Institute of Medical Research in Uganda. Data collection is scheduled to begin in December 2013.
- **Working with 10 implementing partners to improve the quality of safe male circumcision/voluntary male circumcision services in 30 facilities in Uganda.** The goal is to reduce adverse events resulting from the operation, improve adherence to standards for SMC, and improve follow up at 48 hours and at 7 days. After the intervention, the 10 IPs will then scale up improvements to other facilities that they support.
- **Worked with implementing partners to conduct a facility-level assessment of the 30 facilities using the SMC Quality Standards Tool in Uganda,** an adaptation of the WHO Male Circumcision Services Quality Assessment Toolkit, which measures compliance with 53 minimum standards for SMC for HIV prevention across seven areas: (Management systems; Supplies, equipment and environment; Registration, group education and IEC; Individual counseling and

HIV testing for male circumcision clients; Male circumcision surgical procedure; M&E; and Infection prevention. This study seeks to both evaluate the interventions implemented and to better understand why some SMC clients return to the facility for follow-up care and others do not. This is a pre/post evaluation with an embedded qualitative study.

- **Drafted a protocol for a study in Burundi on “Factors associated with HIV testing among male partners of pregnant women.”** Increasing male participation has been identified as a potentially critical strategy to enhance PMTCT uptake in PEPFAR countries. ASSIST has been asked to provide support for the implementation of an improvement collaborative focused on improving the quality of PMTCT services in four provinces in Burundi. This study seeks to enhance the QI intervention package by identifying factors that promote or inhibit HIV testing among male partners of women seeking antenatal care. Findings will inform the development of a package of best practices to promote male testing, which is seen as a proxy for male participation in PMTCT programs. The following research questions will be addressed:
 - What socio-demographic factors are associated with being tested for HIV among partners of women in ANC?
 - What are the individual and structural factors that are associated with testing among partners of women enrolled in ANC?
 - What are the factors that influence not sharing HIV status among couples?
 - ASSIST drafted a protocol for a study in Burundi on “Factors associated with not returning to health centers among pregnant women who tested positive for HIV.” This study seeks to explore factors that influence why women may not return to facilities after testing positive for HIV. The following research questions will be addressed:
 - What is the true outcome of women who do not return to the facility for PMTCT services?
 - What are the facilitators of PMTCT uptake among women who test positive for HIV during ANC?
 - What are the barriers to PMTCT uptake among women who test positive for HIV during ANC?
- **ASSIST finalized a protocol and tools for a study of “Increasing diagnosis of childhood TB in Swaziland: Clinical utility and validity sample collection and diagnostic methods among children in Swaziland.”** The study has been approved by the URC IRB and has been submitted to the Swaziland IRB.
- **Began data collection for a study of “The effectiveness and efficiency of applying the chronic care model to clients with HIV in Uganda: A non-randomized controlled evaluation.”** For more details, see Activity two above.

Activity 5. Evaluating design of improvement activities for lower- and middle-income countries

- **Finalized a research protocol for a qualitative evaluation of AIMGAPS.** This protocol cleared URC’s internal IRB and is currently under ethics review with the National Institute for Medical Research in Tanzania. The research questions for the qualitative evaluation are:
 1. What are clients and providers perceptions of PMTCT services with respect to quality, uptake and retention?
 2. How do clients experience receiving PMTCT services and providers experience delivering these services?
 3. What are the perceptions of and experiences with Option B+ from both provider and client perspectives?
 4. Are there differences in provider and clients perceptions and experiences between those sites with facility-only support and those with facility and community-level support?The findings from this study are expected to contribute to knowledge of how to improve the quality of PMTCT services and client uptake and retention into care.
- **Finalized a research protocol for a study on “The effectiveness and efficiency of integrated service delivery to HIV-positive mothers and their babies in Uganda.”** ASSIST works in 22 facilities across six districts of Uganda to improve retention of mother-baby pairs in care, to attain universal breastfeeding and improved nutrition of mother-baby pairs, and ensure that HIV-

exposed infants are protected through ARVs. The objective of this study is to evaluate these different modes of service delivery among the 87 spread facilities in Uganda with particular attention to infant feeding and retention into care of mother-baby pairs. The specific research questions for this study are:

1. How do mothers experience and perceive care across the different modes of service delivery (i.e., services provided in ART clinics, post-natal clinics or clinics where the services are merged)?
2. How effective are the different modes of service delivery compared to the current mode of service delivery in terms of initiation on ART if indicated, receiving routine health services and retention in care?
3. What is the incremental efficiency of the new modes of service delivery compared to the current mode of service delivery in terms of initiation on ART if indicated, receiving routine health services and retention in care?

This prospective pre-post mixed methods study was approved by the URC IRB and ASSIST is preparing the protocol and tools for submission to Makerere University for in-country ethics approval.

- **Developed a research protocol for a study on “Improving Alcohol and Tobacco Control during Pregnancy in Ukraine.”** This study will evaluate the effectiveness and efficiency of an ASSIST intervention in decreasing the prevalence and intensity of alcohol and tobacco use in the areas targeted for the intervention. The research questions are:
 1. Does the improvement activity change primary health provider behavior such that they improve their delivery of the evidence-based intervention to decrease alcohol and tobacco use during pregnancy?
 2. Does the improvement activity lead to a decrease in self-reported alcohol use among women who report alcohol consumption during their pregnancy in facilities with clinicians exposed to the intervention?
 3. Does the improvement activity lead to a decrease in tobacco use among women who smoke during pregnancy in facilities with clinicians exposed to the intervention?
 4. What is the incremental cost-effectiveness of the improvement activity in terms of expenditure per additional woman who decreases or abstains from alcohol or tobacco during pregnancy?
 5. This protocol will be finalized and submitted for IRB review in the next quarter.
- **Drafted a concept paper for an assessment the impact of a health worker performance intervention on PMTCT quality of care and patient outcomes in Burundi.** This assessment will seek to: 1) Determine whether the implementation of an HWP intervention alone is associated with improved quality of care and patient outcomes; 2) determine whether the integration of an HWP intervention with a QI collaborative enhances quality of care and patient outcomes. The concept paper will be submitted to the Burundi Mission for consideration for FY14.

Activity 6: Evaluation of methods and approaches for effective design and implementation of scale up

While there were not R&E activities specifically focused on the scale-up of improvement intervention, there are studies planned in Mali on MNCH and in Burundi for PMTCT. These potential research activities will depend on the evolution of the programs themselves and therefore cannot be finalized until decisions for scale-up are made later in FY14.

Activity 7. Generate and disseminate learning from multi-country research

Studies examining retention in care of HIV-positive clients were planned in Burundi and Tanzania this fiscal year. It is expected that findings from these two studies will generate multi-country learning.

The R&E unit, in collaboration with country team members, other partners and the ASSIST KM team, plans to disseminate the findings of our research activities in new and interesting ways. Particular attention will be paid to circulating our research findings among those beyond the field of QI. This

includes presenting research in such a way as to make it relevant and accessible to a broader global health audience. Examples of dissemination activities include:

1. Publishing rigorous research in peer-reviewed journals, with a focus on journals outside the field of improvement;
2. Presenting findings at international or regional conferences; and
3. Participating in and/or organizing webinars or other meetings.

The R&E unit will work closely with ASSIST's KM unit to publicize events and publications through such social media as Facebook and Twitter as well as the ASSIST website.

Activity 8. Capacity building for research and support to country programs

- **Dr. Smith traveled to Mozambique to provide support to the Mozambique team to refine project indicators and draft a plan for validation.** The objectives of her trip included providing support in analyzing and presenting focus group data on HBC, beginning to discuss a plan for validating indicators as per the ASSIST mandate, and to provide training in qualitative research methods. Due to staff turnover and the timing of the trip, support for analyzing the focus group data on HBC was not needed. The draft HBC standards had not been received by Mozambique Chief of Party Luke Dausse. Discussions were focused on the development of improvement indicators and the options for validating them. Indicators will be drafted once the draft standards are received. Dr. Smith traveled to Uganda to provide support to the ASSIST Uganda team in formulating and refining their research questions for qualitative studies, and to work with the R&E staff to refine outcome indicators and draft a plan for validation. Plans were developed for five studies:
 1. Impact of Community-based QI on Retention and Adherence
 2. Chronic Care Evaluation
 3. OVC Gender Equity Study
 4. SMC
 5. NACS and PMTCT
- **Dr. Astou Coly traveled to Burundi and Tanzania to work with ASSIST teams to finalize research questions for three studies as described above, draft protocols and plan study activities.** She also provided support for the validation of indicators as mandated by ASSIST to the Burundi and Tanzania Teams.

Directions for FY14

- In FY14, the R&E team will continue with provide technical assistance to country teams to develop, collect and analyze indicator data for improvement activities. Part of this will be developing a system to archive data in a way that allows relatively easy retrieval for further, possibly grouped, analysis in the future as more data across different settings and technical areas, are collected.
- In FY14, ASSIST studies that were developed in FY13 will move into the data collection phase, and the first ASSIST studies will be completed later this year. The ASSIST R&E team will test new means of disseminating the project's research results and activities, including blogs, infographics, and podcasts, in addition to our focus on publishing in peer-reviewed journals, presenting our work at international conferences, and making our research available online.
- During the upcoming fiscal year, the R&E team, in collaboration with other key staff on the project, will develop a track on client-centered care as an integral part of QI. The team will distill the key elements of client-centered care and integrate them into one or two demonstration activities.

4 Obstacles and Remedies

Obstacles

Many ASSIST activities are facing significant difficulties due to the delay in funding obligations. Most significantly for Mission field support-funded activities, the delay in funding has stalled the progress of

multi-year initiatives, prevented the implementation planning and start-up for new activities, and called into question the plans made by both Missions and MOHs this coming fiscal year. Most African Missions' funding continues to await approval by the Africa Bureau. As a result, the project is beginning to incur unnecessary additional transition costs and costs to re-plan and renegotiate scopes of work that were already signed for by Mission personnel in their Country Operational Plans and Integrated Country Improvement Plans. Technical progress will be greatly impeded by this bureaucratic delay. Core funding for global HIV programs is also stalled awaiting approval of the Headquarters Operational Plans. The core-funded work supports a portfolio of personnel and multi-year activities that are adversely affected by the gap in funding. Technical directors at USAID are frustrated by the resulting lack of progress, with ASSIST unable to meet expectations due to the ongoing funding delays.

Remedies

Please expedite the obligation of funding actions that have been pending. Also please adjust funding timelines so as to prevent ASSIST from continuing to have to repeatedly stop and start ongoing activities, as this damages technical progress of work as well as relationships with MOHs.

5 Analysis and Explanation Costs

Costs-to-date have continued to fall below the anticipated spending rates or unit costs as proposed to USAID, due to stringent cost-control policies and procedures exercised by URC. As a result of the delays in funding obligations, spending has lagged significantly behind the proposed burn rates for the first year of the project. Spending levels for the majority of activities reflect the delayed start-up dates due to the actual timing of field-support and core-funded obligations. The only exceptions are the activity in India, which was funded to last 18 months and was also delayed in start-up due to decisions by the Government of India, and the global NACS and PHFS activities, which are follow-on projects to activities which are still being wrapped up by the predecessor project. In both of these cases, projected spending is in line with proposed rates and they will expend all obligated funds in the coming fiscal year.

6 Performance Monitoring Plan

Table 16 summarizes progress through year one (FY13) on key indicators in the ASSIST performance monitoring plan.

Table 16: Progress on USAID ASSIST Project performance monitoring indicators, October 2013

Project Management					
#	Indicator	Baseline	End of Project Target	Progress as of October 2013	Data Source/ Collection methods
1	# of Annual Work Plans submitted on-time to the AOR	0	5	2	Transmission of deliverable to the AOR
2	# of Annual Project Reports submitted on-time to the AOR	0	5	NA	Transmission of deliverable to the AOR
3	Gender Framework submitted within 90 calendar days of the cooperative agreement effective date	0	1	1	Transmission of deliverable to the AOR
4	# of Annual Research and Evaluation Reports submitted on-	0	5	NA	Transmission of deliverable to the

	time to the AOR				AOR
5	# of quarterly financial reports submitted on-time to the AOR	0	20	4	Transmission of deliverable to the AOR
6	# of Semi-annual Performance Monitoring Reports submitted on-time to the AOR	0	10	2	Transmission of deliverable to the AOR
7	Final Report of the cooperative agreement submitted on-time to the AOR	0	1	NA	Transmission of deliverable to the AOR
Documentation and Knowledge Management					
#	Indicator	Baseline	End of Project Target	Progress	Data Source [Benchmark]
1	Knowledge Management Plan submitted within 90 calendar days of the cooperative agreement effective date	0	1	1	Transmission of deliverable to the AOR
2	# of Documentation and Knowledge Management Reports submitted to AOR	0	5	NA	Transmission of deliverable to the AOR
3	Design of ASSIST Knowledge Portal submitted to AOR for approval	-	1	1	Written approval by AOR [Benchmark: completed in year 1]
4	# of country case studies	0	30	2	[Benchmark: 20 completed by the end of year 3]
5	# of research and evaluation studies examining the KM system as a whole or components	0	4	0	[Benchmark: four completed by the end of year three]
6	% of ASSIST country teams with at least one team member with basic competencies in KM and documentation	0	100%	79% (11/14)	Country program quarterly and annual reporting; special surveys
7	% of assisted countries that apply KM approaches to conduct synthesis and knowledge harvesting exercise each year	7% (1/14)	100%	21% (3/14)	Country program quarterly and annual reporting; special surveys
8	Average # of knowledge products developed per country	TBD	3	0.6 (8/14)	Country program quarterly and annual reporting
9	% of assisted countries with local repository of improvement knowledge	0%	Baseline + 25%	0%	Country program quarterly and annual reporting
10	# of communities of practice supported on the ASSIST	0	3	0	HQ quarterly and annual reporting

	knowledge portal				
1 1	# of virtual learning events supported by the ASSIST KM system	0	3	0	HQ quarterly and annual reporting
Global Technical Leadership					
#	Indicator	Baseline	Target	Progress	Data Source/ Collection methods
1	# of articles on improvement methods and results published in peer-reviewed journals; possible topics to be addressed include application of improvement approaches to new areas, major technical issues in the field of improvement, gender integration as an improvement strategy, results of KM activities	0	10	0	Publication of acceptance for publication
2	# of assisted countries with national health care improvement policies and strategies	3 (South Africa, Uganda, Tanzania)	Baseline + 5	4	Country program quarterly and annual reporting
3	# presentations given by ASSIST staff at global health technical conferences	0	25	31	HQ and country quarterly and annual reporting
Field Operations					
#	Indicator	Baseline	Target	Progress	Data Source/ Collection methods
1	% of integrated country design plans signed by country and USAID stakeholders	0	100%	100% (6/6)	Country Improvement Plan signed
2	% of annual country reports submitted on-time	NA	100%	NA	Dates of submission of annual country reports to AOR
3	% of annual country reports that examine magnitude and spread rate of improvement	NA	100%	NA	Review of annual country reports
4	% of country-reported indicators externally validated	NA	25% of reported indicators	(3 country studies underway)	Country quarterly and annual reporting
5	% of improvement indicators tracked with a QI and non-QI intervention comparison groups	NA	10% of reported indicators	Estimated <5%	Country quarterly and annual reporting
6	% of countries collecting and analyzing sex-disaggregated data for improvement when relevant	TBD	100%	86% (6/7)	Country quarterly and annual reporting

7	% of country programs tracking expenditures for the purpose of economic evaluation (integrated into the country plan)	0	80%	7%	Accounting records
8	% of integrated country design plans that address relevant gender-related barriers	NA	30%	43% (3/7)	Review of integrated country design plans

NA = Not applicable (deliverable not yet due)

TBD = To be determined

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