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TECHNICAL REPORT

Uganda-Lesotho knowledge exchange for the Partnership for HIV-Free Survival: *Reflections and recommendations*



SEPTEMBER 2015

This report was prepared by the Institute for Healthcare Improvement (IHI), University Research Co., LLC (URC), and Johns Hopkins Center for Communication Programs (CCP) for review by the United States Agency for International Development (USAID) and authored by Maureen Tshabalala and Patty Webster of IHI with contributions from Amy Stern, URC, and Sidhartha Deka, CCP. The Uganda-Lesotho knowledge exchange was funded in part by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). The USAID ASSIST Project is made possible by the generous support of the American people through USAID and is managed by University Research Co., LLC (URC).

Cover photo: Visiting Lesotho delegation observes a quality improvement team meeting in a Health Center IV, Uganda. *Photograph by Sidhartha Deka, CCP.*

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DISCLAIMER

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Acronyms

ART	Antiretroviral therapy
ASSIST	USAID Applying Science to Strengthen and Improve Systems Project
DG	Director General
DHO	District Health Officer
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
IP	Implementing partners
M&E	Monitoring and evaluation
MoH	Ministry of Health
MUAC	Mid-upper arm circumference
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHFS	Partnership for HIV-Free Survival
PMTCT	Prevention of mother-to-child transmission
Q&A	Questions and answers
QI	Quality improvement
URC	University Research Co., LLC
USAID	United States Agency for International Development
WHO	World Health Organization

Glossary of Terms

Knowledge exchange: A process where individuals or organizations share information, ideas, expertise and experiences for a common purpose.

Exchange session: A period of time devoted to two-way giving and sharing of information, ideas, expertise and experiences.

Mixed-method: A combination of methods used to exchange information, ideas and learning insights.

Report-back: A verbal account of something a group has been tasked to do (for example, a summary of a small group brainstorming session to a larger audience),

EXECUTIVE SUMMARY

Introduction

The Partnership for HIV Free Survival (PHFS) is a six-country initiative (Kenya, Lesotho, Mozambique, South Africa, Tanzania and Uganda) to assist the countries with their current national efforts to improve prevention of mother-to-child transmission (PMTCT), maternal, and infant care and nutrition support. As part of the PHFS, knowledge exchange visits are arranged to share effective implementation strategies/practices between country teams as well as programmatic challenges and how they are overcome. Organized by the USAID Applying Science to Strengthen and Improve Systems Project (ASSIST), this knowledge exchange was held between PHFS participating country representatives from Uganda and Lesotho.

Overview of the Exchange: What and How

A mixed-method agenda was created to provide ample opportunities for knowledge exchange and shared learning. Day one consisted of interactive peer-to-peer learning activities. In addition, interviews were conducted with coaches, who support the sites, to document key areas of learning regarding effective coaching. Days two and three consisted of site visits where participants observed on-site coaching during QI meetings. Days four and five consisted of reflection on the site visits, discussion about effective QI practices, and actions for knowledge sharing, along with the Lesotho team's presentation on what they had heard and learned, how they had processed this learning and how they planned to apply it.

Key Learning: Highlights

Key learning was harvested from exchange sessions, video interviews, one-on-one conversations, report-backs and individual evaluations. Four areas of key learning emerged and are summarized in the sections below: 1) Role of the Ministry of Health (MOH) and Implementing Partners (IPs), 2) Coaching and Engaging Teams, 3) Gathering and Using Data and 4) Tested Changes and Guidance.

Value of Exchange

The exchange enabled valuable direct peer-to-peer learning. Trust-building between all participants was fostered, and as a result, representatives from both countries' ministries were transparent about their gaps, experiences and areas that need improvement, leading to a deeper exchange that often is not possible during large multi-country meetings. The direct sharing of knowledge and experiences by the ministry staff was noted as highly valuable, as was the knowledge shared from supporting partners. The content shared during this visit will provide the remaining PHFS teams with 1) emphasis on maintaining data quality through creating standards around data tracking, collection, and sharing, 2) evidence-based change ideas that they can adapt and test, 3) ways to enhance QI capacity building and 4) a glimpse of how scale-up and spread can be achieved.

Recommendations for Future Exchanges

Participants noted three main recommendations for others to consider when planning similar knowledge exchanges: 1) Allow ample time for planning, preparation, permissions and advanced set-up 2) Be thoughtful and plan in advance for who is participating and how best they can contribute, and 3) Craft the agenda to mix up learning techniques, ensure two-way learning and provide time to map out plans to share what they are learning more widely.

I. BACKGROUND

The Partnership for HIV-Free Survival (PHFS) is a six-country (Kenya, Lesotho, Mozambique, South Africa, Tanzania and Uganda) initiative, conceived by the World Health Organization (WHO) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) to assist the countries with their current national efforts to improve PMTCT, maternal, and infant care and nutrition support through effective implementation of the WHO 2013 Consolidated Guidelines on The Use of Antiretroviral Drugs for Treating & Preventing HIV Infection using quality improvement (QI) and collaborative learning methods. The initiative focuses on ante- and postnatal care and nutrition of mothers and infants in high HIV-burden countries with the ultimate goal of increasing HIV-free survival. The four steps of focus in the care cascade are retention of mother-baby pairs in care; ensuring all mother-baby pairs receive all recommended services including nutrition assessment, counselling and support; mother-baby pair HIV status is known; and optimal antiretroviral (ARV) coverage for the mother-baby pair.

As part of the PHFS, knowledge exchange visits have been arranged to share effective implementation strategies/practices between country teams and programmatic challenges and how they are overcome. Organized by the USAID-funded Applying Science to Strengthen and Improve Systems (ASSIST) Project, this knowledge exchange was held between PHFS participating country representatives from the Ministry of Health (MoH), district and site levels from Uganda and Lesotho. The exchange took place February 9–12, 2015 in Uganda. The visit was also a catalyst to identify lessons and action steps for upcoming exchange visits between other participating PHFS countries and to identify and teach country teams methods that could be used during their in-country peer learning sessions.

At the time of the exchange, the two country teams were at different implementation phases/timelines. The Lesotho team had had one learning session in November 2013 with quarterly coaching visits by central coaches and monthly visits by district coaches. The Uganda team had had five learning sessions spanning from 2013 to 2014. Their last session focused on spread—sharing the learning and spreading it widely by adding new sites. Given Uganda's advanced stage in project implementation progress and their significant achievements in results thus far (including reduction in mother-to-child transmission rate from 23.13% at baseline to average of 3.9% by January 2015), Lesotho team members came to Uganda to learn about project leadership at facility, district and central office levels to help them learn key insights for accelerating progress and moving their work forward. The learning exchange, while still two-way, was heavily geared towards the Lesotho team as the primary learning team.

Planning

Planning for the exchange started approximately two months prior to the exchange. Each team's learning needs were solicited in advance which was consolidated into an agenda. The US-based PHFS team worked the Lesotho and Uganda teams to develop the agenda, plan the logistics, and discuss technical content in a series of four phone-based meetings. Given the advanced progress made by the Uganda PHFS team, having undergone substantial knowledge harvesting and formulation of tested changes and guidance, all teams agreed that Uganda should be the venue for the exchange. As the Lesotho PHFS team was in early stages of their implementation journey and seeking to learn how other countries approached implementation of the work and QI processes, they were prime to serve as the visiting country team. The Uganda PHFS team arranged all logistics associated with the exchange: accommodation for 13 participants from Lesotho and the three facilitators in Kampala and at the site level, arrangements with their MOH and district health counterparts for site visits, ensuring participation of local implementing partners (IPs), and developing the content of the sessions in

the exchange. The Lesotho PHFS team ensured participation of its MOH counterparts along with consolidating its learning during the sessions and site visits into strategic planning toward improving PHFS implementation in Lesotho.

A dynamic, mixed-method agenda was designed to apply specific, well-tested knowledge management/exchange principles and practices with heavy emphasis on addressing the learning needs articulated by Lesotho's PHFS team. The agenda was created to provide ample opportunities for knowledge exchange and shared learning. Refer to **Appendix A** for a high-level agenda. A brief description and overview of each day's exchange activities are provided below. Specific technical details of activities can be found in **Appendix B**.

II. KEY LEARNING: HIGHLIGHTS

A tremendous amount of learning took place over the week, related not only to technical content but also to leadership, work processes and roles. Key takeaways, insights, ideas and greatest lessons learned were harvested and culled from exchange sessions, video interviews, one-on-one conversations, report-backs and at the end of the exchange via individual evaluations. Four areas of key learning emerged and are summarized in the sections below: *Roles of the Ministry of Health and Implementing Partners, Coaching and Engaging Teams, Gathering and Using Data, and Tested Changes and Guidance.*

Roles of the Ministry of Health and Implementing Partners

Roles of MoH

- To take sole leadership and mandate of the implementation of the PHFS initiative
- To coordinate activities of different implementing partners and hold them accountable
- To endorse the lessons learnt (successes) throughout the duration of implementing PHFS, e.g., "The tested changes and guidance"
- To provide technical support
- To provide guideline protocols and policies
- To create an enabling environment
- To mobilize resources, especially human resources

Roles of Implementing Partners

- To complement the efforts of MoH by funding the activities
- To follow MoH guidelines and policies
- To support the MoH team to collect data, share and utilize the data for introducing changes for improvement
- To organize and participate in joint coaching visits

Team members were engaged in a "talk show" activity, which featured the MoH regional and district coaches in an attempt to help the Lesotho team understand their day-to-day roles as improvement coaches. A "talk show" is a facilitation technique where an interviewer can draw out catalysts for learning in a more conversational way.



Mapelaelo Maseli of the Lesotho team reflects on what she learned at the knowledge exchange in a video interview. <https://vimeo.com/123231179>

During the “talk show,” which featured extensive question and answer time with MoH and District Health staff members, the following Q&A provided insights on the role of the MoH and IPs:

Question: *It is a challenge to implement different packages (PMTCT, nutrition, QI) - how do you do it? For example, in Lesotho, PHFS belongs to EGPAF and health workers do not have time for MOH & district staff.*

Uganda MoH response: *The MoH MUST LEAD! It must be a government-led program. Both regional and district must speak as MoH. All trainings need to be opened by the MoH, it can be a regional or district person but must be speaking as the MoH staff. IPs are there only to help us implement on behalf of the MoH.*

Question: *How do you bring IPs on board and continue to consistently engage over time?*

Uganda MOH response: *If a partner withdraws from PHFS, then they withdraw from the MoH. The IP role is to support the MoH. Performance measures help to motivate. At every meeting, Uganda reviews performance of each site, and partners want to show improvement. They have an IP scorecard. It is important to have funders of IPs on the PHFS steering committee.*

Question: *What did Uganda do to reach their current level of commitment and buy-in from senior leadership?*

Uganda District Health response: *We harmonized priorities for both MoH and IPs. IPs cannot conduct or communicate any activities with facilities without the district MoH authorization. If they try, they are sent back from the facilities. Districts are mandated to operate budgets and activities according to their plans, and the central MoH office is not involved. The MoH mandated districts to include PHFS activities in the plans and this is what we did.*

District Work Plan

Country teams may have to seek approval each time from senior leaders (e.g., Director General of Health) for each individual PHFS activity; this is time consuming and can create bottlenecks. Create a district plan at the very start that lays out all of the activities anticipated and seek one-time blanket approval for all activities; consider also seeking blanket approval for sharing data for learning across countries as well.

Coaching and Engaging Teams

To assist the Lesotho team to understand how regional and district coaches perform their duties in Uganda, two regional and one district coach from Uganda’s MoH along with USAID ASSIST Uganda staff shared the following:

What are the roles of a coach?

- Facilitates QI capacity building in the districts and region
- Facilitator and enabler of QI initiatives at facility level; coaches and mentors facility QI teams on implementation of QI methodology
- Coaches keep in touch with the facilities on a regular basis and not only during the coaching visits
- Monitors team dynamics and responds accordingly
- Prepares for the QI coaching visit two weeks before visit (informs facility and agrees on the date of visit, prepares agenda for the visit and makes sure that data for previous month is available to track progress)
- Supports spread sites with QI implementation at sites
- The district coaches support other members of the district health management team who are also QI coaches to spread QI initiatives on to other facilities

How do you ensure QI teams are functional?

- Ensure regular monthly meetings, monthly filed minutes, monthly action plans with designated responsible person, clear objectives and goals for each member
- Ensure team understands indicators (how to collect, analyze and interpret), updates run charts and generates ideas to be tested for improvement on any gaps identified
- Ensure active participation as each member is assigned activities in the month; the team should also have another mini-team that meets regularly, i.e., twice a week when testing changes

What tools are used during a QI coaching visit?

- A QI documentation journal, which includes objectives of the QI project, indicators being tracked, gaps identified, changes being tested, run charts and remarks
- A coaching guide which summarizes all that the team and coach do; it also has standard operating procedures to guide the coach during the visit
- Data tools to be able to review current performance before visit
- Cause and effect tools: fishbone, 5 Whys flow charts and other QI tools

What are some of the successes and results you have seen?

- Being above 90% for all facilities in retaining mother-baby pairs
- 75% of the indicators are performing above 80%
- Facility administration is now interested in QI through engaging them regularly, calling them for meetings

What barriers were faced and how did you overcome them?

- Facility staff initially had poor attitudes and perceived QI initiatives as additional work, which led to resistance (demonstration sites and spread sites). We engaged the facilities in learning sessions and ongoing coaching and were able to create a shared understanding of the importance of improving services through tracking of data and testing changes. We also engaged other stakeholders including the leadership from District Health Officer (DHO) and shared emerging data with good results.
- We have busy facilities where QI team members are unable to participate in the coaching session. We are flexible, and we assist with patient consultations and clear the lines. We focus on data tools to give the staff time to finish consultations, get specific time allocation from the facility, e.g., afternoon hours, and we also start with a few number of QI activities and move gradually with them.
- Data collection was initially a barrier and time consuming as it was done during the visit. Currently data collection is done by QI teams and is available during visits.
- Usage of too many registers was a barrier; we educated the teams on the importance of proper documentation. Now they assign one member to fill all data tools per day as well as assign one member to check all tools and give feedback to everyone who was involved with data collection in a timely way so that they can correct any errors arising; we also encourage everyone to update all data tools before the mother leaves the facility.

Tenets of Good Coaching

- Have patience as a coach
- Make coaching visits regularly (ideally, monthly)
- Understand QI methods and tools
- Maintain frequent communication with all stakeholders
- Understand the distinction between coaching and supervision

How to motivate the QI teams?

- Giving positive feedback during coaching visits
- Encouraging them to maintain good performance and thanking them for good work
- Appreciating them for identifying gaps and generating solutions to be tested
- Supporting them with resources required and sometimes linking facilities for resource sharing
- Acknowledging lower cadre staff who are doing great work during QI meetings and learning sessions
- Use of data to showcase good performance in meetings and learning sessions; also, sharing early achievements to encourage a facility
- Money has never been used as a motivator and is discouraged by the MoH

How to sustain the work that has been done in all these facilities?

- DHOs have integrated PHFS activities into their Primary Healthcare budgets. This means that in the absence of the implementing partners we will be able to continue with the activities.
- District coaches are coaching fellow coaches who are now spreading QI initiatives to spread sites. This has included teaching them QI concepts and having joint visits.
- We have also discarded supervision visits and embraced coaching and mentorship as a methodology during site visits.
- QI capacity building of all members of the district management team
- Key roles within the QI teams are rotated every few months to ensure everyone on the team takes ownership and leadership, to avoid dependency on one team member and to ensure all are able to report about the activities, even if the current QI leader is unavailable. This has assisted the facilities to hold the gains and sustain improvement, especially given high staff attrition.

Thoughts on leadership and team member roles?

- Low-ranking team leaders are advantageous as they are always present (Senior leaders have a lot of commitments)
- Choose leaders and team members based on their participation and not on their titles at the facility (ensuring members discuss all perspectives, especially considering those not represented on the team)
- There should be regular rotation of roles and responsibilities of the team so that all members learn what work is done for different positions

What was key advice from coaches?

- Take time to build your teams—a well-built team is very effective
- Always have supporting documentation and tools available
- Don't overpromise facilities but always do what you said you will do
- Always prepare for your site visits and go on agreed days and times
- Guide teams to have clear roles and responsibilities among the team members and to have a team leader to guide the team
- Guide teams to implement simple, easy-to-apply changes and not complicated changes
- Always have a brief discussion with the QI team leader before the QI coaching session

What has been the USAID ASSIST experience working with the MoH coaches?

- Maintain regular contact with the coaches through email and phone calls
- Regularly update the coaching guide for the coaches to meet their requirements

- Selection of coaches is an important step in getting good results. Select those with technical skills and those that have interest and time to do the work (leadership provides them with time); you then build up their QI knowledge and skills
- Carry out some joint coaching visits with the coaches to transfer skills; initial side-by-side visits are crucial to build coaching skills
- Hold quarterly coaches meetings after every learning session
- Facilitate the coaching visit logistics
- Coaches should provide the facilities with a report after coaching visits
- Give coaches the opportunity to facilitate at learning sessions
- It is recommended to change non-performing coaches (i.e., if coaches are not carrying out their role, do not keep them in this role)
- Start with a few coaches and identify others during implementation at facilities

During open-ended question and answer time with MoH and district health staff members, the following Q&A provided additional insights on coaching:

Question: *Tell us about the role of coaches and coaching visits, how often, who are the coaches?*

Uganda MoH response: *Teams of district coaches go to facilities to mentor, build confidence and help implement. Coaching takes time and is very different than supportive supervision. During supervision, MoH staff look at adherence to policies, the environment and use a checklist. Coaches are trained in QI; they are integral to our improvement and results. We have regional and district coaches. Regional coaches are the most skilled in QI and supervise and support the district coaches. Choose coaches that are interested and who understand the technical issues and improvement. And they must be given the time to coach. We often bring together our coaches after coaching visits to share experiences and learn from each other. Coaching can be hard and get a lot of push back from facility staff so they need mentoring and support.*

Gathering and Using Data

A lot of discussion throughout the exchange focused on data. The Lesotho team was extensively briefed by the Uganda team about how QI teams can use data to monitor and identify gaps and track progress at facility level, formulating the following “how-to” steps for data gathering and use:

- Understand the objective of the QI team: establish facility and district targets to know what it is you want to achieve
- Agree and know the sources of data you will track
- Review indicators, having clear definitions of the numerator and denominator to know what is being measured and why it’s being collected
- Agree to monthly data collection, analysis and interpretation to regularly discuss data for improvement
- Track data and progress on official tools - use simple data collection tools to document data properly (e.g., make simple run charts on paper, use paper QI journal)
- Calculate percentage of actual performance as a team and identify any gaps between actual and targeted performance
- Identify and test changes to improve those indicators that are not doing well

Data’s Critical Role in QI

- Data can be used to help engage authorities: use data as evidence to gain buy-in
- Engaging clinic staff in interpreting and using their own data builds ownership of the work
- Data quality is also critical; IPs need to work with facilities to improve data quality and key indicators

- Continuous testing of new changes using improvement cycles (plan-do-study-act cycles)

During open-ended question and answer time with national and district MOH staff, the following Q&A provided insights on gathering and using data:

Question: *There are still too many reporting tools in Uganda as there are in Lesotho. How have you managed to make facilities collect the data?*

Uganda District Health response: *Your facilities in Lesotho collect the data for you. When they learn that they are collecting it for their use to improve services in their facilities, they will collect it happily. Ongoing coaching, mentorship and use of dashboards have assisted our facilities to understand that. We also have specific individuals responsible for data accountability, and they get support from the DHO and IPs. Learning sessions have also assisted facilities as they analyze and interpret data during the sessions. Data validation is done at facility level before being sent to the district and central offices.*

Tested Changes and Guidance from Uganda

The ASSIST Uganda team had compiled lists of evidence-based changes (i.e., changes that had been shown to yield improvement) that the 22 PHFS demonstration sites had tested to improve data quality, retention of mother-baby pairs and routine visit care. These tested changes and guidance were developed through a consultative process with quality improvement teams. Documentation on the changes tested and guidance on how to implement them are used to inform new facilities. Key discussion around developing, using and revising a document containing tested changes and guidance captured the following ideas:

Developing a document of tested changes and guidance

When working at the clinic level, the facility teams document the changes they are working on using a QI documentation journal. Teams are encouraged to try one change at a time and measure its impact. Once significant progress has been made to test and implement changes, a specially designated harvest meeting is held. Teams bring their data and QI documentation journals to this harvest meeting to show what they have been doing. During the meeting, teams are given time to provide a description of how each change was carried out and answer: who, what, how, and when the change was done and what resources were needed. Teams share data to show that a specific change has led to improvement. After the description and evidence are shared, all of the changes are ranked based on simplicity, scalability, evidence, and relative importance. Changes with a higher ranking are changes that new sites might want to consider first. The ASSIST Uganda team has organized tested changes and guidance around improvement aims—that is, tested changes that worked to improve each improvement aim.

Using and revising the tested changes and guidance

Once a set of proven changes is created, teams should review the concept behind the change to understand broadly what areas need to be improved. For example, to improve data quality, sites need to work on improving staff skills—this is the change concept. The details of how to improve staff skills are the specific change ideas. As sites start to implement changes from the package, it is important for these sites to study their specific situation, to see what works for their settings. This is an ongoing process based on the teams continuing to work and test new change ideas. Naturally, some changes will require adaptation. Additionally, there are also some change ideas that show improvement in data at the start, but in the long run progress declines, therefore this should be noted in the tested changes and guidance document.

Ministry of Health role

The tested changes and guidance informs the MoH about what has worked; this information is

used as a guide to inform the policy making process and what the MoH should roll out for an entire country. The MoH can then provide recommendations to other facilities on what should be implemented and endorse the content of the tested changes and guidance to ensure it is adopted widely.

Tested Changes and Guidance Documents

Since starting their implementation of PHFS, the ASSIST Uganda team has developed documents that summarize tested changes and guidance for improving PMTCT care and services in three key areas. Teams may not necessarily replicate these change ideas; rather, they should adapt them to suit their clinics. Below are links to the three documents developed by ASSIST Uganda based on learnings from the PHFS activities:

- Improving Completeness and Accuracy of Data: <https://www.usaidassist.org/resources/improving-completeness-and-accuracy-data-elimination-mother-child-transmission-hiv-tested>
- Improving Quality of Services Provided for HIV-positive Mothers and Their Babies at Routine Visits: <https://www.usaidassist.org/resources/improving-quality-services-provided-hiv-positive-mothers-and-their-babies-routine-visits>
- Improving Retention of Mother-Baby Pairs: <https://www.usaidassist.org/resources/improving-retention-mother-baby-pairs-tested-changes-and-guidance-uganda>

Way Forward

Lesotho articulated that their way forward would include more targeted involvement of senior leadership, ongoing and regular learning sessions, having an amended work plan with all timelines which can be signed once by the Director General (DG) of Health (the DG has to approve every training that is done outside facilities, a challenge for getting individual authorization for the numerous individual activities), and ongoing mentorship and coaching by well-informed and skilled MoH coaches. Successful practices that were noted from Uganda to be adapted by Lesotho included the following:

- Involving/engaging central office (MoH)
- Ensuring increased mentoring skills of district coaches (facilitation, mentoring, informal interaction between coach and team) as well as enhancing technical skills
- Ownership of QI initiatives by facility team
- Holding QI meetings after clinic days to monitor tested changes and document any emerging patterns
- Improving usage of QI documentation journal
- Increasing capacity for data management within facilities
- Setting up or strengthening the data system so that correct data reaches the national level (through capacitating M&E point person in facility)
- Ensuring a continuous data flow and feedback loop - data should flow from the facility to national level and vice-versa (feedback from national back down to facility level staff)
- Use of dashboard (increase its use and increase capacity to use it)

Additionally, one Lesotho team member noted the exchange provided clarity in what his/her role should be in the overall PHFS program, also citing how much work needs to be done in their home country.

Defining Team Roles

Rotate the focal/lead person on the QI team to make sure that there is no dependency on one individual and for continuity of QI activities.

III. OVERVIEW OF EXCHANGE: VALUE

Methods

The methods used during this peer exchange created space for open, mixed discussions, small-group brainstorming, building on each other's ideas, and direct observation of work processes and improvement practices (coaching, QI team meeting facilitation and methods for data tracking) and built in ample time to have Ministry and implementing partners address questions that came up across the week pertinent to their different roles and responsibilities. One participant noted that: *The rotation of sessions brought insight to the problems we have and the solutions to consider.*

Feedback gathered at the end of the exchange from participants showed that these multiple, mixed methods of knowledge exchange used **all** proved beneficial for enhanced learning. Methods allowed time for individuals to process what they were learning and created ease in extracting insights and ideas from both teams and all participants as individuals (not just a few dominant voices). Methods used also ensured that cross-team "pollination" of ideas occurred, allowing new knowledge to be created together by mixing up discussion groups and topics. Ideas were expanded, added to and analyzed together. Teams were given time to regroup at the end to create an immediate space to formalize ideas to apply the learning into their work on the ground.

Participant feedback on the most helpful activities/discussions for taking their work forward included the following:

- *Now I realize that QI data is results-based and can be attained at the facility level where staff can implement their own changes.*
- *Site visit was the most helpful activity as I was able to see and go through all registers, and see good documentation of data and flow charts.*
- *The presentation by Lesotho team helped us see what they had not understood and correct that.*
- *Talk show; site visits; and group discussions were helpful in understanding what was done in Uganda.*

Noted Value to Teams

The knowledge exchange was a valuable opportunity to promote peer-to-peer learning, something all PHFS country teams noted they wanted opportunities for across the initiative. Since both groups had already started to build relationships previously, open and honest sharing took place. Further trust building between all participants was fostered, and as a result, representatives from both countries' ministries were transparent about their gaps, experiences and areas that need improvement, leading to a deeper exchange that often is not possible during large multi-country meetings. The direct sharing of knowledge and experiences by the ministry staff was noted as highly valuable, as was the knowledge shared from supporting partners, such as ASSIST. Participants noted their appreciation for the transparency and honest sharing that took place.

Both teams noted the exchange was extremely valuable on many levels. Overall, the Lesotho team noted they were inspired to reflect, re-evaluate, identify gaps that were hindering implementation and improve the planning of their work. They learned how to help gain facility buy-in. For example, the Lesotho team quickly learned that facilities will only see the value of this work if learning sessions are taking place regularly and consistently, as this forum fosters

group learning and sharing. They also gained further understanding about how improvement needs ongoing coaching and mentorship of a team and about the importance of using data.

The Uganda team was able to gain appreciation of the progress and great work that districts, implementing partners, facilities and the communities are doing to achieve the results that they have gained thus far. Being able to see their progress through the eyes of others, as one participant noted, provided reward and recognition for the Uganda MoH and the ASSIST team.

Participants, when asked how this exchange visit had been most valuable, noted the following:

- *It has been clear that focusing on improvement aims and not taking for granted each step taken in providing services can improve services and outcomes within shorter times.*
- *Made me realize that it takes a positive attitude and determination to implement change; only small elements of change can bring about positive results that inform the greatest of policy decision making.*
- *Senior leadership has to be engaged at all levels and be able to speak about the PHFS project to facility staff; this will assist facilities to know that it's not an implementing partner's project.*

Additional value-added of the visit specific to facility level work noted by participants included the opportunity to acquire coaching skills through observation, learning how to identify mothers and babies who have to be in care, developing better know-how about how a QI documentation journal is used and learning how various registers are managed to ensure that data are accurate and complete for each improvement aim. One participant noted that the site visits allowed their team to see the high level of knowledge coaches have regarding QI and witness the high functionality (and engagement) of the facility QI teams.

Anticipated Value to PHFS At-large

This type of visit contributes to the PHFS global learning goal as the above-mentioned lessons and shared content offer insights for all teams to learn from at any stage. The visit created space for rapid extraction of quantitative and qualitative data for learning, identified successful changes to processes being tested and allowed individuals to reflect together on progress, barriers and ideas for forward movement. Joint learning accelerates progress toward team aims as teams come away not only with a host of ideas and insights related to technical content but also feeling supported, proud of accomplishments to date, having a renewed sense of commitment and a host of ideas and plans to forward strategy and implementation. As one participant noted: *Sharing experiences is very motivating and should be done more often!* Already, immediately after this exchange visit, the Lesotho team held a four-day retreat to share their learning with team members not present and to better plan and coordinate the PHFS activities. The content shared during this visit will provide the remaining teams with 1) how to maintain data quality through creating standards around data tracking, collection, and sharing, 2) evidence-based change ideas that they can adapt and test, 3) ways to enhance QI capacity building and 4) a glimpse of how scale-up and spread can be achieved.

Additionally, all PHFS country teams can use this type of exchange format not only cross-country but also in-country to maximize peer-to-peer exchanges within their own teams. One participant noted: *I will use the exchange visit format between demonstration and spread sites in Uganda so teams are able to share and motivate each other and further MoH engagement.* Another noted that: *As a knowledge management person, it has shown me the benefit of a knowledge exchange visit.* Another team member noted that they now felt equipped to run this type of exchange.

IV. RECOMMENDATIONS FOR FUTURE EXCHANGES

As teams think about hosting other cross-country or in-country knowledge exchanges, the following suggestions could be kept in mind. These are based on what worked (or didn't) from feedback from facilitators and participants.

1) Allow ample time for planning, preparation, permissions and advanced set-up

Six to eight weeks should be allowed for planning and preparation of the visit from arranging venue and accommodations with the host country to arranging travel and technical preparation with the visiting country. Invitations for the exchange visit for both MoH staff and IPs should come directly from the MoH to ensure ownership and accountability rests with the MoH. Sending invitations to implementing partners six to eight weeks in advance will allow them to arrange schedules to ensure participation. The host country team must facilitate making arrangements with the USAID Mission (if USAID-funded), Ministry of Health or any national health authority, district health offices, and participating facilities who are receiving technical assistance. Costs that need to be considered in conducting a knowledge exchange include: international and local travel, per diem, venue rental (if appropriate), and labor costs for organizers.

2) Be thoughtful and forward plan for who is participating and how best they can contribute

It is important to ensure site-level members are part of the delegation from the visiting team, allowing those directly implementing the work to learn first-hand. And, if possible, have facility QI team members from the host site be part of off-site classroom discussions (in addition to site visit participation). Prior to the meeting/visit itself, have team members identify and share with facilitators what it is they want to learn so the content/agenda will match learning needs as best as possible. Also ensure time is set aside for teaching about topics that arise during the exchange; be flexible to adjust sessions. Keep in mind that the larger the group, the less chance all voices will be heard - split large groups into smaller separate teams for concurrent site visits and for small group discussions in the classroom setting to encourage more individual participation. Ensure ample time to allow participants to get to know each other and feel comfortable with each other before expecting they will share insights.

3) Craft the agenda to mix up learning techniques, ensure two-way learning and provide time for participants to map out plans to share what they are learning more widely

Follow the classroom/site visits/classroom sequence as noted in this exchange agenda so site visits are "sandwiched" in between classroom time to break up long days in a classroom setting. Ensure ample time for both the host and the visitor to share their experiences and learn from each other. And, ensure exchange teams have time to map out plans for sharing what they have learned with those team members not present and how they will share their insights with other countries.

Additional Resources

Additional resources from the exchange visit, including presentation slides, detailed agenda, and video interviews are available on the USAID ASSIST knowledge portal:
<https://www.usaidassist.org/resources/lesotho-uganda-knowledge-exchange-partnership-hiv-free-survival>.

V. APPENDICES

Appendix A: High-level Agenda

MONDAY, FEBRUARY 9

Time	Session Topic
Morning	Welcome, Introductions, and Briefing on the Agenda.
	Introduction to PHFS
	Understanding the PHFS Program (Knowledge Café Session)
Afternoon	Group 1: Meetings with the Uganda Ministry of Health (Nutrition and PMTCT Departments)
	Group 2: Coaches and Implementing Partners Talk Show Session

TUESDAY, FEBRUARY 10

Time	Session Topic
All Day	<u>Travel to Sites:</u> Travel to 3 sites in eastern Uganda (Buwenge, Bugembe and Mukujju Health Center IV)

WEDNESDAY, FEBRUARY 11

Time	Session Topic
All Day	<u>Site Visits and Travel:</u> Participants will observe a coaching visit and have a chance to interact with the site teams through an open Q&A session.

THURSDAY, FEBRUARY 12

Time	Session Topic
Morning	Large Group Debrief (with small group processing) and Review of Site Visits
Afternoon	Large Group Debrief and Review of Site Visits (continued)
	Lesotho Delegation Action Planning Meeting and Preparation for Delegation Presentation

FRIDAY, FEBRUARY 13

Date/time	Session Topic
Morning	Presentation from Lesotho Team
	Feedback and Response from Uganda Team
	Conclusions and Wrap-Up

Appendix B: Description of Knowledge-sharing Activities Used during the Exchange

Day One

Team building and “25-to-10” exercise:

Each participant wrote down their expectations for the knowledge exchange visit on a notecard. Each participant was then asked to pair with another participant and share the expectations they had written on the notecard. Each pair then graded the importance of each expectation on a scale from 1 to 5 and swapped the cards, bringing the partner’s notecard to the next round. This activity continued into three more rounds where participants continued to share notecards that they exchanged from the previous round. Once the activity finished, the participants shared the messages on the highest-graded cards.

PowerPoint presentations:

Time series data from pilot sites was shared and analyzed using run charts with annotations to depict when changes were made and how those changes may or may not have led to improvements in data. Uganda’s dashboard of progress was described, and Uganda team members enumerated the approaches, data elements and tested changes used to achieve results. Lesotho described their PHFS implementation journey, highlighting opportunities and challenges.

Knowledge Café:

During the activity, participants were assigned a table for initial discussion. Each table had a designated topic for discussion, with an assigned facilitator. After initial discussion time ended, participants rotated tables randomly to share learning on another topic and build on the discussion that was held at that table previously. Table conversations were held regarding the different roles played by the Ministry of Health and implementing partners, discussion on tested changes and guidance development and usage and the utilization of data to identify and monitor gaps.

Talk show:

The talk show involved two regional and one district coach from Uganda’s MoH as panelists who shared experiences in response to questions posed by an ASSIST staff member who served as the talk show host. The remaining team members were designated as “guests.” Two-way discussion ensued as guests were able to ask questions and hear immediate responses from the panelists. The talk show created a relaxed, conversational environment for sharing both insights and key challenges to overcome.

Video interviews:

Conducted with the coaches, questions ranged from on-boarding and retention of IPs to successes and barriers to the work. Video interviews were also used to capture insights from the Lesotho team representatives on multiple levels.

Days Two and Three

Site visits:

The whole group was split into three teams. Each team travelled to eastern Uganda for site visits at three 24-hour service centers (two sites in Jinja and one in Mbale) which offer comprehensive services, including theatre. The teams observed a coaching visit done by the district coach with the site QI team during their team meeting. Visitors had a chance to interact

and ask questions. At one of the site visits, a conversation was held with the local MoH leadership at the district office. The District Health Officer led the meeting.

Days Four and Five

Presentations and small-group debriefs:

Presentations included descriptions of the facility, the gaps identified, the improvement aims, the changes being tested, indicators being tracked (both process and outcome), use of QI documentation journals, roles of the coaches, frequency of QI team meetings and documentation. The presentations included photos (of the facilities, the area for mother-baby pair consultations, the staff, the documents, the flow charts, etc.) taken during the site visits with all relevant annotations/descriptions. The pictures illustrated quick stories to participants who visited a different facility. Later teams were divided into small, mixed groups to debrief and share their learnings from the site visits in which they participated. Following small-group debriefs, the entire team sat in a circle and summarized together. By the afternoon, the facilitators also had provided answers for the learning needs mentioned by the group.

Report-back:

The Lesotho team was given time to meet as a team and reflect on their week's learning and pull together their thoughts for a final report-back. They reviewed their objectives for the visit, individual problem statements, system gaps/opportunities and what each member of their team would do differently as a result. They concluded with their way forward and put some recommendations in place.

Time was then given for clarification of anything missing, not fully explained or understood and for any remaining questions to be addressed.

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